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# Cognitive-Behavioral Therapy for Depressed Girls: A Qualitative Analysis of the ACTION Program

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# Cognitive-Behavioral Therapy for Depressed Girls: A Qualitative Analysis of the ACTION Program

**by**

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# DEDICATION

This dissertation is dedicated to all of the amazing girls that participated in the ACTION program. Having the privilege to meet, work with, and know many of you over the past several years has been one of the best experiences in my life and, by far, the most rewarding aspect of my training.

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**Cognitive-Behavioral Therapy for Depressed Girls: A Qualitative Analysis of the ACTION Program**

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This study used a qualitative methodology to examine treatment outcome and mechanisms of change from the perspective of the participants in a group cognitive-behavioral therapy intervention for depressed girls (i.e., the ACTION program). Data were collected from seventeen participants using semi-structured interviews. Seventeen initial and seven follow-up interviews were conducted. Interviews were transcribed and analyzed using the grounded theory approach. A theoretical model emerged from the data that explained mechanisms of change in relation to treatment outcome and evaluation.

Prior to treatment, all participants were diagnosed with a depressive disorder. At post-treatment, approximately 88% of the sample no longer met criteria for depression. Thus, the ACTION program demonstrated a high rate of efficacy. Additionally, all of the participants described treatment as helpful. Level of helpfulness varied from high to low, with most participants rating treatment as very helpful, and depended on the ways in

which the intervention produced positive change in the following areas: stressors, stressor management strategies, emotions, cognitions, and social support.

Participants evidenced high levels of pre-treatment stressors, particularly in the interpersonal domain, and low levels of social support. Passive, emotion-focused strategies were used to manage these difficulties; however, they were largely ineffective. Not being able to resolve stressors successfully led participants to experience unpleasant emotions and negative ways of thinking. Together, these variables resulted in high levels depression prior to treatment.

At post-treatment, most participants experienced several positive changes, including decreased stressors, increased effectiveness of stressor management strategies, elevated mood, and a more positive outlook. These changes were attributed to the acquisition and application of the core treatment components by the majority of participants. Some participants also experienced an increase in social support, which was associated with characteristics of the treatment structure. Thus, the two most important variables in relation to treatment outcome and evaluation were specific mechanisms of change (i.e., treatment components) and non-specific therapeutic factors (i.e., treatment structure). In addition, treatment outcome was also influenced by participant characteristics. Participants that held unrealistic expectations, were not ready for change, or engaged in limited problem-sharing experienced fewer positive changes over the course of treatment.

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# CHAPTER ONE

# INTRODUCTION

Depression in children and adolescents is a growing problem with serious implications for emotional, social, behavioral, and academic functioning. There are numerous adverse outcomes associated with youth depression, including poor self-esteem, diminished physical health, dysfunctional family interactions, poor quality of attachment between caregiver and child, increased risk for substance abuse, peer difficulties, poor academic performance, school failure or drop-out, increased risk of detrimental personal health behaviors, and increased risk for suicide (Allgower, Wardle, & Steptoe, 2001; Brooks, Harris, Thrall, & Woods, 2002; Fleming & Offord, 1990; Fleming, Offord, & Boyle, 1989; Kovacs, Goldston, & Gatsonis, 1993; Levendosky, Okun, & Parker, 1995; Michael & Crowley, 2002; Rao, Weissman, Martin, & Hammond, 1993; Rudolph, Hammen, & Burge, 1994).

Research has shown that the prevalence of depressive disorders among children and adolescents is increasing while the age at which youth are becoming depressed is decreasing (Lewinsohn, Rohde, Seeley, & Fischer, 1993; Stark, Boswell-Sander, Yancy, Bronik, & Hoke, 2000). Thus, depression is becoming more prevalent in youth, and youngsters are developing the disorder at younger ages. Overall, depression is estimated to range from 0.4% to 8.3% in children and adolescents in the general population (Birmaher et al., 1996a; Fleming & Offord, 1990; Lewinsohn, Clarke, Seeley, & Rohde, 1994), with approximately 2% of children and 4% to 8% of adolescents meeting criteria for major depression [American Academy of Child and Adolescent Psychiatry (ACCAP), 1998]. While boys and girls tend to experience similar levels of depression in childhood, adolescent and adult females are twice as likely to experience the disorder as their male

peers (Nolen-Hoeksema & Girgus, 1994; Petersen et al., 1993; Wichstrom, 1999). In addition, some research has shown that adolescent girls experience more severe and longer episodes of depression as well as earlier recurrences than adolescent boys (Dunn & Goodyer, 2006; McCauley et al., 1993; Stark et al., 2000). Thus, beginning in adolescence, depression becomes a particularly salient problem for girls.

Depression in childhood and adolescence is characterized by a slow course of recovery, a high rate of relapse, and risk for recurrent episodes that extends into adulthood (AACAP, 1998; Birmaher, Arbelaez, & Brent, 2002; Dunn & Goodyer, 2006; Strober, Lampert, Schmidt, & Morrell, 1993). The presence of comorbid disorders appears to be the rule rather than the expectation in depressed youth (Birmaher et al., 1996a; Kovacs, 1996; Rao, 2006), and comorbidity can result in more severe impairment, increased suicide risk, diminished response to interventions designed solely for depression, and earlier recurrences (Dunn & Goodyer, 2006; Lewinsohn, Rohde, & Seeley, 1998).

Current interventions for youth depression include psychosocial interventions, such as cognitive-behavioral therapy (CBT), interpersonal therapy for adolescents (IPT-A), and family therapy, and psychopharmacological treatments (i.e., antidepressants). Of the available antidepressant medications, selective serotonin reuptake inhibitors (SSRIs) have shown the most promise in treating depressed youth (Emslie et al., 2002; March et al., 2004); however, psychosocial interventions continue to be considered the preferred, first-line approach due to safety concerns associated with SSRI use in children and adolescents (Courtney, 2004; Moreno, Roche, & Greenhill, 2006).

While some treatments have demonstrated promising results as potentially efficacious treatments for depressed youth such as IPT-A and family therapy, CBT continues to be the best supported psychosocial intervention (Kazdin & Weisz, 1998;

Stark et al., 2006). CBT has been shown to be superior to control conditions (e.g., Asarnow, Scott, & Mintz, 2002; Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999; Lewinsohn, Clarke, Hops, & Andrews, 1990; Reynolds & Coats, 1986; Stark, Reynolds, & Kaslow, 1987; Wood, Harrington, & Moore, 1996), to specific therapeutic techniques such as relaxation training (e.g., Wood et al., 1996), and to other treatment modalities such as family therapy, non-directive, supportive therapy (NST), and life skills training (e.g., Brent et al., 1997; Rohde, Clarke, Mace, Jorgensen, & Seeley, 2004).

Although CBT has demonstrated significant efficacy in studies of depressed youth, particularly with adolescents, it is not without limitations. A few studies have shown that no treatment (Liddle & Spence, 1990), relaxation training (Kahn, Kehle, Jenson, & Clark, 1990; Reynolds & Coats, 1986), treatment as usual (Clarke et al., 2002), IPT-A (Rossello & Bernal, 1999), and SSRIs (March et al., 2004) have equal or greater treatment effects than CBT. However, limitations associated with many of these studies, which are significant in some instances, restrict the usefulness and reliability of some of these findings. Overall, CBT has demonstrated an impressive track record as an efficacious intervention, earning it recognition as an evidenced-based treatment for depressed youth (Kazdin & Weisz, 2003).

Current CBT interventions for children and adolescents are based on an integration of environmental, behavioral, and cognitive models of depression. These interventions tend to incorporate multiple treatment components in an effort to increase efficacy and improve outcomes for participants; however, combining treatment techniques does not necessarily serve this purpose (Kazdin & Marciano, 1998). In fact, researchers suggest that it is best to understand how individual treatment components contribute to therapeutic change rather than creating multifaceted interventions that produce results in unknown ways (Kazdin & Marciano, 1998).

The research intervention explored in this study, the ACTION program (Stark et al., 2004a), is an example of a comprehensive treatment package that combines numerous components such as coping skills training, problem-solving, cognitive restructuring, affective education, self-monitoring, and therapeutic homework. The ACTION program is a group CBT intervention for depressed girls in the 4th through 7th grades. Preliminary results suggest that the treatment is improving participant depression at high rates (K. D. Stark, personal communication, June 22, 2007); however, why and how the intervention is achieving its promising results is not understood. Furthermore, it is not clear if the participants understand, enjoy, apply, and find the various treatment components that comprise the intervention helpful.

The ACTION program is not the only CBT intervention for depressed youth that produces positive change in ways that are not clearly understood. A common challenge with CBT interventions for depressed youth, and with all other psychosocial interventions for that matter, is that the mechanisms of change are rarely studied and, therefore, not well delineated (Kazdin, 2002; Kazdin & Nock, 2003). Thus, researchers know that CBT works, but they do not know how or why it works. Determining the specific (e.g., treatment components) and non-specific factors (e.g., client characteristics, therapeutic relationship) that contribute to treatment outcome is an important area of research.

Another problem associated with CBT interventions for depressed youth is that, while many studies have examined and supported their efficacy in research settings, very few studies have demonstrated their effectiveness in non-research situations. Therefore, it is not clear if CBT can be utilized with the same degree of effectiveness in settings in which time and resources are more limited and degree of impairment may be more severe (Kazdin & Nock, 2003). Since transporting CBT interventions from ideal to real settings is an important goal, it is imperative that treatments demonstrate the highest degree of

efficacy possible with the most streamlined designs. CBT interventions that utilize multiple components, therefore, will need to begin exploring and justifying the utility of each component as well as discarding components that do not prove to be useful in reducing depressive symptoms. Thus, only the components that are necessary and sufficient for change should remain in CBT treatment packages. Preliminary studies have begun to explore the effects of different treatment components in CBT interventions for depressed youth (e.g., Feehan & Vostanis, 1996; Kaufman, Rohde, Seeley, Clarke, & Stice, 2005); however, much more research is needed in this area.

Finally, almost all CBT treatment outcome studies for depressed youth to date have failed to gather data regarding the experience of treatment from the perspective of the participants. It is important to obtain this information since it is assumed, but not verified, that children and adolescents comprehend, use, and benefit from the various treatment components that are included in CBT treatment packages. Additionally, giving the participants a voice informs researchers as to which aspects of treatment deserve further investigation and sets the stage for new theoretical developments. By giving participants the opportunity to describe variables that influenced change from their perspective, researchers can begin to understand the most important factors, specific and non-specific, associated with treatment outcome. This knowledge can contribute to the development of more efficacious treatments.

The goal of the present research effort was to give the ACTION program participants a voice. Specifically, through the use of a qualitative research design, participants that completed this intervention were given the opportunity to express their thoughts, feelings, and opinions about the ACTION program, with specific attention being paid to how the treatment did or did not produce positive change. Semi-structured interviews were conducted with former participants and the grounded theory approach of

qualitative research was used to analyze the data. Seventeen initial interviews were completed. Additionally, seven participants were asked to complete more comprehensive, follow-up interviews after the initial data collection phase. All interviews were transcribed and coded for themes relating to different aspects of treatment outcome. It was anticipated that a theory would emerge from the data that would elucidate the mechanisms of change in the ACTION program as well as guide future research of CBT interventions for depressed children and adolescents.

# CHAPTER TWO

# REVIEW OF THE LITERATURE

This chapter begins with an overview of depression in children and adolescents, reviewing information regarding diagnostic criteria, prevalence, course, comorbidity, gender differences, risk factors, negative outcomes associated with the disorder, and current treatments. In order to provide a framework for understanding the components that are included in current CBT interventions, the following section reviews the different theoretical models that have been used to conceptualize depression in children and adolescents. This discussion is followed by a review of the characteristics and components of CBT interventions for depressed youth, with a detailed description of the specific intervention that will be studied in this research effort: The ACTION program. The next section of this chapter provides a focused discussion of efficacy studies of CBT treatments for depressed youth. Finally, current issues related to CBT interventions are discussed as a means of providing the groundwork for the current investigation.

## Depression in Youth

### *Characteristics and Diagnostic Criteria*

Until recently, depression was thought to be a rare condition in youth with unique characteristics from adult manifestations of the disorder (Rush & Nowels, 1994); however, depressive symptoms (i.e., irritability, sleep disturbance, sadness, fatigue, eating problems) have been observed in infants (Garber & Horowitz, 2002) and depressive syndromes have been documented in children and adolescents in countless studies (see Birmaher et al., 1996a; Birmaher, Ryan, Williamson, Brent, & Kaufman, 1996b for reviews). Thus, among clinicians and researchers, there is now consensus that

youngsters do experience depression and can receive diagnoses of depressive disorders (Garber & Horowitz, 2002). In fact, studies have revealed that adolescent depression is a significant problem that is now generally considered to be on a continuum with adult depression rather than a distinctly different disorder (Emslie & Weinberg, 1994; McCauley et al., 1993; Rush & Nowels, 1994).

According to the current version of the Diagnostic and Statistical Manual of Mental Disorder – Text Revision (DSM-IV-TR), there are three primary diagnoses for unipolar depression in children and adolescents: Major Depressive Disorder (MDD), Dysthymic Disorder (DD), and Depressive Disorder Not Otherwise Specified (DDNOS) (American Psychiatric Association [APA], 2000). To meet criteria for a diagnosis of MDD, a youngster must experience a depressed or irritable mood and/or lack of interest or pleasure in nearly all activities for a period of at least two weeks. In addition, at least four of the following symptoms must also be present: significant weight loss or weight gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness or extreme guilt, impaired concentration, or recurrent thoughts of death or suicidal ideation. Youth with DD evidence a chronically depressed or irritable mood that is accompanied by at least two of the following symptoms: increased or decreased appetite, insomnia or hypersomnia, fatigue, low self-esteem, difficulty concentrating or making decisions, or feelings of hopelessness. To meet criteria for this diagnosis, a child or adolescent must experience these symptoms for at least one year with no more than a two month period in which symptoms are not present. DDNOS is a category of unipolar depression used to classify youth that meet some, but not all of the diagnostic criteria for MDD or DD. This category includes minor depressive episodes, recurrent brief depression, and non-primary depression.

In summary, unipolar depression in children and adolescents presents in three forms: MDD, DD, and DDNOS. There are slight differences in the criteria for adult and youth depression. For example, in youngsters, mood can be characterized as sad or irritable. Also, when diagnosing MDD in youth, failure to make expected weight gains can be replaced with the adult criteria of significant weight loss or weight gain. Finally, children and adolescents do not have to experience symptoms for as long as adults to meet the criteria for certain depressive disorders such as DD. For the full diagnostic criteria for MDD, DD, and DDNOS, please refer to Appendix A.

### *Prevalence*

The rate of depressive disorders among children and adolescents is growing while the age at which youth become depressed is falling (Lewinsohn et al., 1993; Stark et al., 2000). Retrospective reports from adults have found that approximately 25% experienced their first episode of depression before the age of 18 (Sorenson, Rutter, & Aneshensel, 1991). Research on prevalence rates of depression in youth has revealed large discrepancies due to differences in age groups studied, methods of assessing depression, and criteria used for diagnosing the disorder (Birmaher et al., 1996a, b; Emslie & Weinberg, 1994; Poznanski & Mokros, 1994). Overall, the estimated point prevalence rates of major depression ranges from 0.4% to 2.5% in children and from 0.4% to 8.3% in adolescents in the general population (Birmaher et al., 1996a; Fleming & Offord, 1990; Lewinsohn et al., 1994). Prevalence rates increase significantly in clinical populations, with approximately 50% to 60% of psychiatric inpatient youth (Emslie & Weinberg, 1994) and 43% of adolescent outpatients (Asarnow et al., 2005) presenting with a depressive disorder.

MDD is estimated to occur in approximately 2% of children and in 4% to 8% of adolescents (ACCAP, 1998). The estimated lifetime prevalence rate of MDD in

adolescents is 20% (Lewinsohn et al., 1994); however, these rates differ by gender with more recent studies estimating that the lifetime prevalence rate for male adolescents is 10.7%, whereas female adolescents demonstrate a lifetime prevalence rate of 21.4% (Galambos, Leadbeater, & Barker, 2004). Limited research has been conducted concerning the epidemiology of DD in youth. The few studies that have attempted to assess prevalence rates of DD estimate that 0.6% to 1.7% of children and 1.6% to 8.0% of adolescents experience this form of depression (ACCAP, 1998). In a recent study, the estimated prevalence rate of DD in a clinical sample of youth was 0.7% (Asarnow et al., 2005). Thus, while major depression appears to be quite common in children and adolescents, DD appears to be rare.

The prevalence rates of childhood depression in males and females are approximately equal (Kovacs, 1996; Wichstrom, 1999); however, the number of girls that experience a depressive disorder increases in early adolescence and doubles after puberty, a trend that continues into adulthood (Nolen-Hoeksema & Girgus, 1994; Petersen et al., 1993; Poznanski & Mokros, 1994; Stark et al., 2000; Wichstrom, 1999). Thus, by mid to late adolescence, females are twice as likely to experience depression as their male peers.

### ***Course***

Research has shown that the course of MDD and DD in youth is quite different. The average duration of an episode of MDD is estimated to be between 32 to 36 weeks (Kovacs, Feinberg, Crouse-Novak, Paulauskas, & Finkelstein, 1984; McCauley et. al, 1993; Strober et al., 1993) or 7 to 9 months (AACAP, 1998), whereas an episode of DD can have an average length of 3 to 4 years for both clinical and community samples (Kovacs et al., 1984; Kovacs, Akiskal, Gastonis, & Parrone, 1994). Several factors are potentially associated with increased duration of depression, including severity of initial episode, family dysfunction, presence of comorbid disorders, and age of onset (Kovacs et

al., 1984; McCauley et al., 1993). In addition, gender has been associated with the severity and course of a depressive episode, with girls experiencing more severe and longer episodes of depression than boys in some studies (McCauley et al., 1993; Stark et al., 2000), but not in others (Dunn & Goodyer, 2006; Essau, 2007). Recent research suggests that parental alcohol problems, negative life events, ineffective coping, substance use, and suicidal ideation or behavior predicted stability of major depression in a sample of adolescents over a 15-month period, whereas parental depression, family dysfunction, and gender did not (Essau, 2007). Thus, many factors are thought to influence the severity, course, and stability of depressive disorders in youngsters.

Depressed youth tend to experience a slow rate of recovery, with the greatest improvement in an episode of MDD occurring between the 24th and 36th week following onset (Strober et al., 1993). Longitudinal research indicates that approximately 40% of depressive episodes remit within 6 months and almost 80% of children and adolescents no longer meet criteria for a depressive disorder after one year (McCauley et al., 1993). The rate of relapse, however, is high and approximately 40% to 60% of youth do not experience full symptom remission (AACAP, 1998).

Depression in children and adolescents also appears to be recurrent, with longitudinal research demonstrating an estimated 40% chance of another episode within two years of remission (see Rao, 2006 for a review). After five years, the probability of recurrence is approximately 70% (AACAP, 1998; Rao, 2006). Many factors are associated with recurrence, including earlier age at onset, severity of episode, multiple previous episodes, presence of a comorbid disorder, inconsistent compliance with treatment, and psychosocial stressors (Emslie et al., 1997; Kovacs, 1996; Lewinsohn et al., 1993). Early onset depression is linked with psychological difficulties later in life. For example, in a review of several longitudinal studies, Birmaher and colleagues (2002)

found that major depression in childhood increases the risk for repeat episodes in adolescence, which in turn increases the risk for recurrences in later adolescence as well as repeat episodes in adulthood. Finally, recent research has shown that gender may influence recurrence of depression in children and adolescents, with females experiencing earlier recurrences than males (Dunn & Goodyer, 2006). Thus, for many youth, a childhood- or adolescent-onset depressive episode represents the beginning of persistent, continuing, and lifelong psychological difficulty.

### ***Comorbidity***

It is not uncommon for children and adolescents with depression to experience one or more comorbid disorders. In fact, it is estimated that 40% to 70% of depressed youth have at least one coexisting psychological disturbance and 20% to 50% have two or more comorbid conditions (Birmaher et al., 1996a; Rao, 2006). Some studies have suggested that as many as 80% to 95% of depressed youth have a comorbid disorder (Kovacs, 1996). Recent research has shown that the presence of comorbid disorders in community and clinical samples of depressed children and adolescents predicts earlier recurrence of depressive disorders in early adulthood (Dunn & Goodyer, 2006).

Common comorbid conditions include anxiety, disruptive, and substance abuse disorders, which are estimated to be present in 30% to 80%, 10% to 80%, and 20% to 30% of depressed youth respectively (Birmaher et al., 1996a). In addition, in adolescent girls, MDD and Post Traumatic Stress Disorder (PTSD) have been found to co-occur at high rates, with 29% of girls with MDD also presenting with PTSD and 62% of girls with PTSD experiencing comorbid MDD (Kilpatrick et al., 2003). Finally, depressive episodes combined with other disorders in youth may increase risk for the development of Axis II disorders in young adulthood (Lewinsohn, Rohde, Seeley, & Klein, 1997). Furthermore, symptoms of personality disorders in adolescence may contribute to more

severe, chronic depression characterized by higher rates of relapse, more treatment utilization, and more suicide attempts (Lewinsohn et al., 1997). Thus, the presence of comorbid disorders can result in more severely impaired functioning and increased risk for suicide as well as difficulty obtaining symptom relief from therapeutic interventions designed to specifically treat depressive disorders (Lewinsohn et al., 1997).

In addition to other forms of psychological disorder, multiple forms of depression can co-occur. In fact, depressive disorders often coexist in children and adolescents, with approximately 70% of early-onset patients with DD having superimposed MDD (Birmaher et al., 1996a; Garber & Horowitz, 2002) and approximately 30% of youth with MDD also presenting with DD (Garber & Horowitz, 2002). In adolescents, DD tends to precede MDD (Lewinsohn, Rohde, Seeley, & Hops, 1999). These cases of "double depression" often result in more severe and protracted episodes, increased suicidal ideation, elevated rates of other comorbid disorders, and poorer social adjustment (Garber & Horowitz, 2002). Thus, comorbid disturbances appear to be quite common in depressed youth. The presence of these coexisting disorders creates formidable challenges for depressed children and adolescents as well as for researchers designing interventions that solely target depressive symptoms.

### *Gender Differences*

Although boys and girls show similar levels of depression as children, as stated earlier, adolescent girls and adult women are twice as likely to suffer from depression as their male peers (Fleming & Offord, 1990; Galambos et al., 2004; Kilpatrick et al., 2003; Lewinsohn, Hops, Roberts, Seeley, & Andrews, 1993; Nolen-Hoeksema & Girgus, 1994; Wichstrom, 1999). In addition, some research suggests that adolescent girls are more likely to experience more severe depressive episodes with a more protracted course compared with adolescent boys (McCauley et al., 1993; Stark et al., 2000). Gender also

appears to predict earlier recurrence of depression in children and adolescents followed into early adulthood, with females experiencing recurrent episodes of the disorder sooner than their male peers (Dunn & Goodyer, 2006). Finally, in retrospective studies, women report an earlier age of onset of depression than men (Sorenson et al., 1991). The reason for the increased rate of adolescent and adult depression in females is unknown; however, current research has suggested that adolescent girls may possess more risk factors for depression than adolescent boys (Allgood-Merten, Lewinsohn, & Hops, 1990; Galambos et al., 2004; Nolen-Hoeksema & Girgus, 1994; Petersen et al., 1993). These risk factors will be explored more in the following section.

## *Risk Factors*

There are numerous risk factors associated with depressive disorders in youth, covering an array of biological and environmental factors (see Birmaher et al., 1996a, b; Petersen et al., 1993 for reviews). An exhaustive description of all of these factors is beyond the scope of this dissertation; however, the following section will attempt to briefly discuss important traits associated with depressive disorders in children and adolescents such as gender, age, family factors, and social support.

### *Gender*

Gender appears to represent a significant risk factor for depression, particularly in adolescent girls and adult women. As stated previously, gender has been conceptualized as a risk factor for depression due to the fact that females seem to possess more traits that are associated with higher levels of depressive symptoms than males. For example, when compared with their male peers, adolescent girls report significantly higher levels of self-consciousness, passivity, stressful events, and adverse effects related to stressors as well as lower levels of self-esteem and satisfaction with body image (Allgood-Merten et al., 1990; Shih, Eberhart, Hammen, & Brennan, 2006; Simmons, Burgeson, Carlton-Ford &

Blyth, 1987; Wichstrom, 1999). In addition, it appears that adolescent girls tend to cope with problems by employing a more ruminative and self-focused style, whereas adolescent boys tend to be more action-oriented and adopt a more productive problem-solving approach in the face of difficulties (Nolen-Hoeksema & Girgus, 1994; Silk, Steinberg, & Morris, 2003). Rumination has been associated with higher levels of depressive symptoms in youth (Papadakis, Prince, Jones, & Strauman, 2006; Silk et al., 2003). Thus, in addition to having more risk factors for depression than their male peers, adolescent girls may also be more susceptible to depressive disorders because they employ ineffective coping strategies for managing the stress. Although the specific mechanisms that contribute to the increased rate of female depression remain unclear, gender seems to be a robust risk factor for adolescent and adult depression.

### *Age*

Age also appears to be a risk factor for the development of depression in children and adolescents (see Klerman, 1988 for a review). Research has repeatedly demonstrated an increase in rates of major depression in youngsters associated with increases in age (Kashani, Rosenberg, & Reid, 1989), with prevalence studies suggesting that adolescents are substantially more depressed than children (Lewinsohn et al., 1993). Thus, as children get older, their risk for depression increases, which suggests that age is an important risk factor for the development of depressive disorders in youth.

### *Family Factors*

*Parental depression.* Research has consistently demonstrated that parental depression is a potent risk factor for youth depression, with children and adolescents of depressed parents experiencing approximately six times higher rates of the disorder than their peers with non-depressed parents (see Downey & Coyne, 1990; Sander & McCarty, 2005 for reviews). For example, in a 3-year longitudinal investigation of 92 youth ages 8

to 16 years, Hammen, Burge, Burney, and Adrian (1990) found that 45% of youth with depressed mothers met criteria for MDD, whereas only 11% of youth with non-depressed mothers had the disorder. Thus, having a depressed mother seemed to put these children and adolescents at a much higher risk for major depression.

More recent research has suggested that maternal depression alone is insufficient for producing depressive symptoms in youth. Instead, it has been suggested that maternal depression in combination with other factors such as low degree of emotional availability and a high degree of control in mothers as well as low self-esteem in youth increases risk for depression in children and adolescents (Miller, Warner, Wickwamarante, & Weissman, 1999). Other research has suggested that depression may be transmitted from parent to child through multiple pathways, including genetics, parenting behavior, or marital conflict (Downey & Coyne, 1990). Although the pathways through which depression is passed on from depressed parents to their children remain unclear, there is clearly an increased risk of depression in youth with families in which one or more parents have a depressive disorder.

*Family environment.* Family environment has also been implicated as a potential risk factor for depression in youth (see Sander & McCarty for a review). Compared with their non-depressed peers, depressed children and adolescents have family environments that are characterized by higher rates of hostility, rejection, and control as well as lower levels of support, cohesion, and communication (Birmaher et al., 2004). Furthermore, depressed youth tend to view their family environment more negatively than their non-depressed peers, reporting less trust, respect, loyalty, adaptability, and support among family members (Johnson, Inderbitzen-Nolan, & Schapman, 2005; Kashani, Suarez, Jones, & Reid, 1999). Since many of the studies that have examined the relationship between youth depression and family discord have relied on measures from currently

depressed subjects, it is difficult to determine whether depression results from negative family environments or whether families grow increasingly dysfunctional in light of having a depressed youth (Birmaher et al., 2004). Thus, the direction of the relationship between depression and family environment may be reciprocal rather than unidirectional.

#### *Social Support*

Recent research has demonstrated a significant relationship between lack of social support and depressive symptoms in both male and female adolescents. In a longitudinal study, Galambos and colleagues (2004) found that a lack of social support significantly increased depressive symptoms in youth ages 12 to 19 over a 4-year period. In addition, the researchers found that depressive symptoms predicted decreases in social support over time (Galambos et al., 2004). Thus, social support seems to be a robust risk factor for youth depression that may interact with the disorder in reciprocal ways.

### *Consequences*

Depression in children and adolescents presents major difficulties in social, emotional, interpersonal, and academic functioning. As described by Michael and Crowley (2002), youth depression has been linked with several negative outcomes, including "diminished self-esteem, poor physical health, family dysfunction, increased risk for substance abuse, disrupted parent-child attachment, and a substantial risk for morbidity and mortality across the lifespan" (p. 248). Depressed youth also appear to have difficulty in interpersonal relationships (Rudolph et al., 1994; Galambos et al., 2004), decreased academic performance and a heightened risk for school drop-out (Fleming & Offord, 1990; Fleming et al., 1989), lower levels of self-, parent-, and teacher-reported social competence, and increased peer rejection (Levendosky et al., 1995). In addition, depressive symptoms have been associated with a number of detrimental personal health behaviors in adults and adolescents, including smoking, a

sedentary activity level, skipping breakfast, irregular sleep hours, not using seatbelts, poor nutrition, unsafe sexual practices, physical fights, and poor use of preventive health measures (Allgower et al., 2001; Brooks et al., 2002). Finally, although suicide in children and adolescents is still rare despite increasing rates, research has demonstrated a high risk of suicide in individuals with early onset major depression of 4.4% over 10 years (Kovacs et al., 1993; Rao et al., 1993). Compared with other psychological disorders, youth with a history of MDD appear to be four to five times more likely to attempt suicide (Kovacs et al., 1993). Thus, youth depression negatively affects multiple domains of functioning, contributes to risky health behaviors, and substantially increases risk for suicide.

## *Treatment of Youth Depression*

Currently depression in children and adolescents is treated in a variety of ways using both psychopharmacological approaches and psychosocial interventions. From a psychopharmacological perspective, depressed youth are being treated with antidepressant medications that have been found to be useful with adult populations. In terms of psychosocial interventions, a number of adult treatment models have been adapted and applied to depressed children and adolescents, including interpersonal therapy, family therapy, and CBT. This section will briefly describe current psychopharmacological treatments for depressed youth. Following this discussion, a summary of the current psychosocial interventions for children and adolescents with depression will be presented.

### *Psychopharmacological Interventions*

Although the Food and Drug Administration (FDA) has yet to approve the use of most antidepressants for children and adolescent, prescription of these medications for the purpose of treating depression in youth has become a generally accepted practice

(Kaplan, Simms, & Busner, 1994). The most widely studied groups of medications to date for the treatment of youth depression are tricyclic antidepressants (TCAs) and SSRIs. Since TCAs are rarely prescribed to children and adolescents due to significant safety concerns, research on their efficacy will not be presented in this section. Instead, a detailed discussion of SSRIs for youth depression will follow.

*Selective Serotonin Reuptake Inhibitors (SSRIs).* SSRIs were developed and introduced as antidepressants in the 1980s and 1990s (Julien, 2001). This class of medication includes fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), citalopram (Celexa), fluvoxamine (Luvox), and escitalopram (Lexapro). According to researchers in the field, SSRIs have quickly replaced TCAs and other antidepressant medications as the preferred prescription for adult depression because of their lower levels of risks and side effects as well as their demonstrated efficacy, and are becoming the main psychopharmacological treatment for youth depression as well (Wolraich, 2003). In fact, SSRIs are the second most commonly prescribed psychotropic medication for children and adolescents (Jensen et al., 1999) despite the fact that fluoxetine is the only SSRI that has been approved by the FDA for the treatment of youth depression (Cheung, Emslie, & Mayes, 2006).

Although small, preliminary placebo-controlled investigations of the efficacy of SSRIs showed no benefit over a placebo in samples of depressed youth, (e.g., Simeon, Dinicola, Ferguson, & Copping, 1990; Mandoki, Tapia, Tapia, & Sumner, 1997), open studies (e.g., Boulos, Kutcher, Gardner, & Young, 1992; Colle, Belair, DiFeo, & Weiss, 1994; Jain, Birmaher, Garcia, Al-Shabbout, & Ryan, 1992) have demonstrated high rates (70% to 90%) of response to fluoxetine in depressed adolescents. Additionally, larger placebo-controlled studies (e.g., Emslie et al., 2002; March et al., 2004) have shown

significant rates of depressive symptom improvement in children and adolescents taking fluoxetine. A description of these studies follows.

Emslie and colleagues (1997, 2002) have investigated the efficacy of fluoxetine as a treatment for depression in children and adolescents in two separate studies. In 1997, the researchers, using a randomized controlled trial, compared fluoxetine with a placebo in a sample of 96 youth ages 7 to 17 years. The study demonstrated significant efficacy on both of its primary outcomes measures, indicating participants in the fluoxetine group experienced a higher rate of improvement in depressive symptoms than their control group peers. Interestingly, self-report measures used in the study did not show significant effects of fluoxetine. Thus, although measures based on clinical impressions and semi-structured interviews demonstrated improvement in participants taking fluoxetine, the youngsters in this group did not report significant levels of decreased symptoms on self-rating scales.

In 2002, Emslie and colleagues undertook a second investigation of the effects of fluoxetine on child and adolescent depression in a larger, multi-center, randomized controlled trial. This 8-week investigation compared medication and placebo response rates in 219 participants aged 8 to 18 years. Findings indicated that 52% of youngsters in the fluoxetine group evidenced improvement in symptoms as opposed to only 37% of youngsters in the placebo condition. Once again, the primary outcome measures based on clinical impression and semi-structured interviews showed significant improvement in level of depressive symptoms in the active treatment group compared with the placebo group, but the self-report measures did not. Emslie and colleagues (1997, 2002) concluded that fluoxetine is an effective treatment for child and adolescent depression; however, others (e.g., Courtney, 2004; Jureidini et al., 2004) have questioned the clinical utility of these findings.

The best evidence for the effectiveness of fluoxetine in treating youth depression has come from the large, methodologically rigorous Treatment for Adolescents with Depression Study (TADS). In the TADS, March and colleagues (2004) randomly assigned 439 adolescents ages 12 to 17 years with a primary diagnosis of MDD to four treatment conditions for a period of 12 weeks: (1) fluoxetine alone, (2), CBT alone, (3) CBT with fluoxetine, and (4) pill placebo. Results indicated that, compared with a pill placebo, the combination of CBT and fluoxetine produced a statistically significant response rate in participants on the study's primary outcome measure (semi-structured interviews with the participants and their parents). Furthermore, the combination treatment of CBT and fluoxetine was superior to treatment with CBT or fluoxetine alone, and treatment with fluoxetine alone was superior to treatment with CBT alone and to a pill placebo. The response rate of 60.6% for fluoxetine alone was deemed comparable by March and colleagues (2004) to other studies and, therefore, suggests that "...fluoxetine monotherapy is an effective treatment for MDD in adolescents" (March et al., 2004, p. 816).

The TADS provides the strongest evidence for fluoxetine as an effective treatment for adolescent depression; however, the study is not without criticism. Other researchers have noted that there was a significantly higher rate of harm-related adverse events and physiological effects in the fluoxetine groups compared with the CBT alone and placebo conditions, suggesting that the negative consequences associated with the medication may not justify its use as a stand alone treatment (Antonuccio & Burns, 2004).

In addition to fluoxetine, other forms of SSRIs have shown promising and mixed results in treating child and adolescent depression in preliminary studies. In a multi-center, double-blind, placebo-controlled study of 376 children and adolescents ages 6 to

17 years in the United States, Canada, Mexico, Costa Rica, and India, researchers investigated and demonstrated the efficacy of sertraline as a treatment for MDD (Wagner et al., 2003). Wagner and colleagues found significant differences in mean change scores on their primary outcome measure between participants in the sertraline group compared with participants in the control condition. These findings led the researchers to conclude that sertraline is an effective intervention for depressed youth. However, as noted by Courtney (2004) in a review of Wagner's study, "...when broken down into age groups, the treatment effect is only demonstrated in the adolescent group ($p < 0.01$) and is not significant in the child group" (p. 560). Thus, sertraline may not be an effective intervention for depressed children. Since this study is one of the only investigations to date that has attempted to examine the efficacy of this particular SSRI in children and adolescents, it is clear that more studies are needed before conclusions can be drawn about the efficacy of sertraline in treating depressed youth.

Another SSRI, paroxetine, was investigated by Keller and associates (2001) as a possible treatment for youth depression in a randomized controlled trial involving 275 adolescents ages 12 to 18 years. The results of the study did not show a significant difference between the paroxetine and placebo groups on the study's primary outcome measures. The authors, however, did demonstrate a significant response to paroxetine compared with the placebo condition in post hoc analyses. Based on these analyses, Keller and colleagues suggested that paroxetine is an effective treatment for adolescent depression; however, this claim has been challenged due to the use of "secondary outcomes and liberal use of post hoc analysis" to achieve significant results (Courtney, 2004, p. 560). Since very few studies have examined the efficacy of paroxetine in treating depression in children and adolescents, it is premature to endorse or reject it as a psychopharmacological intervention for youth depression.

Although SSRIs are demonstrating relatively promising results in studies investigating child and adolescent depression, more studies are needed before these medications can be considered a well-established or a first-line approach for treating depressed youth. Furthermore, there are limitations to the studies (see Courtney, 2004 for a review), which highlight the need for more research. Additionally, the majority of the investigations of SSRIs in children and adolescents to date have examined the efficacy of fluoxetine on depression. A few investigations exist that examine the efficacy of other antidepressants such as sertraline and paroxetine; however, more studies are needed before SSRIs, as a class of medications, can be considered an efficacious intervention for depressed youth.

In addition to examining efficacy, studies need to better explore the side effects and adverse events associated with antidepressant use in children and adolescents. Although it is believed that SSRIs have fewer physical side effects and lower levels of toxicity compared with TCAs, most studies have failed to systematically assess or report adverse events and, therefore, the negative effects of these medications in youth are not fully understood (Moreno et al., 2006). There is some evidence that SSRIs produce physical (e.g., gastrointestinal effects, slowed growth) and behavioral (e.g., manic switching, hostility, apathy) effects in youth that are serious enough to lead to treatment discontinuation (Moreno et al., 2006). Furthermore, the FDA (2004) found that antidepressant medication is associated with a two-fold increase in risk of suicidal behaviors and thinking in children and adolescents taking SSRIs. As a result, the FDA has mandated that manufacturers of these drugs, and all other antidepressants, include warning labels on their products and expanded warning statements that alert health care providers about these risks. In light of these findings and the clear need for more research, psychopharmacological interventions for depressed youth may warrant

consideration only after psychosocial treatments have failed to produce significant improvements (Moreno et al., 2006). The following section will describe the current psychosocial treatments available for depressed youth as well as the treatment outcome literature supporting their efficacy.

***Psychosocial Interventions***

Several different psychosocial interventions for depressed youth have been tested and found to produce moderate to large treatment effects in clinical and non-clinical samples, including CBT, IPT-A, NST, and family therapy (Birmaher et al., 1996b; Michael & Crowley, 2002; Verdeli, Mufson, Lee, & Keith, 2006). The following section will review relevant research regarding the efficacy of the three most common interventions for youth depression: IPT-A, family therapy, and CBT.

*Interpersonal Therapy for Adolescents (IPT-A).* IPT-A is a time-limited, manualized treatment that focuses on current problems and attempts to reduce depressive symptoms and improve interpersonal functioning by addressing coping deficits in the following areas: grief, role disputes, role transitions, and interpersonal functioning (Mufson et al., 2004). IPT-A assumes that, regardless of etiology, depressive disorders occur within an interpersonal context and that problems in interpersonal functioning significantly contribute to depression in adolescents (Mufson, Gallagher, Dorta, & Young, 2004). IPT-A was adapted from the interpersonal therapy model with adults (Klerman, Weissman, Rounsaville, & Chevron, 1984) and applied to adolescents due to the growing rates of depression among teens as well as the importance of interpersonal relationships during this developmental stage (Mufson & Dorta, 2003). The preliminary effectiveness and efficacy of IPT-A has been examined in recent trials.

The effectiveness IPT-A in comparison to treatment as usual (TAU) in a school-based mental health clinic was assessed in a randomized trial with a sample of 63

adolescents with diagnoses of MDD, DD, DDNOS, or Adjustment Disorder with Depressed Mood (Mufson et al., 2004). Teens in the active treatment condition completed 12 sessions of individual treatment. Mufson and colleagues demonstrated that adolescents treated with IPT-A reported significantly fewer depressive symptoms, significantly higher rates of global and social functioning, and significantly greater clinical improvement and reduction in clinical severity compared to their peers in the TAU condition at the end of treatment. Thus, based on this preliminary trial, IPT-A appears to be more effective in treating adolescent depression than conventional interventions employed in school-based mental health settings.

In addition to attempting to determine the effectiveness of IPT-A as a treatment for adolescent depression, the efficacy of this form of intervention has also been investigated by comparing it with no treatment. In a study by Mufson, Weissman, Moreau, and Garfinkel (1999), the efficacy of IPT-A was examined in comparison to a clinical monitoring condition in a sample of 48 clinic-referred adolescents meeting criteria for a diagnosis of MDD. Participants in the active treatment group were seen individually for 12 weeks, whereas participants in the control condition were seen biweekly and assessed for symptoms, social functioning, and problem-solving skills by "blind" independent evaluators. At post-treatment, the researchers found that adolescents in the IPT-A condition evidenced greater decreases in depressive symptoms and higher overall improvement in several domains of functioning compared to their peers in the control condition. At the end of the trial, 75% of participants in the active condition experienced full symptom remission, whereas only 46% of participants in the control condition met criteria for recovery from depression. Thus, in this study, IPT-A demonstrated significant potential as a treatment for adolescent depression.

IPT-A is a relatively new treatment for adolescent depression that appears to show promise. Initial studies of this form of psychosocial intervention support its potential as an efficacious and effective form of treatment for depressed adolescents in community and school-based settings; however, current IPT-A trials limit the generalization of its effects to other youth populations. The majority of IPT-A trials have been conducted with adolescents (ages 12-18 years) and several trials (e.g., Mufson et al., 1999; Mufson et al., 2004; Rossello & Bernal, 1999) have contained a large proportion of Latino youth in their samples. Thus, it is not currently possible to determine if IPT-A would demonstrate the same rate of efficacy and effectiveness in younger children and/or youth from other ethnic backgrounds. Although IPT-A demonstrates significant promise as an intervention for adolescent depression, much more research is needed before it can be considered a well-established treatment.

It is interesting to note that IPT-A and CBT seem to have similar elements in their design and delivery. Researchers have suggested that these two interventions share common techniques and attempt to resolve comparable issues (Stark et al., 2006, Stark, Laurent, Livingston, Boswell, & Swearer, 1999). For example, a CBT therapist may employ traditionally CBT techniques (e.g., problem-solving) to help a youngster resolve an interpersonal problem (e.g., conflict with a peer), which is a goal of IPT-A. On the other hand, an IPT-A therapist may counter underlying negative core beliefs of being unlovable, a goal of CBT, by using the therapeutic relationship in a way that provides contrary evidence for these fundamental beliefs. Thus, in practice, CBT and IPT-A with depressed youth may not differ quite as much as their models suggest. This may explain overlap in their promise as efficacious treatments for depressed youth.

*Family Therapy.* Family therapy approaches depression in youth from the perspective that the development and maintenance of the disorder is a function of

maladaptive interactions between caregiver(s) and child (Kazdin & Marciano, 1998). Additionally, most forms of family therapy also address issues related to conflict, communication, problem-solving abilities, and role confusion. Although family therapy has proven to be an effective form of treatment for many disorders associated with youth (e.g., eating disorders), it has not been well-established as an intervention for child and adolescent depression. In fact, to date, very few studies have examined the efficacy of family therapy interventions for depressed youth.

In one of the only randomized controlled trials that has attempted to explore family therapy as a treatment for youth depression, Brent and colleagues (1997) tested the efficacy of systemic-behavioral family therapy (SBFT) in comparison to CBT and NST in a sample of 107 adolescents ages 13 to 18 years. The family approach used in this study combined functional and behavioral systems family therapy. According to researchers in the field, this form of family therapy focuses on changing maladaptive patterns of interaction and improving communication among family members through the use of techniques such as reframing, communication skills training, and problem-solving (Cottrell, 2003). The findings from this study did not bode well for SBFT as a fast-acting intervention for depressed youth. By the end of treatment, CBT proved to be superior in reducing depressive symptoms among the study participants; however, two years after treatment, no significant differences in recovery rates were evidenced among the adolescents (Birmaher et al., 2000). Thus, although CBT appears to be more efficacious in immediately providing symptom relief, family therapy may have "sleeper effects" that produce change over time (Cottrell, 2003).

Although there are few controlled trials of family therapy for depressed youth, some researchers have begun incorporating parent training components into alternative treatment interventions. For example, Lewinsohn and colleagues (1990, 1999) have

supplemented their CBT intervention, the Adolescent Coping with Depression course with family training; however the focus of these family groups is psycho-education about depression rather than active family therapy, and the researchers have found that these parent groups do not increase the efficacy of the overall treatment (Clarke et al., 1999).

Additionally, Asarnow and colleagues (2002) recently tested a CBT family education program in which children (4th through 6th graders) with depressive symptoms and their caregivers participated in a 90-minute group meeting after the youngsters had completed nine sessions of CBT. The goal of the family meeting was to provide psycho-education about the skills taught in the CBT sessions, elicit help from the families in applying those skills to "real-life" settings, provide support to the children, allow the participants to teach the skills to their parents, and promote positive interactions between caregivers and children. When compared with a control group, the active intervention with the family component demonstrated non-significant improvement in depressive symptoms; however, it did demonstrate high rates of satisfaction among children (94%) and caregivers (100%). Furthermore, when an outlier was removed from the data, the CBT-family intervention demonstrated significant efficacy in improving depressive symptoms compared with the control group. Thus, CBT interventions that incorporate family training do not decrease efficacy of stand-alone treatments. In fact, they may increase satisfaction among participants and augment symptom improvement.

Overall, family therapy demonstrates promise as an intervention for depressed youth. In comparison to other interventions, such as CBT, it appears to be equally efficacious over time. In addition, CBT programs that incorporate family training, rather than family therapy techniques, do not hinder treatment response and may even increase participant satisfaction. In conclusion, further randomized, controlled trials of family

therapy are needed before this form of psychosocial intervention can be recommended as a treatment for youth depression.

*Cognitive-Behavioral Therapy (CBT).* In general, the underlying principle of CBT interventions is the idea that depression is fostered by cognitive distortions in the perception of the self, others, and the future combined as well as behavioral skills deficits that hinder ability to cope with adverse events (Compton et al., 2004). These interventions, therefore, attempt to alleviate depressive symptoms through the use of specific cognitive and behavioral techniques such as cognitive restructuring, problem-solving, and coping skills in the context of a collaborative, therapeutic relationship. For a detailed description of the model and the components of CBT, please refer the Theoretical Models of Youth Depression and the Empirical Investigations of CBT for Depressed Youth sections in this chapter.

According to researchers in the field, CBT is the favored and most regularly studied and supported psychosocial intervention for youth depression (Kazdin & Weisz, 1998; Stark et al., in 2006). CBT may hold this prominent position in the research base due to the fact that it meets the criteria for empirically supported treatments set forth by Chambless and Hollon (1998) as a "possibly efficacious" intervention for depressed children and adolescents (Kaslow & Thompson, 1998; Kazdin & Weisz, 1998). That is, CBT interventions for depressed youth have been shown to provide more symptom relief than no treatment, a placebo, or an alternate form of treatment.

Despite being considered "possibly efficacious," CBT has yet to receive the title of well-established as an intervention for depressed children since current studies have failed to compare it with an established treatment and multiple investigators or investigatory teams have not tested the same intervention (Kaslow & Thompson, 1998; Verdeli et al., 2006). Furthermore, most CBT interventions for child depression are

considered "possibly efficacious" rather than "probably efficacious" because the majority of studies have failed to specify client characteristics, utilize treatment manuals, and attempt to replicate results (Kaslow & Thompson, 1998). Exceptions include CBT interventions by Stark and colleagues (1987, 1991), which are considered "probably efficacious" for depressed children since results were replicated in two trials (Kaslow & Thompson, 1998; Verdeli et al., 2006).

CBT interventions targeting depressed adolescents are also not currently considered well-established (Kaslow & Thompson, 1998; Verdeli et al., 2006). Although many adolescent studies have employed treatment manuals, provided detailed descriptions of samples, and demonstrated that CBT was more efficacious in reducing depressive symptoms compared with a control condition, investigators have failed to compare their interventions with an established treatment and results have not been replicated by other researchers or research teams (Kaslow & Thompson, 1998). According to Kaslow and Thompson (1998), two investigations by Lewinsohn and colleagues (1990, 1996) "...represent state-of-the art adolescent depression intervention research" (p. 152) and meet the criteria for "probably efficacious" interventions for depressed adolescents due to their detailed description of participant characteristics, usage of a treatment manual, and evidence of efficacy in more than one study.

Although CBT interventions for depressed youth are not well-established, they are considered "effective in reducing depressive symptoms and alleviating depressive disorders in non-clinical samples of children and both clinical and non-clinical samples of adolescents" (Kaslow & Thompson, 1998, p.153). In addition, despite modality (group or individual), CBT interventions demonstrate positive effects both at termination of treatment and at follow-up in some studies (Kaslow & Thompson, 1998). Furthermore, recent intervention studies (e.g., Stark et al., 2004a; March et al., 2004; Rohde et al.,

2004) have attempted to rectify the shortcomings of past investigations by employing treatment manuals and/or comparing CBT interventions with other forms of treatment.

A multitude of studies have demonstrated that CBT for depressed youth is more efficacious than no treatment, placebo, or wait-list conditions (e.g., Asarnow et al., 2002; Clarke et al., 1999; Lewinsohn et al., 1990; Reynolds & Coats, 1986; Stark et al., 1987; Wood et al., 1996). Furthermore, it has demonstrated superior results when compared with other forms of therapeutic intervention such as relaxation training (e.g., Wood et al., 1996). Finally, CBT has shown greater efficacy than other treatments such as SBFT, NST, or life skills training in reducing depressive symptoms in youth (e.g., Brent et al., 1997; Rohde et al., 2004).

Although CBT for depressed youth has a promising track record, it is not without limitations. First, it has not been superior to no treatment in every study (e.g., Liddle & Spence, 1990); however, these findings are limited by methodological issues that will be discussed in a later section. Next, although CBT has demonstrated significantly better treatment effects compared with control conditions and with certain forms of treatment, it has not proven superior to relaxation training (Kahn et al., 1990; Reynolds & Coats, 1986), treatment as usual (Clarke et al., 2002), or IPT-A (Rossello & Bernal, 1999) in some studies. Finally, recent research has shown evidence that treatment with fluoxetine may be superior to treatment with CBT in depressed youth (March et al., 2004). In spite of these findings, overall, trials of CBT have suggested that this form of intervention demonstrates significant efficacy and preliminary effectiveness in reducing depressive symptoms in children and adolescents. A detailed description of the literature concerning the efficacy and effectiveness of CBT with depressed youth will be presented in a later section of this chapter.

### *Summary and Conclusions*

Depression in children and adolescents is a growing problem with serious implications. While rates of depression in youth are rising, the age at which children and adolescents are becoming depressed is falling. There are multiple negative outcomes associated with depression in youth, including poor self-esteem, family dysfunction, increased engagement in risky health behaviors and substance abuse, inadequate child-parent attachment, difficulties in interpersonal relationships, poor academic performance, school failure or drop-out, and suicide. Furthermore, rates of relapse are high, recovery is slow, and depression in youth appears to be recurrent with early onset increasing risk of future episodes in adolescence and adulthood.

Current treatments for child and adolescent depression include pharmacological treatments (e.g., SSRIs, TCAs) and psychosocial interventions (e.g., IPT-A, CBT). Although there are only a few investigations examining the efficacy of SSRIs in treating depressive disorders in youngsters, preliminary results are promising, particularly for fluoxetine. Since SSRIs have fewer known side effects and a better safety record than TCAs, these medications may be a viable psychopharmacological option for the treatment of depression in youth alone or in combination with psychosocial treatments (i.e., CBT). However, recent reports of increased suicidal ideation and behavior associated with SSRIs as well as a paucity of research regarding other possible adverse effects somewhat diminish their potential as a first-line intervention. In fact, after completing an extensive meta-analytic review of psychopharmacological and psychosocial treatments, Michael and Crowley (2002) concluded that "clinicians should consider psychosocial treatments to be first-line interventions until there are more definitive answers regarding the efficacy and safety of antidepressant medications for treating child and adolescent depression" (p. 263). Other researchers in the field have

agreed (e.g., Moreno et al., 2006). Thus, the concern that SSRIs may increase the risk of adverse events renders psychosocial interventions a more suitable initial treatment option.

Psychosocial interventions, such as IPT-A and CBT, have demonstrated encouraging results as interventions for child and adolescent depression and, in practice, share similar goals. Since IPT-A studies has shown promise as a treatment for depression in primarily adolescent Latino populations, these findings need to be replicated with more diverse samples. CBT, on the other hand, has proven to be superior in reducing depressive symptoms in children and adolescents when compared with no treatment or wait-list, attention, or placebo conditions in many studies and with youth of different ages, socioeconomic statuses, and ethnicities. CBT continues to be the most researched, practiced, and supported psychosocial intervention for depressed youth.

Given the current information regarding prevalence, course, and consequences of depression in children and adolescents, a clear need exists to design, test, and establish efficacious and effective interventions for youth. CBT continues to hold promise as such a treatment. The following section will examine the theoretical models from which current CBT interventions are derived. This review will provide a framework for understanding the various treatment components that comprise present CBT treatment programs for depressed youth.

## Theoretical Models of Youth Depression

Depression has been conceptualized from many different frameworks, including biological, social, cognitive, behavioral, and environmental. The majority of theoretical models attribute the development of depression to either internal factors such as behavioral or cognitive predisposition or to external circumstances such as precipitating events. Some theories combine these factors, proposing a diathesis-stress model in which an internal vulnerability for depression is triggered in the face of an external,

environmental stressor. Diathesis-stress models are viewed as advanced conceptualizations of depression that avoid more simplistic assumptions that all individuals are equally vulnerable to the disorder (Coyne & Whiffen, 1995).

The CBT model is a diathesis-stress model that integrates environmental, cognitive, and behavioral theories of depression. According to the CBT model, depression is the result of cognitive and behavioral vulnerability that is activated by stressful life events. For example, depression may develop when an individual with ineffective coping skills and/or a distorted way of processing social information experiences a major loss (e.g., death of a family member, end of a close relationship) or a significant failure (e.g., not passing a grade, getting fired).

A discussion of all conceptual models of depression is beyond the scope of this analysis; however, selected theories that have provided the framework for the CBT model, as well as current CBT interventions with depressed youth, will be explored in this section. Specifically, this section will discuss environmental models (i.e., stressful life events), cognitive models (i.e., cognitive theory, attributional theory, learned helplessness and hopelessness), and behavioral models (i.e., coping skills, reinforcement, self-control), that inform CBT interventions.

## *Environmental Models*

Environmental models of depression attribute the cause of the disorder to external factors. In this section, a specific environmental factor (i.e., stressful life events) will be discussed as a model for the development and maintenance of depression in youth.

### *Stressful Life Events*

Depression has clearly been linked with stressful life events both in adults (Thoits, 1983) and youth (Compas, 1987), with research repeatedly demonstrating that psychological disturbance, particularly depression, is often precipitated by negative life

events (Rafnsson, Jonsson, & Windle, 2006; Shih, Eberhart, Hammen, & Brennan, 2006; Thoits, 1983). Although life stressors, including both major events and minor, daily hassles, have consistently been associated with depression in the literature, the relationship between these variables is modest, accounting for only approximately 10% of the variance (Johnson & McCutcheon, 1980). Furthermore, there is considerable individual difference in responses to stress by children and adolescents (Compas, 1987).

Since negative life events are only modestly linked with depression in children and adolescents, researchers have proposed and tested more complex models of how stress influences the development of the disorder. It has been suggested that individual characteristics may mediate the relationship between life stressors and maladaptive outcomes (Compas, 1987; Lazarus, 1991). R. S. Lazarus (1991) posited that the development of depressive symptoms following a negative life event depended on several factors such as the appraisal of the event's importance, the way in which the event might impact other aspects of life, and the ability to cope with the event and its consequences. Thus, the psychological impact of negative life events may depend on individual perceptions of the events, effects on other areas of functioning, and coping abilities. In support of this idea, attributional style, coping style, and problem-solving ability and orientation have been shown to moderate the relationship between stress and depressive symptoms in adolescents (Rafnsson et al., 2006; Shih et al., 2006; Spence, Sheffield, & Donovan, 2002).

Furthermore, other factors, such as whether the stressor is acute or chronic, major or minor, and within or outside of the impacted individual's control may determine the effect the event has on the development of subsequent psychopathology (see Hammen, 2005 for a review). In addition, the type of stressor and the amount of upheaval associated with the stressor may play a role in how the stressful life event contributes to

the development of psychological symptoms (Brown & Harris, 1989; Hammen, 2005; Monroe & Roberts, 1990).

In summary, negative life events have been linked with depression in children and adolescents; however the relationship between these variables is not large. Other variables such as personal and stressor characteristics may mediate the relationship between stressful life events and depression. The next section will explore cognitive vulnerability factors that may predispose youth to depression following major stressors.

## ***Cognitive Models***

Unlike environmental models of depression which argue that depression is mediated through external factors such as stress, cognitive models attribute the development and maintenance of the disorder to internal factors such as distorted information processing or a negative attributional style. Specifically, cognitive models tend to emphasize the mediating role of cognitions in the development of psychological distress and maladaptive behaviors (Beck, Rush, Shaw, & Emery, 1979). According to these models, the way in which an individual interprets an event is more important in determining psychological adjustment than the event itself or any behavioral consequence associated with it (Blagys & Hilsenroth, 2002). Therefore, cognitive interventions or treatments tend to emphasize resolving dysfunctional thoughts, attitudes, assumptions, and beliefs in order to ameliorate depressive symptoms. The following section will present several cognitive theories that have influenced the development of CBT interventions for youth.

### ***Beck's Cognitive Model***

One of the most influential theories of depression, the cognitive model proposed by A. T. Beck and colleagues (1967, 1979), posits that depressed individuals possess maladaptive schemas or cognitive representations which trigger and maintain the disorder

in the face of stressful events by producing patterns of distorted information processing. Thus, this model represents a diathesis-stress theory in which depression results from a combination of internal cognitive vulnerability and external stress.

The cognitive theory of depression proposes that three specific factors, the cognitive triad, schemas, and cognitive errors, contribute to the development and maintenance of the disorder (Rush & Nowels, 1994). The cognitive triad is comprised of three major cognitive patterns that systematically shape the way in which an individual views herself, her world, and her future (Beck et al., 1979). Individuals with depression tend to have predominantly negative views in these three areas. First, depressed individuals tend to view the self as "defective, inadequate, diseased, or deprived" (Beck et al., 1979, p. 11). This negative view of the self leads to the development of core beliefs of worthlessness, helplessness, or undesirability. Thus, due to a perceived lack of positive personal attributes, depressed individuals believe themselves to be worthless, helpless, or unlovable. Next, depressed individuals also interpret their experiences with the world and others in a distorted manner. For example, a depressed individual may regard her world as excessively demanding, defeating, or depriving (Beck et al., 1979). These interpretations serve to fuel the idea that the individual is ill-equipped or incapable of managing stress and/or getting basic needs met. Finally, depressed individuals hold a decidedly negative view of their future. For example, a depressed individual will see her future as full of insurmountable obstacles, reinforcing her belief that she is inadequate and, therefore, helpless and/or hopeless (Beck et al., 1979). Thus, the cognitive triad contributes to the development and maintenance of depression by continually distorting information about the self, the world, and the future.

In addition to the cognitive triad, depression is also evoked and maintained by distorted schemas. According to Beck and colleagues (1979) schemas are the attitudes

and assumptions that develop from early experiences and act as cognitive filters through which experiences are interpreted and understood. For example, a depressed individual's thinking may be dominated by the schema, "Unless everyone likes me, I am unlovable." This belief may color every interaction that this individual has in such a way that every experience relates to whether or not she is liked by others and, therefore, worthy of love. Thus, schemas serve to shape the way in which an individual interprets environmental information, resulting in cognitive distortions that facilitate and maintain depression (Beck et al., 1979).

Finally, the cognitive theory of depression posits that, during times of distress, depression-prone individuals exhibit distinctive errors in thinking. Beck (1967) identified several specific systematic errors in reasoning that characterize the thinking of depressed individuals. These errors include (1) arbitrary inference, (2), selective abstraction, (3) overgeneralization (4), magnification and minimization, (5) personalization, and (6) absolutistic, dichotomous thinking. For a detailed description of each systematic error, please refer to Beck and colleagues (1979). Depressed individuals tend to overlook or distort information in their environment and, therefore, disregard evidence that may challenge their distorted thinking. Thus, cognitive errors help to maintain depression by reinforcing beliefs of worthlessness or inadequacy.

The cognitive theory of depression has been applied to depressed children and adolescents as a downward extension of the adult model. Consistent with the theory, researchers have demonstrated that depressed youth exhibit specific negative distortions about themselves, their world, and their future (Kaslow, Stark, Printz, Livingston, & Tsai, 1992; Stark, Schmidt, & Joiner, 1996). In addition, studies have shown that depressed youth make more cognitive errors than their non-depressed peers (Leitenberg, Yost, & Carroll-Wilson, 1986). Thus, these studies provide evidence for Beck's cognitive theory

of depression in youth by suggesting that depressed children and adolescents possess negative cognitive triads and make systematic errors in thinking.

Since, depressogenic vulnerability is the result of distorted cognitive processes combined with psychological and/or physical stress, cognitive therapy attempts to identify and test maladaptive thoughts, attitudes, assumptions, and beliefs (Beck et al., 1979). Specifically, depressed individuals are taught to monitor automatic thoughts, recognize and understand the link between thoughts, feelings, and behaviors, examine the evidence that supports or refutes negative thoughts, replace cognitive distortions with more realistic and/or more adaptive thinking, and identify and alter negative core beliefs that trigger and perpetuate the disorder in the face of stress (Beck et al., 1979). The therapeutic process of identifying, testing, and changing negative thoughts, attitudes, assumptions, and beliefs is often referred to as cognitive restructuring in the treatment literature.

In conclusion, according to the cognitive theory, depressed individuals tend to distort information in systematic ways that contribute to the development and maintenance of their symptoms when under stress. Research has suggested that depressed youth exhibit key components of the cognitive theory, such as negative views of the self, the world, and the future as well as systematic errors in thinking. Other theorists have agreed with aspects of the cognitive theory; however they assert that depressogenic vulnerability stems from different cognitive distortions. The next section will review other cognitive models, including attributional style, learned helplessness, and the hopelessness theory of depression.

***Attributional Style, Learned Helplessness, and Hopelessness Theory***

The reformulation of the learned helplessness theory (Seligman, 1974,1975) proposed by Abramson, Seligman, and Teasdale (1978) suggests that individuals are

vulnerable to depression when they make internal, stable, and global attributions for the causes of negative events and external, unstable, and specific attributions for positive events. In other words, depressogenic vulnerability stems from an individual's propensity to view negative events in a personal, pervasive, and permanent manner and to see positive events as impersonal, limited, and temporary. Thus, the reformulated theory of learned helplessness suggests that the way in which an individual interprets the events in her life, or her attributional style, predispose her to depression.

A further reformulation of the learned helplessness theory (Abramson, Metalsky, & Alloy, 1989) proposes that a unique subtype of depression called "hopelessness depression" results from an individual's assumption that desired outcomes will not be achieved and undesired outcomes are inevitable (negative outcome expectancy) as well as from her belief that she is incapable of influencing the likelihood of these outcomes (helplessness expectancy). The hopelessness theory also posits that individuals are vulnerable to depression as a result of making stable, internal, and global attributions for negative events; however, according to this model, depression hinges on the loss of hope that results from having a negative attributional style paired with negative life events. Thus, the hopelessness theory of depression represents a diathesis-stress model in which attributional style is a distal cause of depression and hopelessness is a proximal cause of the disorder when combined, but not in the absent of, negative life events (Joiner & Wagner, 1995). In both theories, depression hinges on the way in which individuals interpret or appraise the situations in their lives. If good situations are attributed to positive internal, global, and stable causes and negative events are attributed to external, specific, and unstable causes, then depression is prevented. On the other hand, if the reverse is true, then depression is likely. Thus, attributional style can create both protection from and vulnerability to depression.

The relationship between attributional style and depression in youth has been tested in a number of studies. In a meta-analytic review of twenty-eight studies, Gladstone and Kaslow (1995) determined that there is a moderate to large relationship between attributional style and depression in children and adolescents for positive, negative, and overall events, which provides support for the reformulated learned helplessness model of depression. Although the authors concluded that the current literature supports an association between attributional style and depression, they reported that the direction of the relationship is not clear. That is, the cross-sectional nature of the studies could not provide information about the direction of causality and, therefore, it is uncertain if negative attributional style leads to depression or if depression contributes to the formulation of a maladaptive cognitive style. Additionally, Gladstone and Kaslow concluded that the role of attributional style as a mediator between stressful life events and depression remains undetermined.

Joiner and Wagner (1995) also conducted a meta-analysis of twenty-seven studies involving attributional style and depression in children and adolescents, looking at both cross-sectional and prospective research designs. The authors came to the same conclusions as Gladstone and Kaslow (1995) with regard to the cross-sectional investigations. That is, a clear, robust relationship between attributional style and depression in youngsters exists. These authors, however, also examined prospective studies, allowing them to make comments on the direction of the relationship between attributional style and depression as well as the role of attributional style as a mediator between negative life events and depressive symptoms. Joiner and Wagner concluded that preliminary evidence moderately supports the position that attributional style can lead to increases in depressive symptoms over time. However, after examining six studies in which the role of attributional style for negative life events and depression was

investigated, the authors concluded that "the interaction has not received overwhelming support as a predictor of depression, but has received sufficient support to warrant further study" (p. 792). Thus, since the evidence for the diathesis-stress model of attributional style, negative life events, and depression remains elusive, the theory deserves further testing.

In more recent empirical endeavors, attributional style has been shown to exert direct and indirect effects on the development and maintenance of child and adolescent depression. For example, Spence and associates (2002) found evidence that negative attributional style interacts with negative life events to predict current depressive levels in a sample of 733 adolescents ages 12 to 14 years; however, attributional style alone, and not in combination with negative life events predicted, increases in depression over time. That is, adolescents who endorsed a negative attributional style reported higher rates of current depressive symptoms and were at increased risk for expanded symptomatology over the course of a year regardless of the number of negative life events that were experienced during that time period. Thus, once again, the diathesis-stress model of depression in which negative attributional style mediates the effects of negative life events was not supported. Although the model was not fully supported, a strong, positive relationship does appear to exist between attributional style and depression in youth. Youth that attribute negative events to internal-stable-global causes and positive events to external-unstable-specific seem to be more likely to exhibit depressive symptoms.

In sum, cognitive models conceptualize depression in terms of how distorted thought processes contribute to and maintain it. Behavioral models, on the other hand, focus on the ways in which actions, or lack thereof, facilitate the development of distress. The following section will explore behavioral models of depression that have influenced the development of CBT interventions for youth.

### *Behavioral Models*

Similar to cognitive theories, behavioral models of depression attribute the development and maintenance of the disorder to primarily internal factors; however, these models examine the way in which depressed individuals cope with problems and stress, obtain reinforcement from their environment, and exercise self-control. Behavioral models posit that basic learning principles contribute to the development of both adaptive and maladaptive behaviors, and that actions mediate the development of psychological distress (Blagys & Hilsenroth, 2002). Behavioral interventions or treatments for depression, therefore, focus on teaching participants adaptive ways of behaving. The following section will describe several behavioral models that have greatly influenced present CBT interventions for depressed youth.

#### *Coping*

Research on coping in children and adolescents has significantly lagged behind research on coping in adults; however, the past 10 to 15 years have shown considerable progress in this area (Compas, Connor-Smith, Saltzman, Thomsen, & Wadsworth, 2001). Coping has been conceptualized in numerous ways and multiple definitions of coping now exist (Compas et al., 2001). The most widely cited definition of coping is "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 141). Thus, the idea that coping is a response to stress is inherent in the definition.

In addition to multiple definitions, coping also has been conceptualized as having various dimensions. According to Compas and colleagues (2001), "the most widely used dimensions of coping are problem- versus emotion-focused coping, primary versus secondary control coping, and engagement (approach) versus disengagement (avoidance)

coping" (p. 91). Lazarus and Folkman (1984) described problem-focused coping as seeking information, generating solutions to problems, and taking steps to change stressful situations, whereas emotion-focused coping is described as expressing feelings, seeking comfort and support from others, and avoiding sources of stress. Primary control coping involves direct attempts to influence events or objects through active strategies such as problem-solving, whereas secondary control coping involves attempts to conform or adapt to stress through strategies such as acceptance or cognitive restructuring (Rudolph, Dennig, & Weisz, 1995; Weisz, McCabe, & Dennig, 1994). Finally, engagement coping involves attempts to respond directly to a source of stress or to the thoughts or feelings that the stressor evokes and disengagement coping involves avoiding the stressor or the stress responses (Ebata & Moos, 1991). It is interesting to note that problem-solving is considered an active form of coping rather than a separate behavioral strategy by some researchers (e.g., D'Zurilla & Chang, 1995). For an extensive review of the different definitions, models, and dimensions of coping, please refer to Compas and colleagues (2001).

Coping is thought to mediate psychological well-being following stressful life events. Effective coping strategies (i.e., active, approach, problem-focused) are posited to serve as a protective factor against the development of psychological symptoms, whereas ineffective coping strategies (i.e., passive, avoidant, emotion-focused) are believed to increase vulnerability to psychiatric disorders. Research has supported this theory, demonstrating that ineffective coping strategies and problem-solving skills are linked with various psychological symptoms, including depression, anxiety, aggression, and conduct problems (Compas et al., 2001).

Coping has been specifically tied to depressive symptoms in several investigations with adolescents (Herman-Stahl, Stemmler, & Petersen, 1995; Herman-

Stahl & Petersen, 1996; Muris, Schmidt, Lambrichs, & Meesters, 2001; Rafnsson et al., 2006) and children (Bokszczanin, 2003; Jeney-Gammon, Daugherty, Finch, Belter, & Foster, 1993). In these studies, depressive symptoms in youth have been positively correlated with the self-reported use of passive, avoidant coping strategies and negatively associated with active, approach methods of coping. Thus, children and adolescents that evidence deficits in coping may be more vulnerable to the development and maintenance of depression.

Consistent with this idea, Nolen-Hoeksema (1987) posited that females evidence higher rates of depression compared to their male peers because they tend to employ passive coping strategies (i.e., rumination) when faced with the increased challenges of adolescence. A recent investigation by Muris and colleagues (2001) supported this hypothesis. These researchers found that among a sample of adolescents, teenage girls exhibited higher rates of depressive symptoms and endorsed higher rates of ineffective coping strategies compared with their male peers. Other studies (e.g., Abela, Brozina, & Haigh, 2002; Abela, Vanderbilt, & Rochon, 2004) have also found support for the hypothesis that a ruminative coping style is associated with the development and maintenance of depressive symptoms and that engagement in active problem-solving is associated with decreases in depressive symptomatology in youth (Abela et al., 2004; Frye & Goodman, 2000).

Not only does engaging in ineffective coping strategies lead to higher levels of depressive symptoms in adolescents; changing coping style can significantly influence the trajectory of depression. In a prospective study of 603 $6^{th}$ through $11^{th}$ graders, Herman-Stahl and colleagues (1995) found that avoidant coping was linked with higher rates of depression and approach coping was associated with lower levels of depressive symptoms over a one-year period. Moreover, the researchers demonstrated that changes

in coping style significantly influenced changes in rates of depression, with adolescents who changed from an avoidant coping style to an approach coping style evidencing decreases in depressive symptoms and adolescents who changed in the opposite direction experiencing significant increases in levels of depression from one year to the next. Thus, changing coping style from avoidant to approach may serve to decrease depressive symptoms in adolescents.

Finally, the idea that a coping deficiency leads to depression may not be entirely accurate. Consistent with previous research Jeney-Gammon and associates (1993) found that elevated depressive symptomatology following a major stressor (i.e., living in the path of a devastating hurricane) was associated with the use of less effective coping strategies (i.e., social withdrawal, self-blaming), whereas lower rates of depressive symptoms were associated with engagement in active forms of coping (i.e., seeking social support, cognitive restructuring). Surprisingly, level of depressive symptoms was also positively correlated with number of coping strategies used. That is, children exhibiting high rates of depressive symptoms engaged in more coping strategies than their non-depressed peers. Thus, depressive symptoms may be associated with using multiple ineffective coping strategies rather than from a lack of coping attempts.

In conclusion, coping strategies appear to play an important role in the development and maintenance of depressive symptoms in children and adolescents. Specifically, the relationship between coping and depression seems to be consistent with a diathesis-stress model in which coping strategies mediate the influence of stressors. Depressed youth do not appear to lack coping skills; however, they seem to employ ineffective coping strategies in the face of stress. Moreover, changing coping strategies from ineffective to effective may serve to decrease depressive symptoms in youth. Thus, teaching effective coping strategies, particularly problem-solving skills, to depressed

children and adolescents is an important and necessary component of any treatment program.

In addition to acquiring productive coping skills, depressed youth may also need to learn how to obtain adequate social support since a lack of positive reinforcement has been hypothesized to increase vulnerability to depression. The link between reinforcement and depression is discussed in the next section.

***Reinforcement Model***

Another behavioral approach to depression is posited by P. M. Lewinsohn and colleagues (Lewinsohn, 1974; Lewinsohn, Biglan, & Zeiss, 1976). According to this theory, depression results from a loss or lack of response-contingent positive reinforcement and high rates of negative reinforcement (withdrawal of reinforcement) or punishment. In other words, individuals become vulnerable to depression when they have lost or simply do not have adequate positive reinforcement in major life domains. According to the theory, insufficient reinforcement may be due to three factors: the environment, a lack of skills in the individual, or a lack of response from the individual. First, the environment may not provide adequate reinforcement to the individual or may produce a loss of reinforcement. For example, the death of a parent would represent a major loss of reinforcement and disrupted care by a grieving spouse would represent inadequate reinforcement to the bereaved child. Next, an individual may not receive adequate reinforcement because she lacks the necessary skills for obtaining reinforcement from available sources. For example, deficit social skills may lead to decreased reinforcement through inability to establish and maintain rewarding interpersonal relationships. Finally, an individual may not be able to enjoy or derive pleasure from the reinforcers that are available to her because she is socially anxious. For example, a

socially anxious person may avoid situations that could provide positive reinforcement such as social gatherings or parties.

Lewinsohn's theory of depression was later revised to include several other components such as coping, problem-solving, and cognitive restructuring, which transformed it into a diathesis-stress model which posited that predisposing vulnerability factors (e.g., negative cognition, low rates of positive reinforcement) and the absence of protective factors (e.g., coping skills) work together to mediate the effects of life stress (see Lewinsohn, Hoberman, Teri, & Hautzinger, 1985).

A core component of Lewinsohn's initial reinforcement model involves the relationship between mood and daily events. According to the theory, positive and negative events can serve as rewards or punishments (positive or negative reinforcers), with the power to elevate or deflate mood. Research has investigated this idea and has demonstrated that mood is positively associated with pleasant events and negatively correlated with unpleasant events in college students, volunteer adults from the community, and depressed patients (Grosscup & Lewinsohn, 1980; Lewinsohn & Libet, 1972; MacPhillamy & Lewinsohn, 1974) as well as in children and adolescents (Wierzbicki & Sayler, 1991). Furthermore, it has been demonstrated that depressed individuals engage in fewer activities, experience less enjoyment from pleasant events, and report less total pleasure compared to non-depressed peers (MacPhillamy & Lewinsohn, 1974).

Findings from these studies are limited by their cross-sectional nature and, therefore, do not provide information regarding the direction of the relationship. Thus, it is not clear if depression causes a decrease in engagement in pleasant activities or if a reduction in pleasant events leads to symptoms of depression. However, studies have shown that interventions that include engagement in pleasant activities in their treatment

design do alleviate depressive symptoms in youth (e.g., Kahn et al., 1990). By engaging depressed children and adolescents in an increased number of pleasant events or potentially reinforcing activities, it is believed that their depressed affect will become more positive.

In conclusion, the reinforcement model of depression argues that the disorder results from a lack of adequate social reinforcement. In interventions with depressed children and adolescents, therefore, a core treatment component would include engagement in pleasant activities and events that have the potential to provide reinforcing experiences. The following section will discuss yet another behavioral theory of depression: the self-control model.

***Self-Control Model***

Self-control theory focuses on how individuals manage their behavior to reach long-term goals. As a model of depression, it focuses on the inability of depressed individuals to modify their behavior to obtain lasting goals (Rehm, Wagner, & Ivens-Tyndal, 2001). L. P. Rehm (1977) posited a self-control model of depression that was adapted from Kanfer's (1970) self-control theory, which incorporates several components of other depression models (e.g., reinforcement, cognitive-behavioral, learned helplessness/hopelessness). According to Kanfer (1970), long-term goals are achieved through three behavioral efforts: self-monitoring, self-evaluation, and self-reinforcement. Rehm (1977) posited that one or more of the following six deficits in self-control/self-management characterize the behavior of depressed individuals: (1) selective attention to negative events and exclusion of positive events, (2) selective attention to the immediate consequences of behavior and exclusion to delayed behavioral consequences, (3) engagement in rigid self-evaluative standards, (4) negative attributions for behavior, (5) administration of insufficient self-reinforcement/reward for behavior, and (6)

administration of excessive punishment. Thus, when attempting to achieve an important goal, depressed individuals engage in certain behaviors such as maximizing negative events, minimizing positive events, focusing on immediate behavioral consequences, ignoring long-term consequences, being overly perfectionistic, not rewarding positive behavior, and severely punishing negative behavior. These behaviors contribute to depression via failure to obtain desired goals.

According to self-control theory, rather than effectively self-regulating behavior, depression-prone individuals rely on external sources of reinforcement and begin to experience symptoms of distress when these sources are insufficient or unavailable (Rehm et al., 2001). Thus, the self-control model of depression is a diathesis-stress model in which pre-existing vulnerability (e.g., deficient self-control/self-management skills) interacts with environmental factors (e.g., lack of external reinforcement) to create symptoms.

Self-control theory-based therapeutic interventions for depression have been developed and evaluated in adults (see Rehm et al., 2001 for a review). Self-control interventions are structured, group treatment programs that utilize a therapeutic manual and homework assignments to alleviated depressive symptoms through cognitive and behavioral strategies, including self-monitoring for positive events, setting long-term goals, self-rewarding for achieving sub-goals, self-monitoring negative, evaluative thoughts and unrealistic behavior standards, and creating reinforcing self-statements. These treatment strategies have been adapted and investigated in children (Stark, et al., 1987), pre-adolescents (Kahn et al., 1990), and adolescents (Reynolds & Coats, 1986).

In summary, the self-control model suggests that depression is related to specific deficits in self-monitoring, self-evaluation, and self-reinforcement. Self-control interventions focus on rectifying these deficits through the use of goal-setting, self-

reward, and other strategies. The self-control model has been adapted and applied to depressed children and adolescents.

Behavioral models of depression target an individual's actions as a means of reducing maladaptive ways of approaching stress, problems, goals, or reinforcement. Unlike cognitive models, behavioral models posit that depression develops from and is maintained by dysfunctional behavior patterns such as ineffective coping and problem-solving skills, inadequate social reinforcement, or deficits in self-control. Behavioral interventions assume that the learning of new, adaptive behaviors can reduce depressive symptoms. The following section will discuss the cognitive-behavioral model, which integrates ideas from environmental, cognitive, and behavioral models to create holistic interventions that address depression on multiple levels.

### *Cognitive-Behavioral Models*

The cognitive-behavioral model of depression is a diathesis-stress model in which cognitive and behavioral deficits serve to create depressogenic vulnerability in the face of stressful life events. Cognitive-behavioral models, therefore, integrate aspects of environmental, cognitive, and behavioral models. According to Braswell and Kendall (1988), cognitive-behavioral models "emphasize the complex interaction among cognitive events, processes, products, and structures, affect, overt behavior, and environmental context and experiences as contributing to various facets of dysfunctional behavior" (p. 167). Cognitive-behavioral models, therefore, posit that depression is best alleviated by targeting multiple aspects of functioning, including distorted thought processes and behavioral deficits such as inadequate coping skills, reinforcement, or self-control. Thus, cognitive-behavioral models of depression incorporate aspects from all of the models of depression presented so far in this section.

Complex cognitive-behavioral models give rise to complex CBT interventions. Current CBT interventions for depressed children and adolescents, which have been adapted from adult interventions, seem to follow a trend in that they tend to incorporate multiple models of depression and include techniques from many different treatments. As noted by Blagys and Hilsenroth (2002), "While some treatments may emphasize cognitive more than behavioral techniques, and vice versa, these interventions typically share an appreciation for both basic learning principles and the role that cognitions play in human behavior and affective experience" (p. 674). Thus, CBT interventions attempt to address the development and maintenance of depression by intervening on multiple levels of functioning.

According to Kazdin and Marciano (1998) the trend of child and adolescent CBT interventions to incorporate techniques from various models of depression "stems from the scope of impairment evident in children (e.g., comorbidity, academic dysfunction) and families (e.g., stress, conflict)" (p. 237). Thus, in order to bolster the efficacy of CBT interventions for depressed youth by not overlooking any possible avenue that contributes to psychological distress, researchers are using a number of intervention techniques (e.g., problem-solving, cognitive restructuring) in a number of ways (e.g., individual therapy, group therapy, family therapy). Kazdin and Marciano (1998) warn, however, that combining treatments does not necessarily ensure their effectiveness and suggest that "there is no substitute for understanding individual components of treatment, how they operate, and how they can be maximally deployed to achieve change" (p. 238). Hence, by borrowing and combining multiple techniques, researchers may lose sight of the individual "ingredients" in their treatment packages, and not fully understand which components of treatment, if any, produce the greatest effects.

### *Summary and Conclusions*

Overall, depression has been conceptualized in multiple ways, including environmental, cognitive, and behavioral. Environmental models of depression argue that external factors (i.e., stressful events) mediate the development and maintenance of the disorder, whereas cognitive and behavioral models attribute psychological distress to internal variables such as distorted information processing and coping deficits. Some theories of depression combine these models, (i.e., cognitive-behavioral models) and suggest that the development and maintenance of the disorder depends on preexisting cognitive and behavioral characteristics that are triggered in the face of stressful life events. These characteristics can include errors in information processing, negative attributional biases, use of inadequate coping and problem-solving strategies, lack of positive reinforcement, or deficits in self-control skills. Each of these adult models of depression has been applied to youth depression as downward extensions.

The cognitive-behavioral model of youth depression posits that many, if not all, of these factors contribute to depressive disorders in adolescents and children. This multifaceted approach is seen in CBT interventions for youth, which target both basic learning principles and cognitions by combining techniques from multiple models of depression in an attempt to address psychological distress and impairment. Thus, current CBT interventions for youth follow a trend of combining numerous treatment components from both cognitive and behavioral models of depression. Although addressing multiple domains of functioning is a noble endeavor, researchers warn that incorporating numerous treatment components may not booster the efficacy of CBT interventions. In fact, interventions that contain numerous treatment components may muddy the waters by obscuring how CBT works to produce positive outcomes. The use of multiple treatment components without understanding or delineating the potential

effect of each one creates complex interventions that do not explain why or how recovery from depression is achieved.

The next section will examine the various treatment components of CBT interventions for depressed youth. Specifically, this section will discuss the general characteristics and components of CBT treatment programs. Then, the specific treatment components of the CBT intervention upon which the present research effort is based, the ACTION program, will be presented in detail.

## CBT Interventions for Depressed Youth

As discussed in previous sections of this chapter, CBT is the preferred psychosocial intervention for depressed children and adolescents. CBT models integrate several different theories of depression, including environmental, cognitive, and behavioral. According to the CBT model, depression in youth results from a combination of distorted cognitive processes, a negative attributional bias, inadequate coping and problem-solving skills, deficits in self-control, and a lack of positive social reinforcement. All of these variables contribute to depressogenic vulnerability by rendering a youth ill-equipped to manage minor and major life events. Since each of these variables is thought to play some role in the development and maintenance of depression, current CBT interventions tend to incorporate multiple treatment components from cognitive and behavioral models into one treatment package in an effort to systematically address each of these underlying vulnerability factors as well as to increase the overall efficacy of the intervention. The following section will explore the general characteristics and treatment components of CBT interventions for depressed youth. It will also review the specific treatment components of the study upon which the present research effort is based.

### *Characteristics and Treatment Components*

One characteristic of CBT interventions for youth is that they are unique. Current consensus is that there is not one model of CBT and that most treatments use a variety of different strategies in many different combinations (Stark et al., 2006). In fact, in a meta-analysis of sixty-four different CBT interventions, Durlak, Fuhrman, and Lampman (1991) identified seven different, core treatment components, including task-oriented problem-solving, social problem-solving, self-instructions, role-playing, rewards, social cognition training, and social skills training as well as a less common category that included "other" CBT strategies. Thus, general CBT interventions are comprised of multiple techniques or treatment components.

This is also the case for CBT interventions that are specifically designed to treat depression in youth. These treatments also use a variety of components (e.g., problem-solving, social skills training, cognitive restructuring) and activities (e.g., role-playing, rewards and reinforcement) to elicit symptom reduction. Additionally, these interventions tend utilize various forms of treatment delivery (e.g., individual, group, family). For example, the major treatment components that comprise Lewinsohn and colleagues' (1990, 1996) Adolescent Coping with Depression course include mood monitoring, social skills training, pleasant events scheduling, relaxation training, cognitive restructuring, communication skills training, conflict resolution, and problem-solving. These components are taught to the participants through a variety of means (e.g., didactic presentations, role-play, homework assignments) and in different formats (e.g., group therapy with the adolescents, family therapy, booster sessions). Thus, like most CBT interventions, the Adolescent Coping with Depression course, an empirically supported CBT treatment, is comprised of multiple treatment components that attempt to

address numerous variables associated with the development and maintenance of depression in order to achieve the greatest possible symptom reduction and relief.

Overall, CBT interventions appear to be designed to teach depressed youth how to recognize sources of stress in their lives, change negative cognitive attributions of major life events, recognize and alter distorted thinking patterns, attitudes, assumptions, and beliefs, engage in self-control behaviors to obtain long-term goals, foster positive reinforcement in their every day experiences, employ effective coping strategies, resolve problems, and regulate negative affect. By addressing each of these variables, it is hoped that youth will gain the necessary tools for coping with dysphoric affect and for preventing further depressive episodes.

The following section will describe a CBT intervention for depressed youth that follows the general trend by combining multiple treatment components into one comprehensive treatment package. This intervention is called the ACTION program and has been developed by K. D. Stark and colleagues (2004a) at the University of Texas at Austin. It is currently being tested in a 5-year treatment efficacy study.

### *The ACTION Program: A CBT Intervention for Depressed Girls*

The ACTION program was specifically designed to treat depressed girls, ages 9 to 13 years, using a group CBT format. Certain elements of the treatment have been tailored for this particular population such as the delivery format, a focus on interpersonal relationships, and the gender of the therapists; however, the overall treatment design is typical of CBT interventions for depressed youth of all ages and genders and contains all of the core components of the cognitive and behavioral treatment models. In addition, the ACTION program integrates self-control and reinforcement theory into its intervention, offering a complex and comprehensive treatment package that is delivered in multiple formats (i.e., group, individual, family meetings). Treatment is delivered

primarily in child groups; however, therapists also meet individually with treatment participants and their families and a parent group is offered to some participants as a comparison condition in the current study. Furthermore, all participants receive "booster" sessions each semester following completion of treatment.

***Background***

The ACTION program is based on a structured therapist's manual (Stark et al., 2004a) and workbook (Stark et al., 2004b) that were designed to be gender specific and developmentally appropriate for young girls. This group CBT intervention is school-based, targeting depressed girls in the 4th through 7th grades. Participants are recruited through a multiple gate screening process from two school districts in Central Texas. In order to participate in treatment, the girls must receive a diagnosis of a depressive disorder on a structured diagnostic interview. All participants are randomly assigned to three treatment conditions: (1) group CBT only, (2) group CBT plus parent training, or (3) waitlist control condition. A detailed discussion of the participants, selection criteria, and procedures is provided in Chapter Three: Methodology.

The children in the active treatment groups participate in 20 group meetings and two individual meetings over a period approximately 12 weeks. These meetings are approximately 45 to 60 minutes in length and are held at school during elective classes whenever possible. Child groups usually contain no more than six members. The CBT plus parent training component condition differs from the CBT only condition in that it includes eight group meetings for the participants' primary caregivers and two individual family meetings. All of these meetings are conducted after school. The girls from the child groups attend four of the eight family meetings. The children in the waitlist control condition receive no immediate therapeutic intervention; however, they are monitored weekly for worsening of symptoms and are offered active treatment at the end of the

waiting period if they are still experiencing a significant level of depressive symptoms. The group meetings are designed to be enjoyable and engaging with the goal of teaching the participants effective ways to alleviate depressive symptoms as well as to manage interpersonal problems and other stress (Stark et al., 2006). The therapists use didactic presentations and activities, modeling and rehearsal, and homework assignments to teach the relevant therapeutic skills.

***Rationale***

According to Stark and colleagues (2006), the ACTION program is based on a self-control model; however, in closely examining the different aspects of treatment it is clear that this particular intervention blends cognitive and behavioral techniques that stem from multiple models, including Beck's (1967) cognitive model, Lewinsohn's (1974, 1976) reinforcement model, and Rehm's (1977) self-control model. Thus, in order to address multiple areas of dysfunction, Stark and colleagues have incorporated therapeutic skills from many different depression models and treatment packages.

The participants in the ACTION program are taught specific skills to alleviate their depressed moods and to maintain more positive affect such as coping strategies, problem-solving skills, and cognitive restructuring. In addition, the girls are also encouraged to recognize a decline in affect, negative thoughts, or other signs of depression as signals to engage in one of these treatment skills. Finally, participates engage in self-monitoring, goal-setting, and pleasant events scheduling to elevate depressed mood and to build a more positive sense of self. Thus, participants are taught to recognize and to regulate their affect using a variety of specific CBT techniques as well as to develop more realistic thought patterns and more positive self-schema. A detailed discussion of the specific treatment components of the ACTION program

follows. For the sake of this analysis, only the components of the child group CBT intervention will be described.

### *Core Treatment Components*

*Affective education.* According to Stark and colleagues (2006), the affective education component of the ACTION intervention program represents a psycho-educational piece in which participants learn about depression and how to manage it. The goal of this component of treatment is to help participants to become more aware of their experience of the disorder, including their thoughts, feelings, and actions. An additional goal of affective education is to teach the cognitive model of depression, with special attention being paid to the relationship between thoughts, feelings, and behaviors. Affective education is also use to help the girls recognize their experiences of depression as cues to engage in self-management techniques.

At the beginning of treatment, the participants are taught to recognize and label their emotions using the "3 Bs": (1) body, (2) brain, and (3) behavior. The girls are asked to discuss feelings that they experience frequently such as sadness, anger, or anxiety and to describe how these feelings are expressed physiologically, cognitively, and behaviorally. For example, a girl may say that when she feels sad, she gets a lump in her stomach (body), she thinks "No one loves me" (brain), and she withdraws and stops talking to her friends (behavior). By learning how to label and identify unpleasant emotions, the girls can recognize times when they need to use different therapeutic skills to elevate their mood. A sample Affective Education Worksheet, which facilitates the acquisition of the 3 Bs, is provided in Appendix B.

Another aspect of affective education is teaching the participants a simplified model of depression in which unpleasant emotions are caused by negative thoughts and/or difficult situations. The girls are specifically taught to manage sadness and other

unpleasant emotions through three strategies: (1) coping, (2) problem-solving, and (3) cognitive restructuring. In order to decide which skill to use, the participants are instructed to use different techniques for different situations. First, the girls are taught to use coping when they experience an unpleasant emotion that stems from a situation over which they have no control (e.g., divorce, death). Next, participants are trained to use problem-solving when their unpleasant feelings are caused by a situation over which they may have control (e.g., failing a test, a fight with a friend). Finally, the therapists instruct the girls to use cognitive restructuring when feelings of sadness, anger, or anxiety stem from underlying, negative thoughts or beliefs (e.g., "I'm a failure"). Thus, participants learn to use different skills to cope with stress from multiple sources.

The final, critical component of affective education is teaching the relationship between negative thoughts and subsequent unpleasant emotions and behaviors (Stark et al., 2006). Per Beck's (1967) cognitive theory, the girls are taught to identify the underlying, automatic thoughts that precede unpleasant feelings or behaviors. The theory is demonstrated through a variety of activities and homework assignments. In addition, in order to elicit negative thoughts and clarify the link between negative thoughts and unpleasant feelings or actions, the therapists ask specific questions such as "What were you thinking when...?" and "What was going on in your brain when you felt...?" when the participants describe experiencing negative emotions and behaviors typical of depression such as sadness or withdrawal. Teaching participants how to recognize and label their negative feelings and thoughts, how to define and conceptualize depression, and how thoughts are related to feelings and behaviors provides the foundation for the introduction and application of skills that will help to manage unpleasant emotions (e.g., coping strategies, problem-solving) and dismantle irrational beliefs (e.g., cognitive restructuring).

*Coping strategies*. One of the core treatment components of the ACTION program is coping strategies. As discussed in a previous section, studies have shown that depressed individuals exhibit significant deficits in ability to cope with stressors. The girls are taught five broad categories of coping strategies as a means of controlling or changing unpleasant emotions that result from uncontrollable events. These categories include (1) doing something fun and distracting, (2) doing something soothing and relaxing, (3) doing something that uses energy, (4) talking to someone, and (5) thinking in a more positive way. Each broad category is demonstrated in treatment through activities in order to show how effective the coping strategies can be in changing unpleasant feelings.

The girls are specifically instructed to use these coping strategies to change their unpleasant emotions when they stem from situations or events that are outside of their control. Situations in which participants would be prompted to use their coping strategies to alleviate feelings of distress might include events such as the separation or divorce of parents, the illness of a family member, or the death of a friend or relative. In these situations, the youngster cannot control the event that causes her distress; however, she can attempt to make herself feel better by engaging in enjoyable, distracting, or soothing activities, by using physical energy to release feelings of sadness, anxiety, or angry, by confiding in a friend or family member, or by engaging in positive self-talk. A sample Coping Strategies Worksheet is provided in Appendix C.

*Problem-solving*. Another core treatment component is problem-solving. In this intervention, problem-solving skills are taught as a separate component from the coping strategies even though they are subsumed under coping in the relevant literature. The specific problem-solving procedure is based on a model described by Kendall (e.g., Kendall & Braswell, 1993). The girls in the ACTION program are taught the following

five problem-solving steps as a means of changing undesirable, but potentially controllable situations that result in unpleasant emotions: (1) problem identification, (2) goal definition, (3) solution generation, (4) consequential thinking, and (5) solution evaluation. To help the girls remember the steps, they are called the "5 Ps."

During the problem identification step the girls learn how to narrow and define the problem that they are experiencing. In the goal definition step, the girls are encouraged to set a goal for the problem by thinking about how they would like the situation to be resolved. Next, the girls generate multiple solutions or plans for the problem. During this step, the girls are encouraged to come up with as many solutions as possible without regard to whether or not they will actually resolve the problem. In the next step, consequential thinking, the girls are encouraged to evaluate each solution based on past experience and feasibility and are encouraged to chose the best plan (or combination of plans) for achieving their goal. They are also encouraged to evaluate plans in terms of whether or not they would create additional problems. For example, kicking your younger brother (plan) might get him to stop teasing you (goal), but it will probably create new problems (getting into trouble with your parents). Finally, the girls are asked to try their solution and then to evaluate its effectiveness. If a selected solution fails, then the girls are encouraged to select another plan from their generated list or to come up with an entirely new solution. If the problem is irresolvable, then the girls are prompted to manage their unpleasant feelings by employing one or more of the five coping strategies.

The therapists model the problem-solving steps for the participants and then apply them to both hypothetical and real-life problems during group meetings. Additionally the participants practice problem-solving at home by completing therapeutic homework assignments. Not only are the girls taught how to solve problems, they are also taught

how to recognize that a problem exists. Specifically, the girls are taught to pay attention to certain signs (e.g., stress, feelings of disappointment, muscle tension) that may indicate that they are experiencing a problem and to use these signals to prompt them to engage in problem-solving. In contrast to the coping strategies, the girls are taught to engage in problem-solving when they are faced with an unpleasant situation over which they may have control such as failing a class, fighting with a friend or sibling, or getting into trouble at home or school. As stated previously, if a problem is uncontrollable, then the girls are encouraged to use the coping strategies to achieve a reduction in distress. A sample Problem-Solving Worksheet is provided in Appendix D.

*Cognitive restructuring*. Cognitive restructuring is another core treatment component. Since distorted beliefs about the self, others, and the world are a hallmark feature of depression (Beck, 1967; Beck et al., 1979), the program attempts to counter these maladaptive ways of thinking by first teaching the girls to recognize their negative, automatic thoughts. Since this sometimes proves to be a challenging task, especially among children, the girls are also taught how to and rewarded for recognizing each other's negative thoughts. The therapist models this behavior in group. In addition, specific therapeutic homework assignments also encourage the girls to "catch" and record their negative thoughts.

Once the girls become proficient in recognizing and articulating their negative thoughts, they are taught specific cognitive restructuring techniques to counter negative thoughts and to create more positive or realistic thoughts. Two specific questions are used to help the girls evaluate the validity of their negative thoughts: "What is another way of looking at it?" and "What are the clues or evidence that suggest that this thought is not true?" The first question helps the youngsters to look for more positive, plausible explanations for certain negative thoughts. For example, if a girl has the negative thought

"She hates me" in response to her best friend passing her in the hall and not saying "hello," then she is encouraged to think of other reasons that may have caused her friend to not talk to her such as she was instructed not to talk in the halls by her teachers, she was in a bad mood, or she just did not see her friend.

The other question is helpful when a girl has a negative thought about herself that is probably quite distorted such as "No one loves me" or "I'm a failure." When girls present with these thoughts in group, they are encouraged to examine the evidence both for and against the thought to see if the thought is valid. For example, if a girl has the thought that no one loves her because her mother is too busy to play with her, she is instructed to put this "evidence" in the category that supports the thought. Then, she is instructed to generate all of the additional evidence that suggests that she is unlovable. After she has come up with all of the evidence for the negative thought, then she, the therapist, and the other group members generate evidence that does not support it such as different ways in which her mother shows that she loves her or that she is cared for by other people such as her friends, teachers, therapist, or group members. In addition to coming up with examples that support or fail to support the negative thought, the girls are instructed to weigh each example in terms of its importance.

Before and after examining their negative thoughts, the girls are instructed to rate how much they believe the thought using a scale from one to ten, with one being "not true at all" and ten representing a definite, true thought. Initially, girls tend to rate their negative thoughts high; however, after using the cognitive restructuring questions, they assign relatively low numbers to the original thought. If they no longer believe it, then the girls are encouraged to come up with a new, more realistic thought to replace the old, negative thought. If the negative thought still seems true, then the girls are instructed to engage in problem-solving and/or coping strategies to change the situation that is eliciting

the thought or to improve their mood. Since the girls are learning to evaluate their negative thoughts, the cognitive restructuring techniques that are used are called the "Thought Judge" questions. The girls learn to "judge" the truth of their negative thoughts and beliefs and to replace distorted ideas with more realistic, more positive ones. A sample of the Cognitive Restructuring Worksheet, which helps participants learn and practice cognitive restructuring, is provided in Appendix E.

***Other Treatment Components***

In addition to the core treatment components derived from cognitive and behavioral models of depression, the ACTION program has also incorporated other therapeutic techniques into its treatment package that are based on self-control and reinforcement theory. These components are important; however, they are less central to the overall intervention.

*Building a positive sense of self.* An important aspect of treatment is the building of a more positive sense of self. Through a unique treatment activity, participants are taught to expand their view of themselves and to discover personal strengths in multiple domains. Through this self-evaluative process it is hoped that participants will begin replace negative self-schema with more realistic, more positive beliefs about the self. Towards the end of treatment, participants are given a diagram. This diagram is called a "self-map" and is made up of different circles that connect to a center circle. The center circle represents the participant and the surrounding circles represent areas of life in which the participant possesses skills or strengths. The areas on the self-map include domains such as interpersonal relationships ("As a friend"), academic and extracurricular activities ("In school"), and physical appearance ("In my looks"). The therapist introduces the self-map by leading a discussion of a particular domain. Together, the group members generate attributes or strengths in each domain. After this discussion, the

therapist instructs the group members to fill in the circle on their self-map that represents this domain with their unique strengths. The girls are encouraged to help each other. For example, when completing the "In my looks" domain, a participant may find only a few strengths (e.g., nice eyes, pretty hair) or none at all. In this situation, the therapist then instructs the other group members to contribute other attributes that they believe that the participant possesses (e.g., rosy cheeks, long fingernails, beautiful smile). Thus, the group helps the participant to recognize strengths in areas that she has failed to see. In addition to receiving input from the therapist and other group members, teachers, parents, and school counselors are also contacted to contribute to various areas of the self-map. A sample self-map can be found in Appendix F.

*Setting goals.* Another treatment component is goal-setting. Based on self-control theory, the intervention utilizes goals as a way for the girls to self-monitor, self-reward, and self-evaluate. At the beginning of treatment, the therapists create detailed case conceptualizations for each group member. These conceptualizations guide goal-setting in that the therapist works collaboratively with the participant to create treatment goals based on the child's underlying cognitive distortions and/or environmental stressors as well as any areas that the child wishes to change. Typical treatment goals include feeling better, not fighting with friends, siblings, and/or parents, and making more friends. In an individual meeting, the therapist and the participant generate treatment goals, ways to achieve these goals, and ways to overcome possible barriers. The participant is asked to share her goals with the group to generate support and ideas for reaching the desired outcomes. Progress towards goals is continuously monitored, discussed, and rewarded in group. At the end of treatment, participants are encouraged to reward themselves for progress towards goals. Additionally, the effects of goal-setting

and achievement are discussed and support for setting new goals is provided. A sample goals sheet is found in Appendix G.

*Self-monitoring.* The ACTION program also contains a self-monitoring component that focuses on noticing and engaging in pleasant activities similar to strategies pioneered by Lewinsohn and colleagues (1974, 1976). The girls are instructed to create lists of activities that they enjoy and that enhance mood (i.e., a pleasant events schedule) and they are encouraged to increase engagement in these activities immediately. This list is referred to as the "Take ACTION List" (TAL). Using these lists, the therapists demonstrate that there is a link between positive mood and engagement in pleasant activities. The girls are taught that they are capable of affecting their mood by doing fun things. Furthermore, the girls are also asked to notice and record positive events in their lives in a weekly diary ["Catch the Positive Diary" (CPD)]. Once again the therapists use this self-monitoring device in group to demonstrate how pleasant events can affect mood. The girls are shown that by "catching" pleasant events and by "doing" fun things, they can exert control over their mood and do not have to feel helpless in the face of depressive feelings. Samples of the TAL and CPD can be found in Appendices H and I.

*Therapeutic homework.* Therapeutic homework is a hallmark CBT treatment and differentiates it from other forms of therapy (Blagys & Hilsenroth, 2002). All of the therapeutic concepts and treatment components that are introduced are practiced by the girls outside of the group via weekly homework assignments. Homework assignments are designed to help participants translate what they have learned in the group meetings into real-life situations. By practicing and applying therapeutic skills outside of group, it is hoped that change will be facilitated in multiple areas of the girls' lives.

### *Summary and Conclusions*

Although there is no one, agreed upon model of CBT intervention for depressed youth, most interventions combine a variety of treatment components that are derived from various models in an effort to increase the efficacy of a particular treatment package. By including multiple treatment techniques, it is hoped that a particular intervention will address the complex nature of depression in youth as well as repair the multiple underlying vulnerability factors suggested by current models of the disorder.

The ACTION program is an excellent example of a comprehensive CBT treatment for youth depression. Following the trend of several other interventions, the ACTION program incorporates and utilizes treatment components from numerous models of depression in an effort to address the multiple areas of vulnerability that trigger and maintain the disorder and to increase treatment efficacy. This multi-level approach to treatment appears to be helpful since early, qualitative data suggest that approximately 88% of participants no longer meet criteria for depression by the end of treatment (K. D. Stark, personal communication, June 22, 2007).

Although the ACTION program is demonstrating impressive preliminary results, the multifaceted nature of the treatment intervention makes it almost impossible to understand which treatment components, if any, are contributing to treatment outcome. Also, because the effect of each treatment component is not measured by the researchers, it is not possible to know if one treatment component renders the intervention more efficacious than another. It will be important for this promising intervention to attempt to partial out the effects of each of the various treatment components to better understand how and why the treatment is contributing to positive outcomes. The following section will review the existing research regarding the efficacy of current CBT interventions for depressed youth.

## Empirical Investigations of CBT for Depressed Youth

CBT has been investigated as a treatment for depressed youth in a number of studies. Furthermore, this treatment modality appears to be widely employed. For example, in a comprehensive meta-analytic review of twenty-four psychosocial studies for depression in youth, Michael and Crowley (2002) found that the most popular treatment modality was group CBT, followed by individual CBT, social skills training or individual NST, and relaxation training. Social skills and relaxation training are, typically, components of CBT. Thus, the majority of youth depression treatment studies to date have examined the efficacy of CBT or some component of CBT. The following section will review past and present treatment outcome research. Studies comparing CBT with control conditions, specific therapeutic interventions, psychosocial treatments, and psychopharmacological interventions will be examined in detail.

### *Studies of CBT in Comparison to Control Conditions*

One way in which the efficacy of a particular treatment can be established is by comparing the treatment to no treatment or to a placebo condition. CBT has been compared with control conditions in a number of investigations (e.g., Butler, Miezitis, Friedman, & Cole, 1980; Clarke et al., 1999; Kahn et al., 1990; Lewinsohn et al., 1990; Stark et al., 1987; Weisz, Thurber, Sweeney, Proffitt, & LeGagnoux, 1997; Reynolds & Coats, 1986). Overall, CBT has repeatedly proved to be more efficacious in reducing depressive symptoms than no treatment (i.e., wait-list control) or placebo (i.e., attention) conditions. The following section will review intervention studies that have tested the efficacy of CBT in comparison to control conditions.

#### *CBT and Wait-List Conditions*

It is common in the child and adolescent treatment literature to see studies that have compared the effects of CBT with a wait-list control condition. In a study with

depressed adolescents using active treatment groups and a waitlist control group, Clarke and colleagues (1999) randomly assigned 123 youth ages 14 to 18 years to three treatment conditions: (1) group CBT, (2) group CBT with a separate parent group, and (3) waitlist control. The two active conditions received sixteen 2-hour sessions of CBT over a period of eight weeks. The CBT with a separate parent group condition received an additional nine sessions of parent training, with the adolescents attending two of these meetings. At the end of the acute phase of treatment, participants were then assigned to one of three follow-up conditions for a 24-month period: (1) assessments and booster sessions every four months, (2) assessments only every four months, or (3) annual assessments.

The researchers found that participants in the active treatment conditions demonstrated higher rates of recovery from depression (66.7%) than those in the wait-list condition (48.1%). Recovery rates between the two active treatment groups were not significantly different. Twelve months after treatment, 100% of the participants in the assessments and booster session group exhibited recovery, whereas only 50% of participants in the other follow-up phase conditions no longer exhibited a significant level of depression. Twenty-four months after treatment, however, recovery rates were similar for the booster group (100%) and the two other groups (90%). Booster sessions did not reduce the rate of recurrence among the study participants; however, they did seem to facilitate the recovery of participants that had not experienced full symptom remission at the end of the acute phase of treatment.

Overall, the researchers concluded that group CBT is an efficacious intervention for depressed adolescents. Furthermore, they reported that CBT interventions that incorporate parent training do not seem to significantly increase overall efficacy. Finally, the researchers suggested that, while booster sessions may be useful in decreasing

depressive symptoms that do not fully respond to acute treatment, they do not appear to prevent the recurrence of future depressive episodes. The finding that booster sessions and parent training components do not significantly enhance treatment outcome is consistent with prior research (e.g., Lewinsohn et al., 1996; Lewinsohn et al., 1990). The results from this study are consistent with a number of studies that have compared the efficacy of CBT with a wait-list control condition and found that participants in active treatment groups evidenced greater symptom reduction (e.g., Asarnow et al., 2002; Kahn et al., 1990; Lewinsohn et al., 1990; Rossello & Bernal, 1999).

***CBT and No Treatment***

CBT has also been compared to no treatment. In a study by Weisz and colleagues (1997), a sample of 48 mildly to moderately depressed 3rd through 6th graders was randomly assigned to a brief CBT intervention (eight 50-minute, school-based group meetings) or to no treatment. The active treatment condition emphasized self-control and cognitive restructuring strategies, incorporating specific techniques from other treatment programs (e.g., Reynolds & Coats, 1986; Stark et al., 1987). Participants in the study were assessed for depressive symptoms at three different times: (1) pre-treatment, (2) within 18 days of completing treatment, and (3) at a 9-month follow-up. Results revealed that participants in the active condition reported significantly lower symptoms of depression on a self-report measure and a semi-structured interview at post-treatment compared to their peers in the no treatment group. Furthermore, the gains associated with active treatment were maintained at the 9-month follow-up, with treated children much more likely than untreated children to be within the normal range on the study's depression measures. Thus, compared with no treatment, brief CBT intervention appears to be better at reducing depressive symptoms in school-age children.

*CBT and Attention Placebo Conditions*

In addition to wait-list and no treatment control conditions, CBT interventions for depressed youth have also been compared with attention placebo control conditions. These control conditions take into account the fact that participants may experience a therapeutic change simply from getting extra attention. To test whether CBT is more efficacious than attention, researchers compare it with control conditions in which the participants interact regularly with the research staff. For example, Vostanis and colleagues (Vostanis, Feehan, Grattan, & Bickerton, 1996a, b) compared the efficacy of CBT with a non-focused intervention (NFI) in a randomized, controlled sample of 57 out-patient children and adolescents ranging in age from 8 to 17. The CBT intervention, which consisted of nine sessions, had three main treatment components: (1) affective education, (2) social skills training (including problem-solving), and (3) cognitive restructuring. The NFI condition also consisted of nine sessions; however, in these meetings, the therapists reviewed participants' mood and social activities without offering advice, interpretations, or therapeutic interventions. Thus, the NFI condition provided the participants with attention; however, it did not explicitly attempt to address depressive symptoms through the use of therapeutic techniques. The participants in both conditions were assessed for depression before and after treatment as well as at a 9-month follow-up.

Vostanis and colleagues (1996a) found that both CBT and NFI reduced depressive symptoms as assessed at post-treatment, with 87% of participants in the CBT group and 75% of NFI participants no longer presenting with a depressive disorder. Fifty-six participants were assessed nine months following treatment. These results revealed that treatment effects were relatively stable between groups, with slight, non-significant increases in depressive symptoms in the CBT group. Thus, in this particular

study, CBT provided no more symptom relief than an attention placebo control condition at post-treatment or at follow-up. The authors concluded that the empathy, listening, reassurance, and attention that the participants received in the NFI condition as well as from family members may have had unintended non-specific therapeutic effects. Furthermore, the same therapists were used in each condition, and they were allowed to offer verbal (e.g., "You are doing well") and non-verbal (e.g., nodding, smiling) praise in the NFI condition. These forms of praise could be interpreted as positive reinforcement (an aspect of CBT) and, thus, therapeutic in nature; however, the similar rates of recovery between the two groups cast some doubt on the specific effects of CBT.

Another study in which the efficacy of CBT was compared with an attention control condition also did not show CBT to be superior in reducing depressive symptoms. Liddle and Spence (1990) found that a brief intervention (eight sessions) which included several established components of CBT (e.g., cognitive restructuring, problem-solving) was not superior to an attention placebo condition or to no treatment in a sample of 31 children (7 to 12 years old). These results, however, were limited by the small sample size used in the study, which decreased power and made it difficult to determine significant treatment effects among groups. Furthermore, other researchers have concluded that, upon further investigation, the participants in the CBT condition did in fact report greater symptom reduction those in the other two conditions (Stark et al., 2006). Thus, CBT did seem to exert a beneficial effect in this study.

The findings from Vostanis and colleagues (1996 a, b) and Liddle and Spence (1990) contrast findings previously discussed in which Brent and associates (1997) found superior treatment effects when comparing CBT with NST. However, it is possible that non-specific factors in the attention placebo control conditions influenced rates of recovery in ways that were similar to the specific effects of CBT. Clearly, more research

is needed in this particular area before firm conclusions regarding the efficacy of CBT in comparison to attention placebo control conditions can be drawn.

In conclusion, CBT has proven to be superior in reducing depressive symptoms in youth when compared with specific control conditions: wait-list or no treatment. When compared with attention placebo conditions or NST, CBT has demonstrated a high degree of efficacy in most instances; however, it has not always provided superior symptom reduction. In future studies with attention placebo conditions, researchers should strive to increase the sample sizes of their trials and to control for non-specific therapeutic effects that may be present when therapeutically-trained personnel conduct control groups.

### *Studies of CBT in Comparison to Specific Intervention Techniques*

It is important to establish that CBT is better than control conditions at treating depression in youth; however, it is equally important to determine that CBT produces superior treatment effects when compared with other therapeutic interventions. If CBT does not perform better than other treatment techniques, then it cannot be considered a front-line intervention for depressed youth. Thus, in addition to comparing the efficacy of CBT with control conditions, researchers have also attempted to evaluate this form of therapy in contrast to specific intervention techniques.

Studies exploring the efficacy of CBT compared with specific intervention techniques have supported its usefulness in reducing depressive symptoms in children and adolescents (Kahn et al., 1990; Reynolds & Coats, 1986; Wood et al., 1996); however, its superiority has not always been consistently demonstrated. This section will discuss the efficacy of CBT in comparison to relaxation training and self-modeling. Both of these therapeutic interventions have their roots in CBT even though they are not generally considered stand-alone treatments for depressed youth.

### *CBT and Relaxation Training*

Several studies have compared CBT to relaxation training (e.g., Kahn et al., 1990, Reynolds & Coats, 1986, Wood et al., 1996). For example, Reynolds and Coats (1986) compared a self-control therapy-based form of group CBT with relaxation training and a wait-list control condition in a small sample of 30 high school students. Both of the interventions were significantly more effective in reducing depressive symptoms at a post-treatment and a 5-week follow-up assessment than the wait-list control condition; however, comparison of the two active treatments showed no significant differences in effectiveness. Due to the small sample used in this study, differences between treatment effects may have been difficult to detect. In fact, the researchers concluded that the small sample size as well as the use of a single therapist for both treatment conditions may have prohibited the determination of differences between these active interventions.

In another investigation of CBT compared to relaxation training, Wood and colleagues (1996) found evidence that CBT was superior to relaxation training in reducing depressive symptoms in a clinical sample of children and adolescents. In this study, 53 psychiatric inpatient youth with major or minor depressive disorders were randomly assigned to brief CBT (five to eight sessions) or to relaxation training. The CBT intervention consisted of a cognitive component based on Beck's (1967) cognitive theory, a social problem-solving component, and a behavioral component targeting sleep disturbance and engagement in pleasant activities. At post-treatment, the researchers found that the CBT intervention evidenced a moderate effect (.73) and was superior to the relaxation training condition in reducing depressive symptoms. Thus, in this study, which included a larger sample size compared to the study by Reynolds and Coats (1986), CBT demonstrated greater effectiveness than relaxation training.

### *CBT and Self-Modeling*

In addition to relaxation training, CBT has been compared to other interventions such as self-modeling. In a study of 6th through 8th graders, Kahn and colleagues (1990) compared the efficacy of CBT, relaxation training, self-modeling, and a wait-list control condition on depressive symptoms in a sample of 68 students that were randomly assigned to one of the four conditions. Children in the CBT and relaxation training conditions met in groups of two to six students over the course of a 6- to 8-week period for a total of twelve 60-minute sessions. The CBT condition consisted of a downward extension of Lewinsohn and colleagues' (1990, 1996) Adolescent Coping with Depression course combined with strategies from a self-control intervention (e.g., Reynolds & Coats, 1986). Treatment components included constructive thinking, goal-setting, self-reinforcement, pleasant events scheduling, problem-solving, and social skills training.

Compared with participants in the wait-list control condition, participants in all three active treatment conditions evidenced significant and substantial gains at a post-treatment assessment and a one-month follow-up with no differences between the various forms of active treatment. Qualitatively, the participants in the CBT and relaxation training groups appeared to experience better symptom improvement over time than in the self-modeling group, with higher rates of students in these groups meeting "non-clinical" criteria at follow-up. Although this study suggests that CBT is not superior to relaxation training or self-modeling in treating depressed youth, these findings are severely limited by the small sample size. With so few participants in each condition, it is very difficult to distinguish treatment effects among the three active interventions.

Given the mixed results of these studies, it is not possible to determine if CBT is a superior treatment for youth depression when compared with other therapeutic

techniques. However, the study with the largest number of participants among different treatment groups (i.e., Wood et al., 1996) provides evidence that CBT may produce greater symptom reduction than relaxation training. Once again, more research comparing CBT with other therapeutic techniques is needed before firm conclusions can be drawn. It is interesting to note, however, that CBT did prove to be superior to wait-list control conditions in the two studies in which they were used despite the fact that it did not always outperform other therapeutic techniques.

### *Studies of CBT in Comparison to Other Psychosocial Interventions*

In order to become recognized as a well-established and superior intervention for youth depression, the efficacy of CBT must be compared with other forms of psychosocial treatment. Thus, in addition to exploring its efficacy in relation to specific therapeutic techniques, researchers are beginning to compare CBT interventions with other forms of treatment such as IPT-A, NST, family therapy, and life skills training. This section will describe these studies.

#### *CBT, Family Therapy, and NST*

As discussed previously, Brent and colleagues (1997) have examined the effects of CBT in comparison to two other psychosocial interventions, SBFT and NST, in a sample of 107 depressed adolescents in a clinical setting. In this study, participants in the CBT group evidenced a higher rate of remission of MDD (64.7%) compared with their peers in the SBFT group (37.9%) or in the NST group (39.4%). However, after two years, participants in all three conditions demonstrated equal improvement, with about 80% no longer meeting criteria for a depressive disorder (Birmaher et al., 2000). Thus, evidence from this study suggests that CBT produces greater immediate symptom change relative to family and supportive therapy; however, over time its superiority does not persist.

***CBT and IPT-A***

In addition to SBFT and NST, CBT has also been compared with IPT-A. Rossello and Bernal (1999) evaluated the efficacy of CBT and IPT-A in a sample of 71 depressed Puerto Rican adolescents. Participants were referred from local schools, assessed for symptoms of depression, and randomly assigned to one of three conditions: (1) CBT, (2) IPT-A, and (3) wait-list control. Youth in the active treatment conditions received weekly 60-minute individual therapy sessions for 12 weeks. The CBT condition consisted of teaching participants how to identify and change dysfunctional attitudes, self-monitor, engage in cognitive restructuring to change negative thoughts, increase pleasant activities, and build a social support system and strengthen family relationships. Youth in the IPT-A condition received care that focused on the development and maintenance of their depression in relation to their interpersonal relationships. Therapists in this condition helped participants to resolve problems related to grief, interpersonal disputes, role transitions, and/or interpersonal deficits. It is interesting to note that techniques used in the IPT-A condition resemble basic CBT strategies. For example, in discussing role transitions, the therapists examined the positive and negative aspects of the new and old roles and helped clients to realistically evaluate what was lost. These strategies are reminiscent of cognitive restructuring techniques in which clients examine the evidence for and against negative thoughts in an effort to find alternative ways of looking at difficult situations.

At the end of treatment, results revealed that both active treatments were effective in reducing depressive symptoms and increasing self-esteem when compared with the wait-list control condition, with 82% of participants in the IPT-A condition and 59% of participants in the CBT condition moving into the functional range. Furthermore, there

was no difference between the treatments at a 3-month follow-up; however, the CBT group continued to make non-significant gains.

Although this study found that CBT and IPT-A equally improved depressive symptoms over time, there are a number of methodological limitations that restrict the conclusions that can be drawn from it. First, the study relied on a small, culturally homogenous sample of youth, which severely limits generalizing the findings to other, more diverse populations. Next, the researchers relied solely on self-report data and did not use an outcome measure capable of diagnosing depressive disorders. Finally, the researchers employed a unique, nontraditional form of CBT and employed a form of IPT-A which resembled CBT. In spite of these limitations, this study does provide evidence that CBT is an efficacious treatment for depressed, Latino adolescents compared with a wait-list control condition; however, it suggests that IPT-A may be a superior treatment in this particular population.

***CBT and Life Skills Training***

In a recent investigation, Rohde and colleagues (2004) compared a group CBT intervention with life skills training in a sample of 93 depressed and conduct disordered adolescents (ages 13 to 17 years) in juvenile justice setting. The youth in both treatment conditions attended 16 sessions over an 8-week period. The researchers attempted to make the groups as similar as possible in regard to the contact time of the interventionist, number of sessions, and non-specific therapeutic factors such as group composition. Participants in the CBT condition were taught several skills, including self-monitoring, pleasant events scheduling, cognitive restructuring, social skills, conflict resolution, and communication techniques. Participants in the other treatment condition reviewed current events, received academic tutoring, and learned basic life skills such as filling out job and rental applications.

At termination, results indicated that 39% of youth in the CBT condition evidenced recovery from major depression compared with 19% of youth in the life skills training condition. These differences, however, were not maintained at 6- and 12-month follow-up. The researchers concluded that the CBT intervention demonstrated significant post-treatment improvements in depressive symptoms; however, they acknowledged that long-term gains were not maintained. This study is somewhat ground-breaking in its attempt to examine both the efficacy and effectiveness of a CBT treatment for depressed adolescents. The fact that CBT performed well in a "real-world" setting lends credibility to the idea that this form of psychosocial treatment can be successfully transported from a research setting into a community setting.

In sum, when compared with other psychosocial interventions for youth depression, the findings are somewhat mixed for CBT. Although some studies have suggested that CBT is equal to or less efficacious as some forms of intervention (i.e., IPT-A), other studies have shown that CBT is superior to treatments such as SBFT, NST, and life skills training. Research comparing the efficacy of CBT to other psychosocial interventions is preliminary and many more studies are needed before it can be determined that CBT is superior to other forms of treatment.

### *Studies of CBT in Comparison to Psychopharmacological Interventions*

In order to further establish CBT as an efficacious treatment for depressed youth, it is important to test this form of psychosocial intervention against current psychopharmacological treatments. Recently, researchers have begun to compare CBT with the use of psychotropic medication for the treatment of depression in youth using randomized controlled trials.

***CBT and SSRIs***

March and colleagues (2004) have examined the efficacy of CBT and fluoxetine separately and in combination in the TADS. In this study, the efficacy of a combined CBT and fluoxetine intervention was compared with fluoxetine only, CBT only, and a control condition in a volunteer sample of 439 depressed youth ages 12 to 17 years. After 12 weeks of treatment, the CBT and fluoxetine group evidenced significant symptom improvement, which was superior to all other groups. Seventy-one percent of participants in the combination therapy condition demonstrated symptom improvement, 60.6% of participants in the fluoxetine only condition showed a reduction in depressive symptoms, 43.2% of participants in the CBT only condition experienced decreased symptoms of depression, and 34.8% of youngsters in the control condition evidenced improvement. Thus, the combination of CBT and fluoxetine proved to be produce greater treatment effects than fluoxetine only or CBT only, and fluoxetine only demonstrated better results than CBT only.

The findings from this study suggest that CBT only is not nearly as effective for treating adolescent depression as fluoxetine or a combination of CBT and fluoxetine; however, these findings are not without criticism. First, the recovery rate of the CBT condition in the TADS (43%) is much lower than the typical rates of recovery (approximately 62% to 63%) in other youth depression CBT intervention studies (see Verdeli et al., 2006 for a review of meta-analyses). In addition, this rate of recovery was measured after 12 weeks of intervention, which is considered an acute phase of treatment and may not account for a delayed effect of CBT, especially given the symptom severity of the population in the TADS (Verdeli et al., 2006). It has also been suggested that the form of CBT used in the TADS was not a well-developed or generalizable version of the intervention (Stark et al., 2006; Verdeli et al., 2006). After reviewing the CBT

intervention used in the TADS, Stark and colleagues (2006) concluded that, essentially, half of the treatment was devoted to learning cognitive and behavioral skills and the other half focused on social skills training. Thus, participants had little exposure to components that teach core CBT skills. Furthermore, it does not appear that the therapists in the intervention attempted to restructure negative automatic thoughts, distorted beliefs, or maladaptive core schemas. Thus, the cognitive restructuring techniques that were used in the CBT condition did not fully address factors that create depressogenic vulnerability. In light of these methodological limitations, conclusions drawn from the TADS regarding the overall efficacy of CBT in treating depressed youth need to be viewed with caution.

In sum, in comparison to psychopharmacological interventions, such as SSRIs, CBT has not been showed to provide superior improvements in depressive symptoms in adolescent in one study in which it was compared with fluoxetine; however, due to limitations associated with the type of CBT that was used in this study, much more research is needed before firm conclusions can be drawn regarding the relative efficacy of these two treatments. Given the safety concerns associated with antidepressant medication that were presented in an earlier section of this chapter, CBT may still prove to be the preferred method of intervention with depressed children and adolescents, especially in the presence of suicidal ideation or potential self-harm.

### *Summary and Conclusions*

In summary, the efficacy of CBT interventions for depressed youth has been tested in a number of studies and in a number of ways. First, CBT has been compared with control conditions such as wait-list, no treatment, or attention placebos. Overall, CBT has consistently proved to be superior to wait-list and no treatment control conditions; however, evidence that CBT is more efficacious than attention placebo

control condition is unclear. Next, CBT been compared with specific therapeutic techniques. In general, CBT appears to provide superior symptom reduction to relaxation training; however, this has not proven to be the case in every study. The efficacy of CBT has also been tested against other psychosocial interventions. The results from these studies have been mixed, indicating that CBT is superior to SBFT, NST, and life skills training in immediate post-treatment assessments, but not over time. Also, IPT-A has been shown to produce equal or greater symptom improvement in relation to CBT. CBT and IPT-A, however, may produce similar results due to commonalities in their treatment models and delivery. Finally, when a CBT only condition was compared with a fluoxetine only condition and a fluoxetine plus CBT condition in a recent study, CBT did not demonstrate superior effects to medication or to the combination of medication and CBT. Due to the limited number of studies that have examined the efficacy of CBT in relation to SSRIs as well as limitations from this particular study, firm conclusions regarding the superiority of these medications in relation to CBT cannot yet be drawn. However, SSRIs may prove to be a superior treatment to CBT for more severely depressed adolescents.

In almost all of the studies reviewed in this section, CBT has shown considerable efficacy even if it has not always produced greater symptom improvement than other forms of treatment. Thus, approximately two decades of research support CBT's position as a "possibly efficacious" treatment for youth depression. Furthermore, researchers have concluded that some CBT treatment packages are "probably efficacious" for treating child (e.g., Stark et al., 1987, 1991) and adolescent (i.e., Lewinsohn et al., 1990; 1996) depression (Verdeli et al., 2006). Current CBT researchers are working to improve their methodology in an attempt to rectify short-comings of past studies. In the

meantime, CBT continues to be the most researched psychosocial intervention for depressed youth and the most preferred among clinicians.

There are several areas that have not been adequately addressed in the youth depression CBT treatment outcome literature. First, although many studies have tested the efficacy of CBT with depressed adolescents, there is a paucity of research studies that have examined the effects of this psychosocial intervention on depressed children. For example, of the studies that were explicitly reviewed in this section, only two (i.e., Liddle and Spence, 1990; Weisz et al., 1997) focused exclusively on elementary school children. Two studies targeted high school students (i.e., Clarke et al., 1999; Reynolds & Coats, 1986), one study focused on middle school students (i.e., Kahn et al., 1990), five studies had a mix of middle and high school students (i.e., March et al., 2004; Brent et al., 1997; Rohde et al., 2004; Rossello & Bernal, 1999; Wood et al., 1996), and one study included participants from elementary through high school (i.e., Vostanis et al., 1996). Clearly, there appears to be a bias in these studies for testing CBT in depressed adolescents. In order to establish its efficacy as an intervention for depressed youth, CBT interventions must be tested in both adolescents and children.

Overall, CBT appears to be an efficacious treatment for youth depression; however, there are many areas of research related to this form of psychosocial intervention that deserve further attention. The next section will detail some of the current issues in treatment outcome research.

## Current Issues in CBT Treatment Outcome Research

In general, CBT interventions for depressed youth demonstrate positive treatment effects; however, there are limitations associated with these treatments and there are several areas of research that remain virtually untapped. This section will explore current issues in CBT treatment outcome research, including the difference between treatment

efficacy and effectiveness, the importance of understanding mechanisms of change, the identification of necessary and sufficient treatment components, and the perspective of the treatment participants.

### *Efficacy versus Effectiveness: From Research to Practice*

One of the major limitations of CBT treatment outcome research with depressed children and adolescents is that almost all of the studies conducted to date have examined the efficacy, not the effectiveness, of this style of intervention. This presents a problem because establishing efficacy in a study does not ensure the effectiveness of a particular treatment when it is applied in a clinical setting. Efficacy can be defined as "how well a treatment is known to bring about change in a target syndrome in research" and effectiveness can be defined as "how well an intervention is expected to perform in a "real world" setting" (Chorpita, 2003, p. 42). Thus, efficacy studies examine a particular treatment in a controlled manner using laboratory conditions, whereas effectiveness studies explore treatment outcome in clinical settings without the use of control procedures. Efficacy studies show what a treatment can do in an ideal situation; however, this may be quite different than what they can do in real setting (Kazdin & Nock, 2003). In order for an intervention to be considered truly evidence-based, it must demonstrate both efficacy and effectiveness. Although CBT interventions for depressed youth have demonstrated promising efficacy, more tests of effectiveness are necessary before they can be considered well-established.

In addition to testing whether or not a CBT treatment package is efficacious and effective, it is important to examine the efficacy and effectiveness of the specific treatment components. That is, it is important to understand which treatment components contribute the most and the least to treatment outcome. Since it is often difficult to generalize efficacious treatments to clinical settings in which time and resources are more

restricted, it will be important to streamline interventions by only including "ingredients" in treatment that are the most capable of producing therapeutic change.

### *Understanding Mechanisms of Change*

Another limitation of the current CBT treatment outcome research on child and adolescent depression is that intervention studies have solely addressed the question "Does treatment work?" and neglected the question "How does treatment work?" That is, multiple studies have shown that CBT is an efficacious intervention; however, they have failed to examine how or why this form of intervention produces therapeutic change (Kazdin, 2002; Kazdin & Nock, 2003).

The mechanisms of change in CBT are assumed to be the specific components that comprise the treatment since they are based on theoretical models of depression; however, multiple factors have been found to contribute to therapeutic outcome. These factors include specific mechanisms of change (i.e., treatment components) and non-specific mechanisms of change such as therapist qualities (e.g., race, gender, years of experience and training), client characteristics (e.g., race, socioeconomic status, gender), change processes (e.g., emotional catharsis, learning and using new skills), treatment structure (e.g., focus), and therapeutic relationship (e.g., therapeutic alliance, transference) (Bickman, 2005). Given the fact that CBT is not always superior to other psychosocial treatments in treating depressed youth, non-specific therapeutic factors may play an important role in treatment outcome. Since both specific and non-specific factors are thought to affect treatment outcome, it is important to understand how these variables contribute, alone and in combination, to therapeutic change.

In the adult literature, the relative contribution of specific and non-specific factors to treatment outcome in CBT interventions is unclear. Burns and Nolen-Hoeksema (1992) demonstrated that compliance with therapeutic homework influenced degree of

recovery in CBT intervention for adults; however, the researchers also found that non-specific factors such as willingness to engage in treatment and coping style contributed to treatment outcome. In another study, Castonguay, Goldfried, Wiser, Raue, and Hayes (1996) showed that the therapeutic alliance significantly contributed to improvement in depressive symptoms and global functioning, whereas adherence to specific CBT treatment components correlated negatively with depressive symptoms in a sample of 30 adults. Thus, in adult CBT interventions for depression it is unclear how specific and non-specific mechanisms of change influence treatment outcome and to what degree.

At present, no known studies have attempted to isolate the effects of specific and common factors in CBT interventions designed exclusively for depressed youth. Some researchers have begun to examine the effects of specific and non-specific variables in relation to treatment outcome in depressed youth with comorbid conditions. In a recent study, Kaufman and colleagues (2005) examined the role specific (i.e., treatment components) and non-specific (i.e., therapeutic relationship variables) factors as potential mediators of treatment outcome in a CBT intervention for depressed and conduct disordered adolescents referred from the juvenile justice system (i.e., Rohde et al., 2004). Six specific factors (e.g., cognitive restructuring, pleasant events scheduling) and two non-specific factors (e.g., therapeutic alliance, group cohesion) were explored. Results from this study suggest that a factor that is specific to CBT interventions (i.e., cognitive restructuring of negative automatic thoughts) was the primary mechanism of change through which depressive symptoms were reduced. In addition, while therapeutic alliance was higher by the third session in the CBT condition compared with the other treatment condition, this non-specific factor did not predict decreases in depressive symptoms. Thus, in preliminary studies of CBT treatments for depressed and conduct disordered youth, the primary mechanism of change was a specific treatment component.

Since most studies of treatment outcome in have failed to explore the contributions of specific and non-specific mechanisms of change in CBT interventions for depressed youth and adults, it is unclear if techniques that are specific to the CBT model have therapeutic effects beyond those of factors that are common to all forms of treatment. In fact, based on the limited data that is available, some researchers have concluded that in adult studies "it is possible that the most important factor in determining whether or not CBT is effective has nothing to do with any CBT-specific component of the treatment" (King, 1998, p. 86). Recent research of mechanisms of change in adolescent treatments for depression (e.g., Kaufman et al., 2005) seems to provide initial evidence to refute this claim; however, clearly, there is a need for further research in this area.

Thus, while we know that CBT appears to be relatively efficacious in treating youth depression, we still do not understand how or why it works. In future investigations, it will be important to isolate the effects of specific and non-specific factors in order to better understand the underlying processes related to treatment outcome. Since it is assumed that the specific intervention facilitates therapeutic change, an examination of the efficacy of the different treatment components of CBT interventions for depressed youth may be a good place to begin understanding mechanisms of change.

### *Identifying the Necessary and Sufficient Components of Treatment*

Typical CBT interventions for depressed youth utilize multiple treatment components in an effort to produce positive treatment effects. Since these treatment packages combine several techniques, it is not clear whether certain treatment components produce more change than others. For example, does problem-solving produce more change than cognitive restructuring? In addition to understanding how and

why CBT works with depressed youth, it is also important to understand which treatment components contribute to positive outcomes and to what degree. That is, researchers must begin to identify which components of treatment are necessary and sufficient for therapeutic change.

Although there is growing empirical support for the efficacy of CBT interventions for depressed youth, there are virtually no data to indicate the relative contribution of the individual treatment components to treatment outcome. In 1998, Kaslow and Thompson reported that no investigations have examined the specific components of depression interventions for youth with the goal of determining which aspects of treatment are most beneficial for which clients even thought the question "What works for whom and why?" is considered the ultimate goal of treatment outcome research. In reviewing the treatment outcome literature, Kazdin and Weisz (1998) concluded that "...outcome studies frequently illustrate that a treatment program has had beneficial effects but rarely identify the "effective ingredients" associated with the effects identified" (p. 30). Examining whether CBT is "better" than other forms of treatment in reducing depressive symptoms may not be as essential as understanding which components of treatment influence which processes and contribute to improved outcomes (Kazdin & Marciano, 1998). Since the underlying goal of all treatments is to optimize recovery, identifying specific intervention components that contribute the most to therapeutic change ought to improve treatment outcome (Kazdin & Nock, 2003).

In order to compare the treatment components of an intervention package to determine their relative efficacy, researchers can conduct components analyses by dismantling treatment packages and testing the parts against the whole. In addition, researchers can conduct trials in which specific treatment components are tested against each other. Finally, qualitative studies can be used to determine the relative helpfulness

of the different treatment components from the perspective of the participants. To date, no known studies have attempted to identify the effect of all of the treatment components of a specific CBT intervention for depressed youth using any of these designs. Furthermore, few such studies have been conducted with adults. The following section will briefly describe the existing studies that have examined the effect of some treatment components in CBT interventions for adults and youth.

***Studies of Treatment Components in CBT Interventions for Depression***

Few studies exist in the adult treatment outcome literature that compares the efficacy of the components of a CBT intervention for depression. In a recent investigation, Christensen, Griffiths, MacKinnon, and Brittliffe (2006) dismantled their on-line CBT intervention for depression and compared the effectiveness of brief versions of the original treatment package with the entire treatment as well as with each other in a randomized controlled trial in a sample of 2,794 adults that completed the study via registration through the researchers' website. Six versions of intervention were compared with one another, including (1) a brief overview of core CBT concepts, (2) a brief overview of core CBT concepts and interpersonal problem-solving skills, (3) a brief overview of core CBT concepts, interpersonal problem-solving skills, and relaxation training, (4) a brief overview of core CBT concepts, cognitive restructuring, and interpersonal problem-solving skills, (5) a brief overview of core CBT concepts, cognitive restructuring, pleasant events scheduling, and interpersonal problem-solving skills, and (6) the full CBT intervention.

Results suggested that scores of depressive symptoms were lower in participants that completed both of the versions that combined brief CBT psycho-education, cognitive restructuring, and problem-solving (i.e., Version 4 and 5). Furthermore, Version 1 and 2 were not found to significantly reduce depressive symptoms in participants. Thus, brief

CBT psycho-education alone or in combination with problem-solving skills was not a powerful enough intervention to produce positive change; however, in combination with cognitive restructuring, these components did lead to fewer depressive symptoms. Given this finding, the researchers concluded that cognitive restructuring seemed to be the most significant treatment component in relation to treatment outcome.

This study is extremely innovative; however, it is not without limitations. Since the researchers used combinations of treatment components rather than comparing one component with another, it is difficult to form firm conclusions regarding which components are truly responsible for change. Also, since the brief versions of the treatment were different lengths and the versions with longer lengths proved more effective, it is possible that depression reduction may have been higher in these treatment conditions because symptoms had more time to spontaneously remit. Despite these limitations, the study represents a novel contribution to the CBT treatment outcome research literature in that it attempts to better understand the effects of the specific components of an intervention for adult depression. Only a few studies have examined the specific components of CBT interventions for youth depression in relation to treatment outcome. Although there are no formal treatment components analyses of these interventions, the following studies do provide interesting, preliminary information regarding the efficacy of specific CBT treatment components and may serve to guide future research.

Butler and colleagues (1980) compared various components of CBT with each other in a treatment study of 56 5$^{th}$ and 6$^{th}$ graders with depressive symptoms. In this investigation the researchers randomly assigned participants to two active treatment conditions and two control conditions (i.e., no treatment and attention placebo). One active treatment condition taught cognitive restructuring principals such as identifying

and changing negative automatic thoughts and the other active treatment condition seems to have taught basic problem-solving skills through a role-play format. Both active conditions contained 14 participants and consisted of 10 intervention sessions.

According to the researchers, the participants in both active treatment conditions evidenced significant improvement in depressive symptoms on quantitative (i.e., self report questionnaires) and qualitative (i.e., teacher interviews) measures; however, the children in the problem-solving/role-play condition experienced a higher rate of improvement (64%) compared with their peers in the cognitive restructuring condition (50%). Thus, in this particular study, problem-solving appeared to ameliorate depressive symptoms better than cognitive restructuring.

These results, however, need to be interpreted with caution given the small sample size of the active treatment groups, the way in which depression was assessed, and the type of cognitive restructuring that was employed by the group leaders. Rather than providing evidence against distorted thoughts and attempting to alter core beliefs, the group leaders identified and replaced negative thoughts with positive ones. In addition, they taught listening skills and talked about the link between thoughts and feelings. Changing negative automatic thoughts is only one aspect of cognitive restructuring and may not be a powerful enough technique to elicit long-term gains since it does not fully address underlying, maladaptive core beliefs. Although this investigation has several limitations, it does provide interesting, preliminary information regarding the efficacy of two core components of most CBT interventions.

Other researchers have attempted to explore the effects of different CBT treatment components using non-traditional research methods. For example, Feehan and Vostanis (1996) used qualitative data to understand how a CBT intervention (i.e., Vostanis et al., 1996a) was perceived and used by participants as well as to explore the

helpfulness of different treatment components. In this study, 57 psychiatric referred youth, ages 8 to 16 years, were randomly assigned to a CBT intervention for depression and a non-focused treatment condition. The CBT condition included nine individual treatment sessions, conducted every other week for no more than 20 weeks. These sessions consisted of three main treatment components: (1) recognizing and labeling emotions, (2) cognitive restructuring, and (3) improving social skills and social problem-solving abilities. At the end of the study, participants in the CBT condition evidenced an 87% rate of improvement in symptoms compared with 75% of participants in the non-focused intervention.

In order to understand the usefulness of the different treatment components, the researchers reviewed therapist session rating sheets and descriptions of participant compliance with treatment components and homework as well as participant, parent, and therapist perception of the helpfulness of treatment. At the end of treatment, participants were also asked to recall the most helpful treatment component. Analysis of the data indicated that children with higher rates of treatment compliance evidenced better treatment outcomes than non-compliers. In addition, participants, parents, and therapists agreed that treatment was above average in terms of helpfulness, with mean ratings ranging from 4.6 to 5.5 on a scale from 1 to 8. Interestingly, although the child ratings of helpfulness were not correlated with their own improvement, therapist ratings of helpfulness did distinguish depressed from non-depressed participants at the end of treatment. Finally, when asked "What did you find most helpful about the treatment?" "most" participants spontaneously stated that problem-solving was the most beneficial component of treatment. Other helpful factors mentioned were learning about the link between thoughts and moods, self-rewards, learning to identify positive aspects of self, and being listened to by treatment therapists.

Findings from this final piece of the study are limited in that the researchers did not indicate the number of interviews that were conducted, the interviews were not systematically analyzed using an approach such as grounded theory, and detailed participant responses were not provided by the authors. Furthermore, only half of the CBT treatment participants (52%) attended one of two cognitive restructuring sessions, whereas all participants were present for one or more of the two sessions that addressed problem-solving. Thus, participants were not exposed to problem-solving and cognitive restructuring in equal doses. In addition, as seen in the previous study by Butler and associates (1980), the cognitive restructuring techniques utilized in this study focused solely on changing negative, automatic thoughts. Despite its limitations, this study deserves recognition for attempting to understand the utility of different components in a CBT intervention for depressed youth from the perspective of the participants.

Overall, there are only a few studies that have examined the efficacy or effectiveness of specific treatment components in CBT interventions for depressed adults or youth. Drawing conclusions from these investigations is difficult given their dissimilar and limited designs; however, tentative results suggest that problem-solving may be an important specific mechanism of change in youth populations, whereas cognitive restructuring may lead to greater improvements in adults.

Since the disparity between research and practice is growing, in part, because research-based treatments are not easily transported to clinical settings due to time, resources, and training constraints (Weisz, Weiss, & Donenberg, 1993), it is crucial to identify the effect of different treatment components in CBT interventions in order to determine which are necessary and sufficient for therapeutic change. Creating streamlined interventions that can be used in clinical settings may serve to bridge the gap between research and practice. Overall, studies that have attempted to isolate the effects

of specific treatment components in relation to treatment outcome in CBT interventions are rare. Furthermore, there are no known studies that have purposely tested specific treatment components in comparison with a complete CBT intervention package to determine which components, if any, offer the greatest reduction in depressive symptoms. Thus, an important goal of future investigations is to identify the treatment components that are essential for therapeutic change.

### *The Participants' Voice: The Missing Link*

Another area of research that has been consistently neglected in CBT interventions for depressed youth is the participants' perceptions of treatment. There are very few studies that have looked at the experience of treatment and/or various treatment components from the perspective of the participants and, furthermore, no known studies have done in a systematic way in children and adolescents receiving CBT treatment for depression. Thus, although various CBT treatment packages may work to produce therapeutic change, we do not know how the youth participants perceive or experience treatment and we do not know if they understand, enjoy, apply, and find the various treatment components that comprise these interventions useful.

CBT is a collaborative intervention in which the therapist and client work together toward symptom reduction or relief. Thus, if we do not obtain the participants' perspective on the treatment process and outcome, then we are neglecting half of the equation that is responsible for change.

Since some forms of CBT are considered probably efficacious in treating youth depression, it is assumed that change results from participants understanding, enjoying, and using the skills that comprise the intervention. Thus, change is attributed to specific factors (i.e., treatment components). At present, there are no known studies have attempted to support this assumption. Furthermore, evidence suggests that non-specific

factors may influence change as much as, if not more than, specific factors in adult populations (Burns & Nolen-Hoeksema, 1992; Castonguay et al., 1996).

The only way to truly know how change occurs in CBT interventions for depressed youth is by giving the participants a voice. That is, in order to understand which therapeutic factors have or have not contributed to treatment outcome and to what degree, we must afford the participants an opportunity to tell us, the researchers, how they did or did not change as a result of being in our treatment programs. With rare exceptions (e.g., Feehan & Vostanis, 1996), most treatment outcome studies to date do not explore the participants' perception of treatment despite the fact that the client is the most important variable in relation to therapeutic change.

## Statement of Purpose

A better understanding of how and why mechanisms of change influence outcome in children and adolescents undergoing CBT treatment for depression is an important empirical endeavor with significant clinical and research implications. First, identifying factors that influence treatment outcome can lend support to existing treatment models, inspire new ways of thinking about old models, or allow new models to emerge. Understanding how, why, and which factors contribute to change can influence the evolution or development of theory and, therefore, lead to better psychosocial interventions. Furthermore, an understanding of which treatment components are sufficient and necessary for therapeutic change is needed for practical and theoretical reasons. From a practical perspective, understanding which treatment components are most efficacious in eliciting change can result in more efficient and cost-effective treatments. For example, if the treatment effects associated with problem-solving are minimal, then this treatment component could be discarded and a more streamlined intervention would result. Given the devastating and enduring effects of youth

depression, it is imperative to utilize efficacious treatments. Finally, it is essential to capture the effects of different treatment components as well as the experience of treatment from intervention participants, and in their own words, in order to refine and create treatments that best serve the most important factor in therapy: the client.

An unanswered question in the field of child and adolescent treatment outcome research is whether the treated youngsters enjoy, understand, and find CBT helpful and, if so, which therapeutic factors, specific and non-specific, are the most useful in producing change from their point of view. Thus, in order to examine how a CBT intervention for depressed youth contributes to positive change from the perspective of the treatment participants, a qualitative research design would be useful. A qualitative study would further our knowledge of factors that influence treatment outcome as well as the relative usefulness of different treatment components from the perspective of the individuals that they are most likely to affect. In addition, it would bring us one step closer to designing more effective treatments as factors that facilitate change could be maximized in future treatment packages. A qualitative study of the mechanisms of change in relation to treatment outcome in a CBT intervention would also expand our knowledge of the theoretical models upon which these treatments are based.

Although there are many possible mechanisms of change in therapy, this investigation focused primarily on specific factors and, more explicitly, on treatment components. The goal of this research effort was to further our understanding of the effect of the treatment components in a specific CBT intervention for youth depression: The ACTION program. This intervention has evidenced preliminary success in treating depressed girls ages 9 to 13 years; however, because the program is comprised of multiple treatment components and the researchers have not assessed the relative contribution of each one, it is not clear which therapeutic technique, if any, produce

positive change. Thus, this research effort attempts to capture the experience of treatment, with a particular focus on the helpfulness of the different treatment components, from the perspective of the participants using a qualitative research design. As the study evolved, it became clear that common factors or non-specific mechanisms of change also played an essential role in treatment outcome. Therefore, the study was expanded to better understand how variables such as treatment structure and participant characteristics influenced treatment outcome.

# CHAPTER THREE

# METHODOLOGY

Although a relatively well-developed body of literature documents the efficacy of CBT in treating depression in youth, little is known about how or why this form of psychosocial intervention produces positive change. In other words, the specific and non-specific mechanisms of therapeutic change are not well understood. In addition, since CBT interventions use multiple therapeutic techniques in an effort to decrease depressive symptoms, optimize recovery, and increase overall efficacy, the treatment components (i.e., specific factors) that are necessary and sufficient for change are not well delineated. Finally, few studies have attempted to understand the process and outcome of treatment from the perspective of participants. Thus, the children and adolescents that undergo CBT treatment for depression have not had the opportunity to contribute to existing theories, models, or interventions.

This study examined the mechanisms of change in a group CBT intervention for depressed girls from the perspective of the participants. Specifically, the investigation explored the overall helpfulness of treatment as well as the effects of specific and non-specific factors on treatment evaluation and outcome. The initial focus of the study was the specific mechanisms of change (i.e., treatment components); however, as data collection and analysis proceeded, it became evident that non-specific factors (i.e., treatment structure), alone and in relation to specific factors, played a crucial role in treatment evaluation and outcome. Therefore, the investigation was amended to gather information regarding these important variables.

Since an additional aim of the study was to provide an opportunity for youth that had undergone treatment for depression to discuss their experience, data were gathered

directly from former participants of the ACTION program. According to Patton (2002), "...the purpose of interviewing, then, is to allow us to enter into the other person's perspective" (p. 341). Thus, data were collected via semi-structured interviews in order to "gather the stories" of the participants. In addition, therapist reports, therapeutic homework assignments, quizzes, diagnostic interviews, and self-report measures were compared with data from the interviews to check for accuracy and consistency.

Qualitative research methods are particularly well-suited for studying areas of inquiry about which little is known (Strauss & Corbin, 1990). Additionally, "...qualitative methods can give the intricate details of phenomena that are difficult to convey with quantitative methods" (Strauss & Corbin, 1990, p. 19) such as individuals' thoughts, feelings, and perceptions. Qualitative research methods have many purposes, including clarifying or extending quantitative findings, developing knowledge, guiding practice, directing future research, or building theory (Strauss & Corbin, 1990). Among the many forms of qualitative research are ethnography, phenomenology, life histories, discourse analysis, and grounded theory. The grounded theory approach of qualitative research was used to analyze the data in the present study. The following section will present an overview of this particular approach.

## Overview of the Grounded Theory Approach

Grounded theory is a form of qualitative research in which a theory is developed from the data through an inductive process while exploring a particular phenomenon. In other words, a grounded theory is one that is "...discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon" (Strauss & Corbin, 1990, p. 23). Thus, rather than utilizing data to test a specific theory, the grounded theory approach allows a theory to emerge from studying a particular phenomenon. Instead of devising and testing hypotheses, the grounded theorist

begins her investigation with broad research questions that begin to narrow in scope as data collection and analysis proceed. The purpose of the grounded theory approach is to uncover or construct theory that represents and expands what is known about the phenomenon under investigation. An additional goal of this qualitative research approach is to develop theory that will be useful in guiding future research and that will have practical applications.

The grounded theorist typically uses comprehensive interviews and/or observations to collect data, and she acts as the primary data collection agent. By using in-depth methods to gather information, the researcher is able to derive meaningful findings from smaller sample sizes than typically encountered in quantitative studies. The researcher may conduct multiple interviews and/or observations with different informants or compare information gathered in this manner with other sources, such as records, reports, or measures, to ensure that her data is valid and reliable.

The collection and analysis of data occurs simultaneously and in alternating sequences so that each stage can shape and inform the other. Thus, continued data collection is guided by on-going data analysis. When analyzing data, the researcher uses a series of coding methods to break the information down into meaningful units of comparison as well as to allow concepts to blend together to form guiding themes. Specifically, the researcher employs open, axial, and selective coding to analyze data.

According to Strauss and Corbin (1998), open coding involves identifying concepts in the data and developing these concepts in terms of their properties and dimensions. During axial coding, relationships among these concepts or categories are described in relation to causal conditions, specific dimensional locations, and context. In addition, actions or strategies associated with the concept and consequences of actions or strategies are also identified. During selective coding, the researcher selects a core

category (i.e., the central phenomenon around which the categories are integrated) and relates it to other categories, examines and validates the relationship between those categories, and further develops and refines categories. Thus, by breaking the data down into categories and constantly comparing these concepts, a central phenomenon or theory is allowed to emerge from the data.

## Research Questions

As noted earlier, qualitative efforts begin with general inquiries that guide data collection. In the present study, these broad research questions were:

1. How is a group CBT intervention for depressed girls perceived by the participants? Is the treatment helpful? How effective is the treatment in reducing depressive symptoms, increasing skills, and elevating mood from the perspective of the participants?
2. Are there identifiable stressors that are associated with depression? If so, what are they? How do the participants manage these stressors prior to treatment? How do their stressor management strategies change as a result of being in treatment?
3. How do the participants experience treatment? Do they change over the course of treatment? What changes do they make? What factors (i.e., specific or non-specific) influence change?
4. How do the treatment components influence change? Which treatment components are most frequently recalled, best understood, most frequently used, and perceived as most helpful? How do these skills help? Which components are least recalled or perceived as least helpful?

## Participants

Seventeen girls were drawn from six schools (three elementary and three middle schools) in two school districts in Central Texas. The mean age and grade of the participants at the time of the initial interviews was 11.35 (SD = 1.27) and 5.47 (SD = 1.07) respectively. The following section will present an overview of participant demographic information.

### *Demographic Information*

The participants reflected the cultural and economic diversity of the school districts in which they attend elementary and middle school. In terms of ethnic background, three participants described their ethnicity as White or Caucasian, five participants indicated that they were of Hispanic or Latino descent, one participant stated that she was Black or African-American, and eight participants identified themselves as bi- or multi-racial.

With regard to family composition, ten participants reported that they lived in in-tact families in which both biological parents were living in the home. Three participants came from single-parent homes in which a mother or a father had sole or joint custody. Four participants identified their family configuration as blended, stating that a biological parent and a step-parent or a domestic partner were present in the home. In addition, three participants reported having families in which extended family members such as aunts, uncles, cousins, or grandparents were also present in the home. For more detailed demographic information for each participant, please refer to Table 1. As discussed previously, culturally sensitive pseudonyms created by the researcher will be used throughout this document in order to protect the participants' privacy.

Table 1

*Demographic Information*

| Participant | Age | Grade | Ethnicity | Family Composition | Highest Level of Parental Education |
|---|---|---|---|---|---|
| Courtney Ainsworth | 11 | 6 | C | Intact | Unknown |
| Alika Williams | 12 | 6 | AA | Intact | Unknown |
| Mahina Washington | 12 | 6 | AA & H | Single parent | Some college |
| Sophie Stuessi | 13 | 7 | C | Intact | Some college |
| Lydia Fuentes | 12 | 6 | H | Intact | Unknown |
| Alexandra Aguilar | 13 | 6 | H | Single parent | Some high school |
| Angelina Salazar | 12 | 6 | C & H | Single parent | Some college |
| Olivia Ramirez | 13 | 7 | H | Intact | Some high school |
| Lucia Castillo | 13 | 7 | C & H | Intact | High school diploma |
| Mia Mancini | 11 | 5 | H | Intact | Some college |
| Jamilla Wick | 11 | 5 | AA & H | Intact | Some college |
| Danielle Aiza | 11 | 5 | H | Intact | Unknown |
| Gwendolyn Griffith | 10 | 4 | C | Intact | College degree |
| Paris Lopez | 10 | 4 | C & H | Blended | High school diploma |
| Shaneika Bowen | 10 | 4 | AA & C | Blended | College degree |
| Devora Abbott | 9 | 4 | C & NA | Blended | Unknown |
| Sarah Schneider | 10 | 5 | C & NA | Blended | College degree |

*Note*. AA = African-American; C = Caucasian; H = Hispanic; NA = Native-American.

## Procedure

### *Participation in the Larger Study*

#### *Participant Recruitment*

Participants were drawn from a larger study evaluating the efficacy of a group CBT intervention for depressed girls (i.e., the ACTION program). In the ACTION program, participants are recruited from several schools within two school districts in Central Texas through a multiple gate assessment process. Letters describing the study and requesting permission to participate in an initial screening process (see Appendix J) are sent home to all girls at participating schools in the $4^{th}$ through $7^{th}$ grades. The girls are given a small incentive (e.g., a pencil) to return the forms. Graduate Research Assistants work closely with the school principals, school counselors, and teachers to ensure distribution and return of screening permission forms.

Measures of depressive symptoms are completed in large groups by girls who receive parental consent and assent to participate (see Appendix K) in the screening. Participants at both school districts complete the Children's Depression Inventory (CDI; Kovacs, 1981). At one school district, participants also complete the Beck Depression Inventory for Youth (BDI-Y; Beck, Beck, & Jolly, 2001). Girls scoring 16 or higher on the CDI and/or 25 or higher on the BDI-Y go on to complete a brief symptom interview, the DSM-IV interview (Stark, 2003). Girls reporting a significant number of depressive symptoms on the DSM-IV interview are given a letter to take home to their parents that describes the next phase of the study (see Appendix L). Once parental permission and child assent (see Appendix M) are received, the child and her primary caregiver are independently interviewed with the Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present State (K-SADS-P IVR, Ambrosini & Dixon, 2000). After completing the K-SADS interview, the girls and their parents are given feedback

over the telephone or in person. If a girl meets criteria for a diagnosis of MDD, DD, or DDNOS, she and her primary caregiver(s) are given a letter inviting them to participate in the study (see Appendix N). If parent permission and child assent are obtained, then the girls and their parent(s) complete pre-treatment assessment batteries in small groups, which are administered by trained doctoral students at the participating schools. These measures include self-report questionnaires designed to assess depressive symptoms, cognitive style, life events, and family functioning.

Exclusionary criteria for the ACTION program include presence of significant psychotic symptoms, an IQ below 85, learning disabilities that prevent the completion of researcher measure or the comprehension of treatment concepts, severe medical conditions that prevent regular attendance and participation in treatment meetings and activities, a diagnosis of an emotional or behavioral disorder that is primary to and more severe than an existing depressive disorder, current psychosocial and/or psychopharmacological treatment for depression, and active or severe suicidal or homicidal ideation.

***Content of Treatment***

The ACTION program is a 20-session group CBT intervention for depressed girls. It includes individual meetings and a parent training component. The intervention is a gender specific, developmentally sensitive treatment program that adheres to a structured therapist's manual (Stark et al., 2004a) and child workbook (Stark et al., 2004b). The treatment program uses the self-control model of depression, as well as other theories, to teach participants to utilize specific skills to change unpleasant feelings and distorted thoughts in order to achieve and maintain positive moods and cognitions (Stark et al., in 2006). The primary objectives of the treatment are to reduce depressive symptoms in participants through the use of several core CBT techniques, including

affective education, coping strategies, problem-solving skills, and cognitive restructuring. In addition, other therapeutic techniques (i.e., building a positive sense of self, goal-setting, self-monitoring, therapeutic homework) are also used to facilitate recovery from depression. For a full description of the different treatment components, please refer to the CBT for Depressed Youth section in Chapter Two: Review of the Literature.

The ACTION intervention is delivered in stages, with specific sessions being devoted to the core treatment components. The first session is an introduction to the treatment and to the other group members. Meetings 2-4 focus on affective education and coping skills, teaching participants how to identify their emotions, how to use unpleasant feelings as a cue to cope, and how to use different strategies to improve mood. Participants continue to explicitly practice affective education and coping skills in Meetings 5-10; however, these concepts are also integrated in all future sessions at the discretion of the therapist. Problem-solving is introduced in Meeting 5 and explicitly practiced in Meetings 7-9. Like affective education and coping skills, problem-solving is integrated in all future sessions at the discretion of the therapist. Identifying negative thoughts and introducing the link between thoughts and feelings begins in Meeting 6 and continues in Meeting 11. Cognitive restructuring is explicitly taught and practiced in Meetings 12-17. All of the core treatment components are integrated and practiced in Meetings 18-20.

Each session follows a structured format typical of CBT interventions and includes a brief rapport building activity, a review of the session agenda and an elicitation of additional agenda items, a review of the previous session, a review of therapeutic homework, a discussion of the session's topic, skill building activities, a review of the main concepts introduced in the session, and assignment of new therapeutic homework to

encourage practice of the skills at home. An excerpt from the treatment manual is provided in Appendix O.

***Treatment Conditions***

Participants in the ACTION program are randomly assigned to one of three treatment conditions: (1) CBT only, (2) CBT plus parent training, or (3) minimum contact control (MCC). Participants in the CBT only condition meet in groups of two to six members and complete 20 sessions over the course of approximately 12 to 16 weeks. The group meets two times per week. In addition, participants in this condition complete at least two individual meetings over the course of treatment. Participants in the CBT plus parent training condition complete the same course of treatment as the participants in the CBT only group and the same number of meetings; however, these participants' parents attend eight group meetings once per week for approximately 10 weeks and the girls and their families complete at least two individual family meetings. The participants in this treatment condition attend about half of the parent meetings. Participants in the MCC condition are monitored on a weekly basis by trained doctoral students. They are continually assessed for symptom severity with the CDI and DSM-IV interview, and are offered active treatment at the end of the waiting period.

***Therapist Training***

All treatment conditions are conducted by trained doctoral students under the supervision of the primary investigator, a full professor in school psychology and a licensed psychologist. Therapists have completed didactic and practicum courses in CBT and a minimum of two years of training in a doctoral program in school psychology. In addition, prior to conducting therapy groups as the primary therapist, all therapists undergo an extensive training process in which they first participate in a group as an observer or secondary therapist under the guidance of an advanced, primary therapist.

During this phase of training, the primary and secondary therapists meet with the primary investigator once per week for supervision for approximately one hour. During these sessions, the trio listens to the therapy audiotapes and the primary investigator reviews strengths and weaknesses of the therapy sessions and offers suggestions for improving treatment delivery. In addition to meeting for individual supervision, both therapists attend weekly group supervision meetings with the primary investigator and all of the therapists in the program. These group meetings last approximately one and a half hours. During these meetings, therapists present case conceptualizations, review session audiotapes, and seek feedback and suggestions from the primary investigator as well as from the other therapists.

After observing an active therapy group, therapists-in-training then practice conducting a therapy group with participants who have completed the MCC condition. An advanced therapist also attends these meetings and provides supervision to the therapist-in-training. Once again, the advanced and the training therapists meet with the primary investigator on a weekly basis to receive feedback and further supervision as well as attending weekly group supervision meetings with the primary investigator and the other therapists. After successfully completing this course of training, secondary therapists become primary therapists and are allowed to lead a treatment group. Thus, by the time that a therapist acts as a primary therapist and leads a treatment group, she has participated in approximately 40 to 56 group therapy sessions and 16 to 32 individual therapy sessions. Additionally, she has received approximately 24 hours of individual and 36 hours of group supervision.

## ***Participation in the Present Study***

### ***Participant Recruitment***

For the present study, participants were recruited directly by the researcher from one ACTION program cohort. This cohort consisted of seventeen girls that had participated in both CBT only and CBT plus parent training treatment conditions during the 2005 to 2006 academic year. After completing treatment, participants and their primary caregivers were given letters explaining the study (see Appendix P). Parents were then asked to complete a consent form for the study that included permission to audio-tape the interviews (see Appendix Q). Upon receiving parental consent, the study was explained to the child participants in more detail and they were asked to complete a child assent form (see Appendix R). All participants were assured that their decision to participate or to decline to participate in the present study would in no way influence their participation in the larger study. All of the families and the participants that were recruited for the present study agreed to participate.

## ***Data Collection***

Once permission and assent were obtained, the primary data collection phase consisted of individual, semi-structured interviews with the participants. All of the participants completed initial interviews, which were approximately 30 to 45 minutes in length, and several girls completed follow-up interviews, which were approximately 15 to 30 minutes in length. The interviews were conducted in private at the participants' schools. An ACTION program staff member conducted three of the initial interviews and one of the follow-up interviews. The researcher conducted all other initial and follow-up interviews. An additional interviewer was utilized due to the fact that three of the participants came from an ACTION program group which had been co-led by the researcher in her role as an ACTION program therapist. All interviews were audio-taped

and transcribed by the researcher. All identifying information in the interviews was changed to ensure confidentiality and to protect the privacy of the participants and their families. The primary researcher attempted to create pseudonyms that were culturally consistent with the backgrounds of each girl.

Since the majority of the interviews (20) were conducted by the researcher, a triangulation approach was used to analyze the data in order to avoid subjective experience biasing the results. The triangulation approach, defined as gathering data from multiple sources and comparing consistency across sources, included comparing secondary sources of data such as therapist reports, therapeutic homework assignments, skills quizzes, self-report measures, and diagnostic interviews with the semi-structured interview data. These additional sources of data provided information regarding comprehension and application of treatment components, level of participation in the treatment, treatment progress, background and family situations, symptom presence, severity, and global functioning at the beginning and end of treatment, presence of comorbid disorders, and level of treatment satisfaction.

***Semi-Structured Interviews***

Semi-structured initial and follow-up interviews were the primary source of data. An interview guide was used to conduct all interviews. The basic outline of this guide is presented and described in Table 2. The initial interview guide was constructed by the researcher and piloted with two former ACTION program participants from an earlier cohort before being conducted with the participants in the present study. Preliminary analyses of the pilot data were completed by the researcher and a dissertation committee member. Results from these analyses helped to shape and refine the subsequent interview guide that was used with active participants.

Table 2

*Interview Guide*

| Sample Questions |
| --- |
| Rapport Building: Before we get started, I would like to learn a little bit about you. Who do you live with? What grade are you in? When did you do the ACTION program? How many girls were in your group? |
| Opening: Today I would like to find out what it is like to be in the ACTION program. I know about the program, but I've never been in it. So, it would help me a lot if you could explain what it's like to be in it. |
| General Treatment Response: What was the ACTION program like for you? What did you like/not like? Tell me about its strengths/weakness. |
| Pre- and Post-Treatment Functioning: How did you feel (about yourself) at the beginning of group? What was going on for you back then? How did you deal with those things? How do you feel (about yourself) now? What makes you feel down now? How do you deal with those things now? What do you tell yourself about those things now? |
| Helpfulness of Treatment: Did the ACTION program help you? Tell me about how it did or did not help. What helped the most/least? Tell me about why these things helped the most/ least. Why does the ACTION program help some girls, but not others? |
| Treatment Components: Tell me about what you did or learned in group. Give me an example of when you used that. Was it easy or hard to use? How often did you use it? Did anything get in the way of using it? Did it help you? How did it help? Out of all of the things that you did or learned, which helped you the most/least? How come? |
| Structure of Treatment: What was it like being in a group (with other girls)? Compare the individual and group meetings. Which was more helpful? How come? |
| Process of Change: Do you feel like you made changes during the ACTION program? What changes did you make? What helped you to change? What got in the way? |

Since data collection and analysis occurred simultaneously, each interview served to inform successive interviews and, therefore, the concepts incorporated into early interviews changed over the course of the study. Questions for follow-up interviews were formulated once all of the participants had completed initial interviews. Once again, an interview guide was used to conduct follow-up interviews and this guide changed as data collection and analysis proceeded.

After conducting the initial interview with all participants, seven girls were asked to participate in a more in-depth, follow-up interviews based on the findings from the initial interviews. The second interview was conducted in order to gain a more comprehensive understanding of the concepts that emerged in the initial interviews. Participants were chosen for follow-up interviews for several reasons. First, they reflected the composition of the original sample in terms of their ages, grades, and treatment conditions. Next, in order to compare responses from participants that did and did not recover over the course of treatment, both of the girls that continued to meet criteria for a depressive disorder at post-treatment were selected for secondary interviews. In addition, an attempt was made to complete follow-up interviews with approximately equal numbers of participants that rated the level of helpfulness of the ACTION program as low and high. Finally, in order to obtain the most comprehensive data, selection for secondary interviews also depended on each participant's level of detail and articulation. Participants that were able to verbalize and elaborate on their thoughts, feelings, and ideas in the initial interview were more likely to be considered for secondary interviews.

Initial interviews were completed within one to sixteen weeks after treatment ended. Follow-up interviews were completed within two to eight weeks of the initial interviews. Prior to conducting the initial interview, participants were introduced to the interviewer and the study, and were allowed to ask questions. After answering questions,

the interviewer obtained assent from each participant and proceed with the interview. Rapport-building techniques, such as questions about likes/dislikes, hobbies, etc., were employed to help the participants feel comfortable with the interviewers. The initial interview began with open-ended questions intended to elicit general information (e.g., "What was the ACTION program like for you?"). Then, it proceeded to more specific topics (e.g., "How did you feel at the beginning of group?"). Follow-up interviews focused on specific themes that emerged during initial interviews such as the experience of treatment structure (e.g., "What was it like to be in a group with other girls?").

***Therapist Reports***

In addition to conducting semi-structured interviews with participants, data were also collected from the treatment therapists. During the intervention, therapists were asked to keep specific records. At the end of each meeting, therapists recorded whether or not the session objectives were met for each meeting and provided information about which treatment components were successfully introduced to and practiced by the participants. In addition, therapists noted rates of participant attendance, which treatment components, if any, seemed helpful to each participant, and any specific examples of participants using different therapeutic skills. Finally, therapists provided information about their general impressions of each meeting. A sample of the Therapist Session Summary from is provided in Appendix S.

In the present study, therapist reports were used to obtain information regarding participant skill acquisition, comprehension, and application. This information was compared with data from the semi-structured interviews to evaluate the accuracy and consistency of the information provided by the participants. In addition to utilizing session summaries, initial and on-going Case Conceptualizations (see Appendix T)

completed by therapists were examined to gain a better understanding of the social, environmental, behavioral, and cognitive backgrounds of each participant.

***Homework Assignments***

As discussed previously in Chapter Two: Review of the Literature, therapeutic homework assignments are given to participants every session as a means of encouraging acquisition, practice, and application of different treatment components.

In order to better understand participant application of different treatment components, weekly homework assignments were gathered and examined by the researcher in the present study. In addition, homework assignments were used to check the consistency of information obtained in the semi-structured interviews. Sample homework sheets are provided in Appendices B, C, D, and E.

***Skills Quizzes***

Over the course of treatment, participants complete three skills quizzes to test their knowledge of various concepts and components of the intervention. Skills Quiz 1 is given to the participants between the $6^{th}$ and $7^{th}$ meetings, Skills Quiz 2 is administered after Meeting 12 and prior to Meeting 13, and Skills Quiz 3 is completed at the end of the last treatment session, Meeting 20. A sample skills quiz is provided in Appendix U.

In the present study, information from skills quizzes was compared with data from the semi-structured interviews to evaluate the accuracy and consistency of participants' comprehension and application of specific treatment components.

***Diagnostic Interview***

The Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present State (K-SADS-P IVR, Ambrosini & Dixon, 2000) is a semi-structured interview that assesses current and past presence and severity of DSM-IV criteria based

symptoms in the following areas of psychological disorder: major depression, mania, eating disorders, anxiety, behavioral disturbances, substance abuse, and psychosis. Each symptom is rated by the interviewer along a continuum of none to most severe using sample questions and anchors. The interview is administered independently to the youth and to her primary caregiver, and symptom severity ratings are determined separately from information provided by each informant. A summary rating is then made by the clinician using all available sources of information including both child and parent interviews as well as observations and other reports (e.g., school records, teacher reports).

As the most recent version, the K-SADS-P IVR has limited psychometric data supporting its use; however, in a preliminary investigation, interrater-reliability was found to be high for diagnoses of MDD, DD, generalized anxiety disorder, separation anxiety disorder, and oppositional defiant disorder (Ambrosini, 2000). Earlier versions of the interview have evidenced high test-retest reliability (.67 or higher) on the depression scale and high internal consistency (.68 or higher) (Chambers et al., 1985). In addition, coefficient alphas, ranging from .76 to .89, have been reported for each of the scales, and intraclass coefficients, ranging from .85 to .97, have been found for the depression scales (Ambrosini, Metz, Prabucki, & Lee, 1989).

The child and parent pre- and post-treatment K-SADS-P IVR interviews were used in the present study to examine treatment recovery (defined as no longer meeting criteria for a depressive disorder upon completion of treatment) as well as to gather information regarding symptom severity, global functioning, and presence of comorbid disorders before and after treatment. This information was also compared with data from the semi-structured interviews to evaluate the accuracy and consistency of the participants' answers.

***Self-Report Measures***

*Children's Depression Inventory (CDI).* The Children's Depression Inventory (CDI; Kovacs, 1981) is a 27-item self-report measure designed to assess presence and severity of depressive symptoms in youth ages 7 to 17 years over a preceding 2-week period. Each item on the CDI has three answer choices, ranging from 0 to 2. The total score range is 0 to 54, with higher scores indicating higher levels of impairment. Total scores of 19 or greater indicate a significant level of depressive symptoms (Smucker, Craighead, Craighead, & Green, 1986; Kovacs, 1992). The CDI has demonstrated good internal consistency, with reliability coefficients ranging from .71 to .89 in various samples (Kovacs, 1981; Kovacs, 1992; Smucker et al., 1986). Test-retest reliability correlations range from .38 in normal youths to .87 for psychiatric inpatients, with both groups being tested and retested within one week (Kovacs, 1992). The CDI also demonstrates strong concurrent validity, criterion validity, and construct validity (Kovacs, 1992).

In the present study, the CDI was used to obtain pre- and post-treatment information regarding presence and severity of depressive symptoms. This information was compared with data collected via the semi-structured interviews to evaluate the accuracy and consistency of the participants' responses.

*Beck Depression Inventory for Youth (BDI-Y).* The Beck Depression Inventory for Youth (BDI-Y, Beck et al., 2001) is a 20-item self-report inventory that assesses the presence and severity of depressive symptoms in children and adolescents ages 7 and 14 years. According to Beck and colleagues (2001), internal consistency of the BDI-Y when administered to children is high, with coefficient alphas of .91 for girls and .90 for boys ages 7 to 10. When given to pre-adolescents and adolescents, internal consistency is also high, with coefficient alphas of .91 for girls and .92 for boys ages 11 to 14.

Test-retest reliabilities have ranged from .79 to .92 over a median retest interval of seven days. The BDI-Y is correlated with the CDI total score (r = .72) and, in a clinical sample, children with mood disorders scored significantly higher on the BDI-Y than children in other diagnostic groups (Beck et al., 2001). Additionally, the CDI has been shown to be more positively correlated with the BDI-Y in small clinical samples than with the other Beck Inventories (anxiety, anger, disruptive behavior, and self-concepts) (Steer, Kumar, Beck, & Beck, 2001).

Pre- and post-treatment BDI-Y scores were used in the present study to gain information about the presence and severity of depressive symptoms at the beginning and end of treatment. Information obtained with BDI-Y questionnaires was also compared with data gathered from the semi-structured interviews to examine the accuracy and consistency of participant responses.

*Satisfaction Questionnaire (SQ).* The Satisfaction Questionnaire (SQ; Stark, 2001) was created for the ACTION program to capture both child and parental satisfaction with treatment as well as information concerning perceived credibility of treatment. Parents and children rate 10 items, balanced equally between potentially positive and negative aspects of treatment, on a 1 to 7 scale. A copy of the child SQ is provided in Appendix V.

The SQ was used in this study as a comparison with information obtained during the semi-structured interviews to ensure trustworthiness of the data. Answers on the SQ concerning helpfulness and enjoyment of treatment were compared with answers from the interviews to evaluate accuracy and consistency of participant responses.

## Analysis of Data

In the grounded theory approach of qualitative analysis, data collection and data analysis occur concurrently and inform each other. In the present study, interviews were

transcribed and analyzed as they were collected using open, axial, and selective coding procedures. This section will briefly describe each of these coding procedures. A more detailed description of the data analysis used in the present study will be provided in Chapter Five: Overview of Analysis.

### *Open Coding*

During open coding, the interview data are conceptualized and broken down into small, meaningful units or concepts that are given descriptive codes. These concepts are grouped into categories and subcategories based on their similarity with a particular phenomena. Categories and subcategories are developed in terms of their properties and dimensions. During the open coding phase of data analysis, the researcher is guided by two principles: asking questions about the data and constantly making comparisons to examine similarities and differences between among concepts.

### *Axial Coding*

Axial coding is used to analyze the data concurrent with open coding. During axial coding the data are examined in a more holistic way "...by making connections between a category and its subcategories" (Strauss & Corbin, 1990, p. 97). Categories, or phenomenon, are specified and described in terms of the conditions that give rise to them, the context in which they rooted, the actions or strategies by which they are managed, and the consequences associated with those actions or strategies. Thus, the axial coding process helps the researcher to better understand the conditions, strategies, and consequences that are associated with a particular phenomenon in a way that allows her to form relational statements about the data. By asking questions and constantly comparing the data, relational statements are supported or revised. Dimensions and properties of categories and subcategories continue to be examined during axial coding.

### *Selective Coding*

Selective coding involves selecting a core category that is related to all other categories, finding support for those relationships, and further developing or refining existing categories. The core category is selected based on its ability to represents the central phenomenon around which all other categories can be integrated. It is the "story line" that brings together all of the data in a way that makes sense. During the selective coding process, categories are integrated to form a grounded theory. As in the previous steps of analyzing the data, the properties and dimensions of the core category are developed in the selective coding process and all categories are compared with each other to form hypotheses about their relationships.

## Trustworthiness of the Study

In order for the results of a qualitative study to be deemed trustworthy, the collection and analysis of data must demonstrate credibility, transferability, dependability and confirmability (Morrow, 2005). These concepts are respectively related to the conventional research criterion known as internal validity, external validity, reliability, and objectivity. Each of these concepts will be described in this section.

Similar to the definition of internal validity in quantitative studies, credibility in qualitative investigations describes the extent to which the research findings accurately reflect reality (Hoepfl, 1997). Unlike conventional research studies, credibility in qualitative investigations depends more on the richness of the information gathered and the ability of the researcher to conduct in-depth analysis of the data than on sample size (Patton, 2002). Thus, the use of in-depth interviews and/or observations as well as comprehensive and exhaustive coding procedures can increase the credibility of qualitative findings obtained from smaller samples.

Transferability in qualitative research is similar to external validity. In more conventional research, this concept involves the way in which research findings generalize across different settings (Hoepfl, 1997). To increase transferability, one must provide dense and detailed descriptions of the role of the researcher, the research context, the researcher-participant relationship, and the research participants, design, and analysis (Morrow, 2005). Thus, in qualitative studies, the researcher must record and present detailed information regarding each step of the data collection and analysis in order to bolster the transferability of her findings.

Dependability is similar to reliability in that it deals with whether or not the findings can be replicated. To increase dependability in a qualitative analysis, detailed information should be provided regarding the emerging research design as well as information that can be audited such as "...a detailed chronology of research activities and processes; influences on the data collection and analysis; emerging themes, categories, or models; and analytic memos" (Morrow, 2005, p. 252).

Confirmability in qualitative research corresponds to objectivity in conventional research methods; it is the degree to which the researcher can demonstrate neutrality regarding the research findings. Like dependability, confirmability is increased through the use of an audit trail (Morrow, 2005). In addition, qualitative researchers can increase confirmability by tracking, recording, and disclosing personal and professional biases that may affect data collection and analysis.

Several techniques can be used in qualitative studies to increase the overall trustworthiness of the data and the results. In the present study, strategies that were used for this purpose included triangulation, peer debriefing, member checks, and reflexive journaling. Each of these techniques will be described thoroughly in Chapter Five: Overview of Analysis. Briefly, triangulation is a means of gathering and analyzing data

from multiple informants and sources, peer debriefing consists of meeting regularly with colleagues to discuss data collection and analysis and to develop hypotheses about emerging themes, member checks involve having selected participants review and report feedback regarding preliminary categories and relationships found in the data, and reflexive journaling is a way for the researcher to record her personal reactions to the research process, her biases, and her decisions related to methodology.

## Ethical Considerations

The ethical standards of research published by the American Psychological Association (APA) and set forth by the University of Texas at Austin were followed in the present investigation. Approval for the study was obtained from the Departmental Review Committee in the Department of Educational Psychology and the Institutional Review Board of the University of Texas at Austin.

Ethical considerations were particularly important in this study since participants included children and adolescents that had experienced (or continued to experience) significant emotional distress and had undergone psychosocial treatment for depression. Issues such as informed consent, confidentiality, and protection from harm are particularly relevant when working with youth with documented histories of psychological difficulties. To address these issues and to ensure the well-being of the participants, consent and assent forms were utilized, the study was explained in detail to all participants, all questions or concerns regarding participation were addressed by the researcher and/or her colleagues, confidentiality (and its limitations) was explained to all participants, and pseudonyms were used to mask the identities of the participants and their families.

In the event that a participant reported information beyond the scope of confidentiality, a plan was in place to assess the situation and to take the necessary

precautions to keep the youngster safe. The researcher and her colleagues were to follow the protocol of the larger study, which involves assessing the level of risk, contacting the appropriate school personnel and/or legal agencies, relaying the risk to the primary caregiver(s), and enlisting the assistance of the primary investigator. Fortunately, a situation did not arise in which it was necessary to take these steps.

# CHAPTER FOUR

# THE PARTICIPANTS

Seventeen former ACTION program participants were included in the study. As discussed in the previous chapter, pre-treatment depressive symptoms were assessed with self-report questionnaires (i.e., CDI, BDI-Y) and depressive disorders were diagnosed using a structured diagnostic interview (i.e., K-SADS-P IVR). Upon completion of treatment, depressive symptoms and diagnoses were assessed again using these measures. In order to understand how the participants' psychological functioning changed over the course of treatment, their pre- and post-treatment diagnoses and depressive symptoms will be presented in this chapter. In addition, more detailed information about each of the participants, including background information, treatment group composition, behavioral observations, and consistency of interview information will be discussed.

## Pre- and Post-Treatment Diagnoses and Depressive Symptoms

### *Pre- and Post-Treatment Diagnoses*

At the beginning of treatment, all participants presented with a depressive disorder. Initial, primary diagnoses in this study included MDD and DD. In addition, some participants presented with MDD, in partial remission. Thirteen participants were diagnosed with MDD, two participants met diagnostic criteria for MDD, in partial remission, and two participants were given a diagnosis of DD.

In addition, several of the girls presented with a range of pre-treatment comorbid disorders such as Attention-Deficit/Hyperactivity Disorder (ADHD), General Anxiety Disorder (GAD), Post Traumatic Stress Disorder (PTSD), Specific Phobia (SP), and Social Phobia. Overall, approximately 70% of participants (12) had one or more

comorbid disorders. Eight participants had GAD, two participants had ADHD, Predominantly Inattentive Type, two participants had ADHD, Combined Type, two participants had PTSD, and three participants had a SP. One participant received a diagnosis of Social Phobia, one participant received a diagnosis of Eating Disorder Not Otherwise Specified (EDNOS), and one participant was diagnosed with Bulimia Nervosa (BN). All diagnoses were made using the K-SADS-P IVR interview. For more detailed information regarding pre-treatment diagnoses, please refer to Table 3.

After completing treatment, approximately 88% of participants (15) no longer met criteria for a depressive disorder. The remaining two participants continued to receive a diagnosis of MDD. Thus, over the course of treatment, the majority of participants experienced a remission of depressive symptoms. Some participants continued to evidence comorbid disorders after treatment. At post-treatment, approximately 53% of participants (9) evidenced disorders other than depression. One participant received a diagnosis of GAD, two participants met criteria for ADHD, Predominantly Inattentive Type, two participants received a diagnosis of ADHD, Combined Type, three participants met criteria for a SP, and one participant received a diagnosis of EDNOS. A discussion of how comorbid diagnoses changed over time follows.

The participant that received a diagnosis of EDNOS at pre-treatment continued to meet criteria for this disorder at post-treatment, whereas the participant that was initially diagnosed with BN, no longer met criteria for this disorder at post-treatment. The participant that was diagnosed with Social Phobia at pre-treatment did not meet criteria for this disorder at post-treatment. All of the four participants that were diagnosed with ADHD at pre-treatment continued to meet criteria for this disorder at post-treatment. On the other hand, none of the eight participants that had received a diagnosis of GAD prior to treatment continued to meet criteria for this anxiety disorder at the end of treatment.

Interestingly, one participant that did not meet criteria for a diagnosis of an anxiety disorder at pre-treatment was diagnosed with GAD at post-treatment. Similarly, another participant received a diagnosis of a SP at post-treatment despite the fact that she did not meet criteria for this disorder at pre-treatment. Overall, changes in comorbid diagnoses followed a fairly consistent pattern. That is, participants with anxiety disorders experienced a remission of symptoms over the course of treatment and participants with externalizing disorders or specific phobias continued to struggle with these difficulties.

### *Pre- and Post-Treatment Depressive Symptoms*

Information from self-report questionnaires completed prior to treatment yielded more descriptive data regarding the level of depressive symptoms present among participants. The participants in this study demonstrated a mean score of 14.53 (SD = 6.35) on the CDI and a mean score of 15.53 (SD = 7.39) on the BDI-Y prior to treatment. At the end of treatment, participants demonstrated a mean score of 8.65 (SD = 7.06) on the CDI and 8.94 (SD = 6.23) on the BDI-Y. Thus, mean CDI and BDI-Y scores fell markedly from pre- to post-treatment. Participant specific pre- and post-treatment scores are provided in Table 3.

## Introduction to the Participants

The following section will describe the participants in greater detail. First, it will include a discussion of each girl's background and a brief description of pre-treatment stressors. Second, pre- and post-treatment diagnoses will be presented as well as a description of specific depressive symptoms experienced before treatment. Next, the treatment group in which each girl participated will be described. Finally, observations regarding the presentation, behavior, and consistency of the participants during the study interview(s) will be summarized.

### *Sophie Stuessi*

Sophie Stuessi is a 13-year old, Caucasian girl in the 7th grade. Sophie lives in an in-tact home with her father, mother, and 17-year old sister. According to her therapist's notes, Sophie experienced two significant losses, including the death of a close friend approximately one year before treatment and the death of a grandparent approximately three years before treatment. In addition, Sophie reported that she experienced significant stress related to peer conflict (e.g., rumors, friends "back-stabbing" her) before being in the ACTION program. She also reported that she and her parents would occasionally fight with each other.

Sophie was diagnosed with recurrent, chronic MDD at the beginning of treatment. She reported experiencing feelings of sadness and irritability, diminished ability to concentrate, psychomotor agitation, psychomotor retardation, excessive guilt, and a poor self-image. Her overall level of symptoms was rated as moderate, indicating some difficulty in daily functioning. In her initial case conceptualization, Sophie's therapist hypothesized that she had a core belief of inadequacy related to a low self-esteem and feelings of worthlessness. Upon completion of treatment, Sophie no longer met criteria for a depressive disorder.

Sophie participated in a 4-member treatment group at her middle school. This group consisted of one other 7th grader and two 6th graders, and was designated as a CBT plus parent training group. The child and parent meetings were led by a primary therapist and were observed by a therapist-in-training. According to the primary therapist's notes, Sophie's parents regularly attended the parent meetings. In fact, the family participated in a total of ten parent meetings and one individual family meeting, and both parents were present at all meetings except for one in which only Sophie's mother attended.

Table 3

*Pre- and Post-Treatment Diagnoses and Self-Report Scores*

| | Diagnoses | | CDI | | BDI-Y | |
|---|---|---|---|---|---|---|
| Participant | T1 | T2 | T1 | T2 | T1 | T2 |
| Courtney | DD; GAD; ADHD, IT | ADHD, IT | 14 | 19 | 17 | 9 |
| Alika | MDD; PTSD; Social Phobia; ADHD, IT | ADHD, IT | 17 | 4 | 13 | 5 |
| Mahina | MDD; GAD; SP; ADHD, R/O | SP; ADHD, R/O | 16 | 19 | 16 | 17 |
| Sophie | MDD, Recurrent, Chronic | No diagnosis | 9 | 3 | 20 | 8 |
| Lydia | MDD; GAD | No diagnosis | 12 | 12 | 26 | 17 |
| Alexandra | MDD, in PR | No diagnosis | 13 | 4 | 12 | 5 |
| Angelina | MDD, Chronic; GAD; BN | No diagnosis | 27 | 19 | 27 | 15 |
| Olivia | MDD; PTSD, Chronic; SP | MDD | 25 | 14 | 25 | 21 |
| Mia | MDD, Recurrent | No diagnosis | 15 | 16 | 18 | 16 |
| Jamilla | MDD; GAD | No diagnosis | 17 | 11 | 25 | 8 |
| Lucia | MDD, Chronic; GAD | SP | 11 | 1 | 3 | 4 |
| Danielle | MDD | No diagnosis | 10 | 0 | 9 | 0 |
| Paris | MDD, Recurrent; GAD | No diagnosis | 6 | 2 | 15 | 10 |
| Shaneika | DD | No diagnosis | 19 | 11 | 12 | 0 |
| Gwendolyn | MDD, in PR; EDNOS | MDD; GAD; EDNOS | 1 | 10 | 3 | 5 |
| Devora | MDD, Chronic; ADHD, CT; SP | ADHD, CT; SP | 18 | 1 | 13 | 4 |
| Sarah | MDD; GAD; ADHD, CT | ADHD, CT | 17 | 1 | 10 | 8 |

*Note*. CT = Combined Type; IT = Inattentive Type; PR = Partial Remission; R/O = Rule Out.

Sophie completed the initial interview approximately one month after her treatment group ended. During the initial interview, Sophie appeared confident and relaxed. She was very articulate, readily answering questions and providing extensive detail. Sophie seemed to be giving thoughtful and honest answers to questions. She indicated that she enjoyed the interview and would be willing to provide more information if the interviewer needed to contact her again. Sophie was selected to participate in a second interview, which was conducted approximately two months after the initial interview. Once again, she appeared talkative and engaged, providing detailed answers to questions. Sophie's answers during the second interview were remarkably consistent with her answers during the first interview.

### *Lydia Fuentes*

Lydia Fuentes is a 12-year old, Hispanic girl in the 6th grade. She lives with her father, mother, and two, younger sisters (9 and 6 years old). Lydia speaks both English and Spanish; however, she identified English as her primary language. Before treatment, Lydia reported that she experienced several stressful situations, including fights with her family members and not having many friends. She indicated that she was very shy and that she had difficulty "feeling comfortable around others."

Prior to treatment, Lydia was diagnosed with MDD and GAD, both of which were rated as moderately impairing. Her pre-treatment symptoms of depression included sadness, irritability, loss of interest or pleasure in most activities, diminished ability to concentrate, psychomotor agitation, insomnia, increased appetite, weight gain, excessive guilt, feelings of hopelessness, and a poor self-image. Lydia's therapist, in her initial case conceptualization, hypothesized that Lydia had a core belief of inadequacy related to thinking that she was not as good as other people. At post-treatment, Lydia no longer met criteria for a depressive or an anxiety disorder.

Lydia participated in the same treatment group as Sophie. Thus, her group contained three other middle school girls and was led by a primary therapist and observed by a therapist-in-training. Lydia's treatment condition was CBT plus parent training. According to the primary therapist's notes, Lydia's family did not attend any of the parent meetings. The therapist stated that Mrs. Fuentes was unable to attend due to "occupational unpredictability." That is, Lydia's mother was unable to come to the meetings because her work schedule was constantly changing.

Lydia completed the initial interview approximately one month after treatment ended. During the interview, she appeared somewhat shy. She was quiet and did not give detailed answers to questions. Lydia seemed to have some difficulty either understanding the questions or explaining the skills that she had learned in treatment. Given her self-reported history of feeling shy and uncomfortable around others, Lydia's difficulties during the interview may have been related to anxiety about talking with a relative stranger. Despite her difficulties, Lydia indicated that she enjoyed the interview and was willing to participate in a second interview.

### *Alexandra Aguilar*

Alexandra Aguilar is a 13-year old, Hispanic girl in the $6^{th}$ grade. She lives with her mother, maternal uncle, brother (10 years old), and two male cousins (15 and 12 years old). Alexandra indicated that she is fluent in both Spanish and English; however, she stated that Spanish is her primary language. Alexandra reported that her parents separated two years ago, with their divorce becoming final this past year. According to Alexandra, the divorce prompted her mother to move to the current city in which the family resides. Thus, Alexandra indicated that she has only been in this city and this school for the past year. She reported that her father lives in a neighboring city, and that she visits him twice a month. Her therapist noted that Alexandra's father has a history of

incarceration. Alexandra reported that her parents' divorce was the most significant source of stress for her prior to treatment. She stated that it caused her to feel "pretty bad." In terms of other pre-treatment stressors, Alexandra reported that she experienced some peer conflict before beginning the ACTION program.

Alexandra received a pre-treatment diagnosis of MDD, in partial remission. This diagnosis was given because she met many, but not all, of the criteria for a major depressive episode. Alexandra's primary depressive symptoms included sadness, irritability, fatigue, psychomotor agitation, psychomotor retardation, insomnia, self-pity, hopelessness, and a poor self-image. In addition, Alexandra reported engaging in self-damaging acts such as cutting. Her overall level of symptoms was rated as moderate indicating some difficulty in daily functioning. In her initial case conceptualization, Alexandra's therapist hypothesized that Alexandra had core beliefs of inadequacy and unlovability. Upon completion of treatment, Alexandra no longer met criteria for a depressive disorder.

Alexandra was assigned to the same treatment group as Sophie and Lydia. Their 4-member middle school group included both child and parent meetings. According to the primary therapist's notes, Alexandra's mother was unable to regularly attend the parent meetings. The therapist noted that her mother attended the first two meetings; however, she was unable to continue to attend the meetings due to other family commitments and Alexandra's reluctance to come to evening meetings.

Alexandra completed the initial interview approximately one month after her treatment group ended. During the initial interview, she appeared shy and reserved. Alexandra was quiet and soft-spoken; however, she readily answered questions. Alexandra seemed to have some difficulty expanding on her answers when prompted to elaborate. At the end of the interview, she indicated that she was willing to participate in

a follow-up interview. Alexandra was asked to complete a second interview. This interview was conducted approximately two months after the initial interview. During the second interview, Alexandra appeared more relaxed and less shy. She seemed to give honest and thoughtful answers to questions. Alexandra continued to have some difficulty with providing details; however, despite minor discrepancies, her responses were fairly consistent with the initial interview.

### ***Lucia Castillo***

Lucia Castillo is a 13-year old, biracial (Hispanic and Caucasian) girl in the 7th grade. Currently, she lives with her mother and father as well as her four siblings. Lucia has two biological brothers (12 and 10 years old), one biological sister (9 years old), and one adopted sister (6 years old). According to her therapist's notes, Lucia had to repeat a grade in elementary school. Prior to treatment, Lucia reported that she experienced several stressful events, including her parents "always arguing and wanting to get a divorce," being teased about her weight by her family, getting into fights with her mother, and getting into fights with other girls. Being the oldest, Lucia seemed to bear the brunt of her parents' fights and took it upon herself to try to shield her siblings from the on-going conflict.

Lucia was diagnosed with markedly impairing, chronic MDD at the beginning of treatment. She also received a diagnosis of moderately impairing GAD. Lucia's primary depressive symptoms included feelings of sadness and irritability, loss of interest or pleasure in most activities, insomnia, fatigue, psychomotor agitation, decreased appetite, self-pity, a poor self-image, weight gain, and suicidal ideation. In her initial case conceptualization, Lucia's therapist hypothesized that Lucia had a core belief of inadequacy related to thoughts that she was a failure. Her therapist also noted that Lucia had a negative self-image. After completing treatment Lucia no longer met criteria for a

depressive or an anxiety disorder. She did meet criteria for a mildly impairing specific phobia.

Lucia was the fourth member in the CBT plus parent training treatment group that included Sophie, Lydia, and Alexandra. Thus, Lucia's group contained one other 6th grader and two 7th graders, and was led by a primary therapist and observed by a therapist-in-training. According to the primary therapist's notes, Lucia's family was only able to attend one of the parent meetings. The primary therapist indicated that the family was unable to attend the rest of the meetings because one of their children was ill and required on-going parental supervision.

Lucia completed the initial interview approximately two months after her treatment group ended. During the interview, she appeared to be in a good mood, smiling and making eye contact with the interviewer. She appeared comfortable and relaxed. Lucia indicated that she was tired because she had just finished taking an important exam; however, she readily answered questions and declined to take a break when the interviewer asked her if she wanted to stop for a while. Lucia struck the interviewer as very mature for her age. Overall, she seemed to give honest responses to questions. At the end of the initial interview, Lucia indicated that she would be willing to participate in a second interview.

### *Angelina Salazar*

Angelina Salazar is a 12-year old biracial (Caucasian/Hispanic) 6th grader. She lives with her mother, her older brother (14 years old), and her younger, half sister (4 years old). Angelina's father was killed in an automobile accident when she was 4 years old. According to therapist notes, Angelina experienced the death of a close family friend one month before treatment. In addition, Angelina reported several areas of pre-treatment stress, including the transition from elementary to middle school, difficulty

balancing her schoolwork with her involvement in extracurricular activities, numerous fights with her mother and friends, and difficulty sleeping. Finally, Angelina indicated that, at the beginning of treatment, she was struggling with feelings of sadness associated with the death of two family friends.

Before treatment, Angelina was diagnosed with recurrent MDD. In addition, she was also diagnosed with GAD and an eating disorder. Her pre-treatment symptoms of depression included sadness, severe irritability, anhedonia, severe fatigue, severe difficulty concentrating, psychomotor agitation and retardation, severe self-pity, increased appetite, weight gain, hopelessness, an extremely negative self-image, and suicidal ideation. Her overall level of symptoms was rated as serious, indicating an evident need for intervention. In her initial case conceptualization, her therapist hypothesized that Angelina had core beliefs of unlovability and worthlessness. After completing treatment, Angelina no longer met criteria for depression, anxiety, or an eating disorder.

Angelina participated in a 3-member treatment group with two other 7th graders; however, one of the participants was moved to individual rather than group treatment after approximately ten meetings because she was having difficulty getting along with the other girls in the group and she seemed to benefit more from one-on-one interactions. Thus, Angelina's group was reduced to two members. Angelina's group was designated as a CBT only group, and was led by a primary therapist and observed by a therapist-in-training. Prior to participating in this ACTION program group, Angelina had been in another ACTION treatment group as a 5th grader; however, her participation ended after five meetings because her family moved and she changed elementary schools. This former group was led by a primary therapist and observed by a therapist-in-training and was designated as a CBT plus parent training group. According to Angelina's former

therapist's notes, she and her mother attended two of the parent meetings before their participation was discontinued.

Angelina completed the initial interview approximately two months after her treatment group ended. During the initial interview, Angelina appeared nervous. She talked at a rapid pace with few pauses between words and avoided making eye contact with the interviewer. As the interview progressed, she seemed to relax and her speech slowed down. Prior to initiating an audiotape recording of the interview, Angelina talked openly about the group member that had discontinued group treatment, indicating that she had not cared for her and that she had made group difficult. Interestingly, once the audiotape recording began, she was less forthcoming about her feelings toward this former participant. Overall, Angelina appeared to enjoy talking about her experience in the ACTION program and she provided detailed answers to interview questions. She often laughed and smiled when describing her different experiences in treatment. At the end of the interview, Angelina indicated that she would be willing to talk again if the interviewer had further questions.

### *Olivia Ramirez*

Olivia Ramirez is a 13-year old Hispanic 7th grader. She lives with her father, mother, older brother (16 years old), younger brother (1 year old), three cousins, and aunt. Olivia reported that she is fluent in both English and Spanish. She noted that Spanish is spoken in the home; however, she indicated that English is her primary language. Per her therapist's notes, Olivia's mother endorsed some symptoms of depression on a pre-treatment self-report questionnaire as well as a past history of self-harm behaviors. Olivia reported that she was experiencing a high degree of peer conflict prior to treatment. She stated that her boyfriend and her male best friend did not get along, which caused frequent fights between all three of them. In addition, Olivia

reported that her female friends were "jealous" of the time that she was spending with her boyfriend and would get upset with her and call her names. Finally, Olivia stated that, before treatment, she was frequently getting in trouble because she was helping one of her cousins engage in risky behaviors (e.g., sneaking out).

Prior to treatment, Olivia received a diagnosis of MDD. In addition, Olivia was also diagnosed with chronic PTSD related to a history of sexual abuse. Olivia also met criteria for a diagnosis of a specific phobia. Olivia's depressive symptoms included sadness, irritability, excessive guilt, fatigue, diminished ability to concentrate, psychomotor agitation, psychomotor retardation, insomnia, decreased appetite/weight loss, hopelessness, a poor self-image, and engagement in self-damaging acts (e.g., scratching). Her overall level of symptoms was rated as serious. At post-treatment, Olivia continued to meet criteria for MDD. She no longer met either of the pre-treatment comorbid disorders.

Olivia participated in the same treatment group as Angelina. Thus, Olivia was in a CBT only group at her middle school with one other member, a 6th grader. Olivia's group was led by a primary therapist and observed by a therapist-in-training. In addition to participating in the group, Olivia met with her primary therapist for eight individual sessions after the group ended due to continuing depressive symptoms and issues related to her history of sexual abuse.

Olivia completed the initial interview approximately three months after her treatment group ended. During the interview, Olivia appeared somewhat nervous. Initially, she maintained limited eye contact with the interviewer and she laughed somewhat nervously in response to some of the questions. As the interview continued, Olivia seemed to relax. She became more engaged and talkative, building rapport with the interviewer. Olivia gave thoughtful answers to questions, and she seemed to be quite

honest with her opinions. She also seemed to possess a high level of insight about herself and about the ways in which treatment did and did not help her to feel better. At the end of the interview, Olivia indicated that she enjoyed talking with the interviewer and stated that she would be willing to complete an additional interview. Olivia was selected to complete a second interview, which was conducted approximately two weeks after the initial interview. Once again, Olivia was very open and honest with her responses. She had no difficulty discussing both the strengths and the weaknesses of the ACTION program as well as identifying factors that contributed to her treatment response.

### ***Danielle Aiza***

Danielle Aiza is an 11-year old, Hispanic 5th grader. She lives in a multi-generational family, which includes her mother, father, grandfather, grandmother, biological brothers (12 and 7 years old), and an adopted sister (16 years old). Danielle reported that she speaks both English and Spanish fluently. She indicated that Spanish is her first and primary language. Danielle reported that her most significant concern prior to treatment was related to her academic performance. She stated that she was "afraid" that she would not pass 5th grade because her grades were low. In addition, Danielle reported that she experienced added academic pressure because her brother was an "honor roll student" that earned mostly straight "As."

Prior to treatment, Danielle was diagnosed with MDD. Danielle reported several symptoms of depression, including sadness, fatigue, diminished ability to concentrate, psychomotor agitation and retardation, insomnia, and a poor self-image. Her overall level of symptoms was rated as moderate. Upon completion of treatment, Danielle no longer met criteria for a depressive disorder.

Danielle participated in a 3-member, CBT only treatment group at her elementary school, which included two other 5th grade girls. The group was led by a primary

therapist and observed by a therapist-in-training. In addition, the school counselor attended and observed some of the meetings.

Danielle completed the initial interview approximately four months after treatment ended. During the interview, Danielle appeared somewhat shy and was not able to maintain continuous eye contact with the interviewer. As the interview progressed, however, she seemed to become more comfortable, and often smiled and laughed. It seemed as though Danielle understood most of the interview questions; however, there were times when the interviewer suspected that she may have had some difficulties with comprehension since English is not her primary language. Overall, Danielle seemed to enjoy the interview and stated that she was willing to meet with the interviewer again.

### ***Mia Mancini***

Mia Mancini is an 11-year old, Hispanic female in the 5th grade. Currently, she lives with her father, mother, and three, younger sisters (8, 3, and 2 years old). Although her family is originally from Mexico, Mia indicated that she does not speak Spanish fluently and that English is her primary language. Per her therapist's notes, Mia has a past history of individual therapy for symptoms of sadness. Mia reported that she was experiencing three significant stressors prior to treatment. First, she stated that her grades had fallen and that she experienced frequent pressure from her mother to perform better in school. Next, Mia reported that a relative who had come to live with her and her family for most of the year had moved away suddenly and unexpectedly. This loss caused Mia to feel very sad because she regarded this person as a "good sister." Finally, Mia reported that she was being bullied by a boy at school.

Prior to treatment, Mia received a diagnosis of recurrent MDD. Her primary depressive symptoms included sadness, irritability, excessive guilt, fatigue, difficulty

concentrating, psychomotor agitation and retardation, insomnia, loss of appetite, hopelessness, and a negative self-image. Overall, her level of symptoms was rated as moderate. In her initial case conceptualization, her therapist hypothesized that Mia had core beliefs of helplessness and worthlessness. After completing treatment, Mia no longer met criteria for a depressive disorder.

Mia participated in the same treatment group as Danielle. Thus, she participated in a CBT only group at her elementary school that contained two other 5th graders. Mia's group was led by a primary therapist, observed by a therapist-in-training, and observed by the school counselor on occasion.

Mia completed the initial interview approximately four months after her treatment group ended. During the initial interview, Mia appeared extremely articulate and very mature for her age. She gave detailed and thoughtful answers to interview questions and she seemed to enjoy talking to the interviewer. She maintained continuous eye contact and engaged with the interviewer in an open and friendly manner. At the end of the interview, Mia indicated that she was willing to speak with the interviewer again. Mia was selected to participate in a second interview, which she completed approximately six weeks after the initial interview. Once again, Mia presented as very insightful, articulate, and mature for her age. Her responses during the second interview were consistent with her replies during the initial interview.

### *Jamilla Wick*

Jamilla Wick is an 11-year old, biracial (Hispanic and African-American) girl in the 5th grade. She lives with her mother, father, and two, older sisters (17 and 18 years old). According to her therapist's notes, Jamilla's mother seemed somewhat disconnected from her family and may have been experiencing symptoms of depression when the family began the ACTION program. Before beginning treatment, Jamilla

reported that she was having difficulty getting along with peers and with one of her siblings. She indicated that her sister was constantly "messing" with her. In addition, Jamilla reported that, because of having fights with other students, she was frequently getting into trouble at school.

Jamilla was diagnosed with moderately impairing MDD and mildly impairing GAD prior to treatment. She reported experiencing feelings of sadness, irritability, diminished ability to concentrate, psychomotor agitation and retardation, insomnia, self-pity, hopelessness, and a poor self-image. In her initial case conceptualization, her therapist hypothesized that Jamilla had core beliefs of helplessness and worthlessness. Upon completion of treatment, Jamilla no longer met criteria for a depressive or an anxiety disorder.

Jamilla was the third member in Danielle and Mia's treatment group. Thus, her elementary school group contained two other 5$^{th}$ graders, was designated as a CBT only group, and was led by a primary therapist and observed by a therapist-in-training. The school counselor occasionally attended and observed the meetings.

Jamilla completed the initial interview approximately three months after treatment ended. During the initial interview, Jamilla appeared confident; however, she maintained minimal eye contact with the interviewer and appeared somewhat distracted. Oftentimes, the interviewer noted that Jamilla was gazing at drawings on the walls in the interview room. At times, it was a little difficult to follow her train of thought; however, overall, Jamilla was able to provide articulate answers to the interview questions. At the end of the interview, she indicated that she enjoyed talking about the ACTION program and agreed to provide more information, if necessary.

### *Courtney Ainsworth*

Courtney Ainsworth is an 11-year old Caucasian girl in the 6th grade. She lives with her father, mother, and 18-year old sister. Courtney also has two older brothers (25 and 28 years old) that live outside of the home. Per her therapist's notes, Courtney has a history of ADHD for which she was taking medication on school days. In addition, Courtney's mother reported that two of Courtney's immediate family members suffer from severe, on-going depression. For Courtney, her most significant stressor prior to being in treatment was the fact that she "didn't have many friends." Courtney reported that she spent most of the summer playing by herself and, as a result, felt very lonely at the beginning of the year.

Prior to treatment, Courtney was diagnosed with moderately impairing DD and GAD as well as with mildly impairing ADHD, Predominantly Inattentive Type. Her primary depressive symptoms included sadness, fatigue, diminished ability to concentrate, psychomotor retardation, hopelessness, and weight gain. In her initial case conceptualization, Courtney's therapist hypothesized that Courtney had core beliefs of unlovability and helplessness. Upon completion of treatment, Courtney no longer met criteria for a diagnosis of a depressive or an anxiety disorder. She continued to meet criteria for a diagnosis of ADHD.

Courtney participated in a treatment group at her middle school which contained two other members. Initially her group contained four members, but one girl dropped after four meetings. Per the therapist's notes, this particular girl had difficulty being supportive of other group members, and did not appear to be as depressed as the other participants. All of the girls in Courtney's group were in the 6th grade. This group was designated as a CBT only group and was led by a primary therapist and was co-led by a therapist-in-training; however, after twelve meetings, the primary therapist left for

predoctoral internship interviews and the therapist-in-training assumed full responsibility for the group for the remaining eight sessions. According to the therapists, the school counselors did not participate in the meetings.

Courtney completed the initial interview approximately two and a half months after treatment. During the initial interview, she appeared mature for her age, demonstrating very controlled and poised body movements and facial expressions. Although Courtney's affect appeared somewhat flat to the interviewer, she would spontaneously smile at humorous moments during the interview. Courtney appeared to give careful and thoughtful answers to questions. She was cooperative and pleasant; however, she appeared somewhat aloof. At the end of the interview, Courtney indicated that she was willing to meet with the interviewer again and answer any further questions.

### ***Mahina Washington***

Mahina Washington is a 12-year old biracial (Hispanic and African-American) girl in the 6th grade. She lives with her mother, younger brother (10 years old), and younger sister (3 years old). According to her therapist's notes, Mahina's father was incarcerated for several years and was released from prison at the beginning of the ACTION program. After his release, Mr. Washington resided with a girlfriend and had minimal contact with Mahina and her siblings. Prior to treatment, Mahina reported that her father's apparent lack of interest in reconnecting with her was a significant source of stress. She stated that she had not seen her father "in about four years" and that he continually disappointed her by making plans to see her and then not following through. In addition, Mahina also reported that, at the beginning of treatment, she was having difficulty obtaining passing grades in some of her classes.

Based on the results of a diagnostic interview that was completed with Mahina and her mother before treatment, Mahina was diagnosed with moderately impairing

MDD, mildly impairing GAD, and a moderately impairing specific phobia. In addition, although she did not meet the full criteria, the diagnostic interviewer could not rule out the possibility that Mahina had ADHD, Predominantly Inattentive Type. Mahina's primary depressive symptoms prior to treatment included sadness, irritability, excessive guilt, fatigue, diminished ability to concentrate, psychomotor agitation, psychomotor retardation, insomnia, increased appetite, and self-pity. In an initial case conceptualization, her therapist hypothesized that Mahina had core beliefs of unlovability and inadequacy related to fears of being rejected by others. After treatment, Mahina no longer met criteria for a depressive disorder or generalized anxiety; however, she continued to meet criteria for a specific phobia. Once again, a diagnosis of ADHD, Predominantly Inattentive Type could not be ruled out.

Mahina participated in the same treatment group as Courtney. Thus, her treatment condition was a CBT only. The group contained two other 6th graders and was led by a primary therapist for the first twelve meetings. A therapist-in-training led the group for the last eight meetings.

Mahina completed the initial interview approximately three months after her treatment group ended. During the initial interview, she appeared comfortable and relaxed, immediately establishing rapport with the interviewer. Mahina appeared to provide open and honest answers to questions. At times, her responses were conflicting and she appeared to have a somewhat incoherent and unstable frame of reference as if she were creating her experience as she answered the questions rather than recalling it. At the end of the initial interview, Mahina agreed to participate in a second interview. Mahina was selected to complete a follow-up interview, which was conducted approximately one month after the initial interview. Once again, Mahina appeared to be providing candid and thoughtful answers to inquiries. She seemed somewhat confused

during the second interview, often asking the interviewer to repeat questions. Overall, her responses during the second interview were fairly consistent with her responses during the initial interview.

### *Alika Williams*

Alika Williams is a 12-year old African-American girl in the 6th grade. She lives with her mother and father. Alika has an older brother that lives outside of the home. According to her therapist's notes, Alika was diagnosed with ADHD in elementary school and she repeated a grade. Alika's mother reported that her daughter took stimulants in the past to help manage her difficulty with attention; however, she stated that Alika's father was uncomfortable with this and, therefore, the medication had been discontinued. Mrs. Williams also reported that Alika had recent episodes of enuresis and was unable to spend the night away from home. Before treatment, Alika reported that she experienced two significant stressors. She stated that she was having difficulty passing her classes. Alika indicated that she was afraid that she would not advance to the 7th grade. In addition, she reported that she "had no friends," which caused her to feel sad and lonely.

Prior to treatment, Alika was diagnosed with moderately impairing MDD, PTSD, and Social Phobia. In addition, she received a diagnosis of mildly impairing ADHD, Predominantly Inattentive Type. Alika's primary depressive symptoms included sadness, excessive guilt, fatigue, diminished ability to concentrate, psychomotor agitation and retardation, insomnia, decreased appetite, self-pity, feelings of hopelessness, a poor self image, and engagement in self-damaging acts. In an initial case conceptualization, her therapist hypothesized that Alika had a core belief of inadequacy related to her history of poor school performance and untreated ADHD. During treatment, it was suspected that Alika may have a learning disability due to reading and writing difficulties that were

noted by her primary therapist. Alika's therapist discussed her concerns with Mrs. Williams and, with permission, contacted the appropriate school personnel to recommend a psycho-educational assessment; however, the evaluation was not completed by the end of the school year. Upon completion of treatment, Alika no longer met criteria for a depressive disorder, PTSD, or Social Phobia; however, she continued to receive a diagnosis of ADHD, Predominantly Inattentive Type, which was rated as mildly impairing.

Alika was the third member in the treatment group that contained Courtney and Mahina. Thus, all of the girls were in a CBT only treatment condition at their middle school that was co-led by a primary therapist and a therapist-in-training.

Alika completed the initial interview approximately two months after treatment ended. During this interview, Alika appeared shy and introverted. She spoke in a soft, low voice. Alika appeared nervous, demonstrating a rigid posture and maintaining minimal eye contact with the interviewer. As the interview progressed, she seemed to relax a little bit and even smiled and laughed from time to time. At times it seemed as though Alika was producing responses to please the interviewer rather than stating her true opinions. On the other hand, sometimes it also seemed as though she did not clearly understand some of the questions. Overall, she seemed to demonstrate good effort and she agreed to participate in a second interview if necessary.

### *Paris Lopez*

Paris Lopez is a 10-year old, biracial (Hispanic/Mexican-American and Caucasian) girl in the 4$^{th}$ grade. She lives in a blended family that includes her mother, step-father, and 14-year old brother. Paris indicated that she speaks both Spanish and English fluently; however, she noted that English is her first and primary language. Paris's parents divorced when she was 2-years old and she currently visits her father

every other weekend in a neighboring town. According to Paris, her father is engaged and has a son (8 weeks old) with his fiancée. Her father's household also includes one of Paris's brothers (12 years old) and two step-daughters (10 and 9 years old). Paris experienced several significant stressors prior to treatment. First, she reported that her mother and step-father argued "almost every night" and that she and her siblings would sleep together in one bed because they were so "scared" of the fights. Next, Paris indicated that one of her brothers was using drugs and was becoming involved in the legal system. Paris also reported that her grandfather, with whom she was "really close," passed away and that his death had caused her significant sadness and pain. Finally, she noted that she had experienced peer difficulties at school, including having rumors spread about her "all this year."

Prior to beginning treatment, Paris was diagnosed with markedly impairing, recurrent MDD and moderately impairing GAD. Her primary depressive symptoms included sadness, irritability, loss of interest or pleasure in most activities, decreased appetite, insomnia, fatigue, psychomotor agitation and retardation, diminished ability to concentrate, and excessive guilt. In her initial case conceptualization, Paris's therapist hypothesized that Paris had core beliefs of helplessness and worthlessness. Upon completion of treatment, Paris no longer met criteria for a depressive or an anxiety disorder.

Initially, Paris was assigned to a 4-member treatment group at her school; however, after three meetings, one of the girls dropped out. All of the remaining members of Paris's group were in the 4$^{th}$ grade. Paris's group was designated as a CBT plus parent training component group and was led by a primary therapist. According to the therapist, the school counselor participated in some of the meetings. In her notes, the therapist indicated that Paris's family attended three parent meetings and two individual

family meetings. Both Paris's mother and step-father were present at two parent meetings and one individual family meeting; however, the therapist noted that the parents decided to separate during the program and only the mother attended the remaining meetings with her daughter. At the time of the initial interview, Paris reported that her step-father was once again living in the home.

Paris completed the initial interview approximately three months after treatment ended. She was asked to participate in a second interview, which was completed one month after the first interview. During the initial interview Paris appeared very comfortable. She smiled at the interviewer and made continuous eye contact. She provided detailed and thoughtful answers to all of the interview questions. Paris was extremely articulate and appeared very mature for her age. She shared very personal information with the interviewer and seemed to be very honest about her experience in the ACTION program. The initial interview was very long and towards the end, Paris became a little distracted and had a little difficulty staying on topic; however, overall the initial interview went very well. During the second interview, Paris's disposition was markedly different. She was still thoughtful and articulate, giving detailed answers to questions, but she appeared fatigued and overwhelmed. She described several new stressors in her life and she stated that she was tired at the end of the interview. Despite her change in demeanor, the second interview also went well and her answers were very consistent with her responses during the initial interview.

### *Shaneika Bowen*

Shaneika Bowen is a 10-year old, biracial (African-American and Caucasian) girl in the 4$^{th}$ grade. Shaneika lives with her mother, her step-father, and two half brothers (3 years and 11 months old). According to Shaneika, she also has several full, half, and step siblings from both her mother's and her father's current and previous relationships,

including six sisters (25, 24, 21, 19, 17, and 11 years old) and two brothers (26 years old and 6 years old). Information on an intake form that was completed prior to treatment indicated that Shaneika visits her father two to three times per year. For Shaneika, her most significant source of stress prior to treatment was her relationship with her step-father. She reported that she had difficulty getting along with him.

Before treatment began, Shaneika was diagnosed with DD. In addition, the therapist's notes indicated that Shaneika was also experiencing enuresis. Shaneika's primary depressive symptoms included sadness, self-pity, weight gain, loss of interest or pleasure in most activities, insomnia, diminished ability to concentrate, excessive guilt, and a poor self image. Her overall level of depressive symptoms was rated as moderate, indicating difficulty functioning in some areas. In an initial case conceptualization, her therapist hypothesized that Shaneika had core beliefs of unlovability and worthlessness. After treatment, Shaneika no longer met criteria for a depressive disorder.

Shaneika participated in the same treatment group as Paris. Thus, she was in a CBT plus parent training group with two other 4$^{th}$ grade girls that was led by a primary therapist and observed by a school counselor on occasion. In her notes, the primary therapist indicated that Shaneika's family attended five parent meetings and one individual family meeting. Shaneika's mother and step-father attended one meeting together, Shaneika's mother and 20-year old step-sister attended one meeting together, and Shaneika's mother attended four meetings by herself. The therapist noted that Shaneika's family failed to appear for one of the individual family meetings. She also noted that Shaneika's mother had difficulty arriving on time to the final parent meeting.

Shaneika completed the initial interview approximately three months after her treatment group ended. During the initial interview Shaneika appeared sad. Her affect was very flat, she did not smile, and she maintained minimal eye contact with the

interviewer. Shaneika had difficulty remembering specific details about her experience in the ACTION program group and she seemed unable to articulate her thoughts and feelings. At the end of the interview, Shaneika indicated that she would be willing to answer further questions if necessary.

### ***Gwendolyn Griffith***

Gwendolyn Griffith is an overweight 10-year old, Caucasian 5th grader. She lives with her father, mother, two brothers (18 and 3 years old), and sister (11 years old). According to her therapist's notes, Gwendolyn has a history of psychiatric treatment for concerns related to hoarding food and binging. Before treatment, Gwendolyn reported that she had several negative thoughts that she did not know how to manage. She also reported that she experienced a stressful event when she was younger; however, she declined to disclose details during the interview. Interestingly, Gwendolyn did not mention her on-going difficulties with her weight.

Gwendolyn was diagnosed with MDD, in partial remission before beginning treatment. She did not meet full criteria for MDD because she endorsed slightly fewer symptoms than are required. Gwendolyn also received a diagnosis of EDNOS. She reported several symptoms of depression, including sadness, excessive guilt, fatigue, psychomotor agitation, diminished ability to concentrate, and self-pity. Her overall level of symptoms was rated as mild. In her initial case conceptualization, Gwendolyn's therapist hypothesized that Gwendolyn had a core belief of worthlessness. Over the course of treatment, her therapist worked with Gwendolyn's mother to generate ideas for managing her daughter's weight such as consulting with a nutritionist. Upon completion of treatment, Gwendolyn was diagnosed with moderately impairing MDD and GAD. She also continued to meet criteria for EDNOS. Thus, over the course of treatment, Gwendolyn's symptoms worsened.

Gwendolyn participated in the same treatment group as Paris and Shaneika, which was a CBT plus parent training component group that was led by a primary therapist and sometimes observed by a school counselor. According to the therapist's notes, Gwendolyn's mother and father attended all of the parent meetings as well as two individual family meetings.

Gwendolyn completed the initial interview approximately three months after treatment ended. During the initial interview, Gwendolyn was engaged and talkative. She seemed to recall a lot of details about her experience during the ACTION program and she appeared very candid in her responses to questions. Gwendolyn also appeared somewhat scattered during the interview. She would frequently get off topic and have to be redirected by the interviewer. Although Gwendolyn was very talkative, she was very clear that she did not feel comfortable talking about certain subjects. Overall, Gwendolyn seemed to enjoy the interview and stated that she was willing to meet with the interviewer again. She was selected to participate in a second interview, which occurred approximately two weeks after the initial interview. Once again, Gwendolyn was very engaged and talkative yet, at times, she demonstrated difficulty staying on topic. When focused, she appeared to give thoughtful and honest responses to inquiries. Overall, Gwendolyn's answers were very consistent from one interview to the next.

### *Sarah Schneider*

Sarah Schneider is a 10-year old biracial (Caucasian and Native American) 5$^{th}$ grader. Sarah lives with her mother, step-father, and younger, half sister (7 years old). Sarah has two older step-siblings (ages 18 and 20) and two older, biological siblings (ages 23 and 25) that live outside of the home. Sarah reported that her mother and father divorced when she was 3 years old. She indicated that her biological father lives in a different state and that she has had no contact with him in the past two or three years.

Sarah noted that she does not wish to see or speak with her father. According to an initial intake with Sarah's mother, Sarah had received individual, weekly therapy for six months prior to her participation in the ACTION program. Sarah reported that her most significant areas of stress prior to treatment were related to peer, family, and academic problems. She stated that she was having difficulty in school, that other children were gossiping about her, and that her family "doesn't really do stuff together," which made her feel sad.

Prior to treatment, Sarah was diagnosed with moderately impairing MDD, mildly impairing GAD, and moderately impairing ADHD, Combined Type. A review of records revealed that Sarah also had a history of enuresis and that she was taking stimulant medication for her symptoms of ADHD. Sarah's pre-treatment depressive symptoms included sadness, irritability, decreased appetite, fatigue, diminished ability to concentrate, psychomotor agitation, psychomotor retardation, insomnia, feelings of hopelessness, self pity, and a poor self-image. In an initial case conceptualization, her therapist hypothesized that Sarah had a core belief of inadequacy. At the end of treatment, Sarah no longer met criteria for a depressive or an anxiety disorder. She continued to meet criteria for ADHD.

Sarah participated in a 3-member treatment group at her elementary school. The group was reduced to two members after one member decided to discontinue her participation. The remaining member of Sarah's group was in the 4th grade. Her group was led by a primary therapist.

Sarah completed the initial interview approximately one week after the end of her treatment group. During the initial interview, Sarah appeared fairly distracted. She played with a pencil that was given to her by the interviewer, she did not engage in continuous eye contact, and she frequently requested that questions be repeated. Sarah

interacted in a somewhat odd manner. She would occasionally act out answers to questions and use a silly, young tone of voice. About two-thirds of the way through the interview, Sarah stated that she was tired. She repeated that she was sleepy a few times and, eventually, asked the interviewer if she could sit on the floor, stating that she was tired of sitting in the chair. As the interview progressed, Sarah became more and more distracted and had difficulty staying on task and answering questions. When the interview was completed, Sarah agreed to complete a second interview, if necessary.

### *Devora Abbott*

Devora Abbott is a 9-year old biracial (Caucasian and Native American) female in the 4th grade. She lives with her mother, step-father, and 12-year old sister. Devora reported that her biological father lives with her paternal grandmother and that she has not seen him during the past two years. According to her therapist's notes, Devora biological father has a history of mental illness and incarceration. In addition, Devora had a history of ADHD for which she was not taking medication at the time of treatment. Her therapist's notes also indicated that Devora was in individual therapy prior to the ACTION program. According to Devora, before treatment, she "didn't have any friends" and her older sister frequently yelled at and was mean to her. Thus, sibling conflict was a significant source of pre-treatment stress for Devora.

Prior to treatment, Devora was diagnosed with severely impairing, chronic MDD. In addition, she received a diagnosis of markedly impairing ADHD, Combined Type and a moderately impairing specific phobia. Devora's primary depressive symptoms included sadness, irritability, fatigue, diminished ability to concentrate, psychomotor agitation and retardation, insomnia, feelings of self-pity and hopelessness, increased appetite/weight gain, a poor self-image, and engagement in self-damaging acts (e.g., head-banging). In an initial case conceptualization, her therapist hypothesized that

Devora had a core belief of inadequacy. After treatment, Devora no longer met criteria for a depressive disorder. She continued to meet criteria for ADHD and a specific phobia.

Devora participated in the same treatment group as Sarah, which was led by a primary therapist and observed by a therapist-in-training. Their treatment condition was CBT only.

Devora completed the initial interview approximately one week after treatment ended. During the initial interview, she seemed tired and distracted. She stated that she was sick, but when asked if she wanted to go to the nurse's office or to call her mother, she turned down both offers. She appeared very reluctant to engage with the interviewer or to provide thoughtful or detailed responses to questions. Oftentimes, she used one word answers or she stated that she did not know the answer. Several times during the interview, she put her head on her desk and did not make eye contact with the interviewer. Devora also appeared somewhat immature for her age, speaking in a child-like voice. Because she appeared so reluctant to complete the task, the interviewer stopped the interview and told her that they could reschedule it for a time when she was feeling better. Devora indicated that she wanted to continue the interview, so it was resumed. Overall, Devora's responses to questions were somewhat inconsistent.

## Chapter Summary

Prior to treatment, all of the participants experienced several symptoms of depression and were diagnosed with either MDD or DD. In addition, they demonstrated a high rate of comorbid conditions. Many of the girls experienced disorders such as GAD, ADHD, and phobias in addition to depression. Thus, the participants tended to demonstrate considerable psychological distress at the beginning of treatment.

After completing pre-treatment assessments, the participants were randomly assigned to a CBT only or a CBT plus parent training component treatment condition at their respective elementary or middle schools. All of the girls participated in treatment during the same academic year. The participants' treatment groups contained two to four members and, in general, were led by a senior and a junior therapist. By the end of treatment, the majority of girls (15 out of 17) no longer met criteria for a depressive disorder. A number of participants also experienced a remission in comorbid conditions, particularly anxiety disorders.

Within several weeks of completing treatment, the girls participated in the present study. All of the participants completed an initial interview and approximately half of the girls (7) completed follow-up interviews. After some initial shyness, most of the girls were remarkably engaged and articulate throughout the interviews. Almost all of the participants seemed to enjoy discussing their experience in the ACTION program, and they appeared to give thoughtful and candid responses to questions. Based on their high level of honesty and expressiveness as well as the consistency among answers, it is believed that the information gathered in the interviews represent an accurate depiction of the participants' experience and evaluation of treatment.

The next chapter will provide an overview of how the data that was gathered in the interviews were analyzed. In addition, the precautions that were taken to ensure the trustworthiness of the data and results will be reviewed. Finally, the storyline that emerged from the data analysis will be presented.

# CHAPTER FIVE

# OVERVIEW OF ANALYSIS

The present study utilizes the grounded theory approach of qualitative research in an attempt to answer the following questions regarding a group CBT intervention for depressed, pre-adolescent girls:

1. How is a group CBT intervention for depressed girls perceived by the participants? Is the treatment helpful? How effective is the treatment in reducing depressive symptoms, increasing skills, and elevating mood from the perspective of the participants?
2. Are there identifiable stressors that are associated with depression? If so, what are they? How do the participants manage these stressors prior to treatment? How do their stressor management strategies change as a result of being in treatment?
3. How do the participants experience treatment? Do they change over the course of treatment? What changes do they make? What factors (i.e., specific or non-specific) influence change?
4. How do the treatment components influence change? Which treatment components are most frequently recalled, best understood, most frequently used, and perceived as most helpful? How do these skills help? Which components are least recalled or perceived as least helpful?

Since a qualitative rather than a quantitative research methodology was chosen for this study, it is important to discuss the ways in which precautions were taken to ensure the trustworthiness of the findings. After exploring this subject in some detail, this chapter will review the data collection and analysis process. It will provide information

regarding all stages of coding as well as the development of themes. Finally, the chapter will end with a detailed description of the storyline that emerged from the data.

## Trustworthiness

As discussed previously, several techniques were employed to increase the trustworthiness of the results. First, I examined possible personal and professional biases that may have affected both data collection and data analysis. Second, I utilized triangulation to ensure that the information gathered in the interviews was accurate and credible. Third, I met regularly with dissertation committee members and graduate student colleagues for peer debriefing sessions. Fourth, I performed member checks by meeting with some of the participants after preliminary data collection and analysis to review emerging concepts and models. Finally, throughout data collection and analysis, I kept a reflexive journal in which I recorded personal reactions to the research process and decisions regarding methodology. The following section will explore these techniques in more detail.

### *Researcher Biases*

In qualitative research, the researcher is the primary agent of data collection and analysis. Since all of the data are filtered through the researcher's personal and professional experiences, her biases can color all aspects of the research. It is crucial for the researcher to become aware of how her assumptions, beliefs, and experiences can influence data collection, data analysis, and, ultimately, the research findings.

As a graduate student in educational psychology, I became involved in research during my first semester. Having taken and thoroughly enjoyed an undergraduate course in CBT, I was immediately drawn to a research project spearheaded by Kevin Stark, Ph.D. that aimed to examine the efficacy of a group CBT treatment for depressed, pre-adolescent girls. This project received funding from the National Institutes of Mental

Health at the end of my first year of graduate training and quickly evolved into the ACTION program treatment study. As one of the initial members of the research team, I had the opportunity to be involved in the development of the study as well as the treatment materials. Along with Dr. Stark and several colleagues, I helped create the original therapist workbook, child workbook, and parent workbook. At the end of each year, I was also involved in revising and streamlining these treatment materials.

In addition to assisting with the creation of the treatment materials, I also became a therapist-in-training by the end of the first year of the study. At the beginning of the second year, I assumed full responsibility as a primary therapist and began running treatment groups on my own. Later in that year, I started to train new therapists. During my four years on the ACTION project, I served as a therapist, co-therapist, or therapist-in-training on eight groups. I worked with a total of twenty-seven girls and nine families and I assisted in the training of four therapists. Thus, I was deeply involved in both the planning and implementation of the treatment.

Having committed so much time and energy to the ACTION project, my bias is that I have always hoped that it would prove to be successful in reducing depressive symptoms in its participants. Through my experiences with the girls in my groups, I have witnessed first hand how it significantly helps depressed girls feel better. I have seen over and over again girls that are completely withdrawn and hopeless blossom over the course of the treatment into girls that smile, laugh, and enjoy life once more. Watching and being a part of this transformation was truly the best experience in my graduate career.

Of course, no treatment for depression, psychosocial or pharmacological, is completely effective in treating all clients, and this was also the case for the ACTION program. Despite its impressive, preliminary high rate of efficacy, as a therapist, I knew

that it was not able to help every participant. A few of the girls that I worked with over the years continued to struggle with feelings of sadness and hopelessness despite receiving treatment. Since so many of the girls from my groups did get better by the end of treatment, I often wondered what it was about the participant or the program that prevented positive change in the few girls that remained depressed. Thus, although my bias is that the ACTION program can be a very powerful tool in alleviating depression in young girls, I also know that it does not help every girl.

In collecting and reviewing the data, I was mindful of my role as an ACTION program therapist and my biases about the treatment. I endeavored to be extremely open-minded. Although I expected that many participants would say that the treatment was helpful, I made a concerted effort to appear neutral as they explained their experiences so that the girls would feel comfortable disclosing their possible frustrations or disappointments with it. In fact, I decided not to tell the participants that I was a therapist or that I had led ACTION groups. Instead, I assumed a role of complete naiveté. I told the participants that I knew about the program, but that I had never been in it and, therefore, needed to gain the perspective of someone that had participated in it. When the girls talked as if I knew the skills, I would remind them that I had never been in the program and ask for explanations. In many ways, I set up the interviews so that the girls were the experts; they were teaching me about the program. By adopting the role of a naïve interviewer, I was less likely to allow my biases to influence the interviews. In addition, I hoped that the girls would be more honest about their experiences if they believed that they were speaking with someone that was not an expert on the treatment. Finally, by allowing the girls to teach me about the treatment, they were able to focus on information that was important to them.

Given their age, I had wondered if the girls would be able to articulate their thoughts, feelings, and experiences. I was amazed at how eloquent even the youngest participants were. I found that I felt proud of the participants, particularly those that were willing to disclose negative experiences with treatment. Thus, I think that I was extremely receptive to what the girls had to say despite the fact that my bias was that the ACTION program is an effective intervention. Rather than wanting to prove that the treatment is helpful, I approached the interviews with the desire to make the ACTION program even better. I truly wanted to know what did not work as much as what did work so that the treatment could be changed to help even more children.

In any interaction, be it personal or professional, one is likely to have stronger connections with some individuals than others. I thought that it was important to be thoughtful about these reactions during the interviews and how they influenced data collection or analysis. Fortunately, one of my strengths as a clinician is that I easily connect with others and I am able to quickly establish rapport. This is a trait for which I have received continual praise throughout my graduate training. During the data collection process, I found that my abilities in this area served me well. I was able to quickly establish trust and rapport with the participants, which I felt contributed to candid responses to questions. I found that I really enjoyed talking with each of the girls, and was captivated by their stories. I think that this increased the trustworthiness of the data because the girls felt comfortable discussing their thoughts, feelings, and experiences with me. Their high level of openness and candor served to increase my confidence in the credibility of my findings.

When I began the study, my goal was to better understand the different variables that contribute to treatment outcome. Initially, the focus of the investigation was on the treatment components. Having taught the specific skills on so many occasions as a

project therapist, I believed that the treatment components would be a very important variable in terms of treatment outcome. As a result, I needed to be mindful about any biases related to this aspect of treatment. In thinking about this, I found that I did have preferences for some of the skills in the treatment. Specifically, I tend to use problem-solving and cognitive restructuring when faced with difficulties in my own life. For me, coping strategies, setting goals, and self-monitoring are less helpful skills. In addition, having run several ACTION program groups, I found that the girls seemed to really enjoy and understand some skills more than others. For example, most of the girls like the activities related to the coping strategies, whereas some of the problem-solving activities seem to be less engaging. In addition, the girls in my groups seemed to do well with identifying negative thoughts, but, sometimes, had difficulty with challenging them. Finally, having helped to design some of the specific activities such as "Muck Monster UNO" and the self-map, I obviously felt a sense of pride and ownership in relation to these particular aspects of treatment. Thus, based on my own preferences, experiences as a therapist, and contributions to the treatment, I thought that problem-solving, cognitive restructuring, and building a positive sense of self would be rated as more helpful than the coping strategies, setting goals, and self-monitoring. Knowing that I felt this way, I had to be careful not to probe more when the girls talked about the former skills or to probe less when they discussed the latter.

Finally, I also explored my biases related to non-specific factors of change. Having established excellent therapeutic relationships and meaningful connections with the girls in my ACTION groups, I anticipated that the participants would report that the therapeutic relationship or alliance was one of the most important variables in relation to treatment outcome. I had to be careful to structure questions in such a way that allowed the participants to talk about all of the relationships that developed as a result of their

participant in treatment rather than focusing exclusively or narrowly on the participant-therapist interaction.

### *Triangulation*

In addition to being aware of my own biases, triangulation techniques were employed to increase the trustworthiness of the results. Information was gathered from multiple sources and informants, and compared with the interview data to determine its accurateness and credibility. Sources of information included self-report inventories, semi-structured diagnostic interviews, and other quantitative measures. Informants included participants, therapists, and diagnostic interviewers. There were very few instances where I had doubts about the truthfulness or accuracy of the interview data. For the most part, triangulation was used to increase credibility in data that already appeared accurate. For example, if a participant reported that she believed that problem-solving was the most helpful skill in the ACTION program, then I would check to see if she understood or attempted to use other skills by looking at her therapeutic homework assignments or by reading her therapist's session notes. If it was determined that she had used other skills, then her evaluation of problem-solving as the "best" skill was considered valid. This was the case with Alexandra Aguilar. She reported that problem-solving was the skill that helped her the most. In reviewing her therapeutic homework assignments, it was clear that she had attempted to use other skills; however, over and over again, problem-solving provided her with the best results. Thus, her evaluation of this specific skill appeared to be valid.

Triangulation was also used to ensure consistency in the data. By comparing information gathered in the interviews with other sources it was possible to determine if participants' responses were consistent across different methods of data collection. Overall, information gathered in the interviews was strikingly consistent with data

collected by other means. For example, during the initial interview Sophie Stuessi indicated that she experienced many interpersonal stressors prior to treatment. In particular, Sophie reported that rumors were spread about her at school. Information on one of the skills quizzes completed during treatment confirmed Sophie's reports. On the quiz, she indicated that "a big rumor went around about me and I lost a lot of close friends." Thus, by examining other sources of information, it was possible to determine that participants' interview data was reliable. Thus, Sophie's responses were consistent across sources of information, which increased the reliability of the data gathered from this particular participant.

### *Peer Debriefing*

Peer debriefing was another strategy that was used to increase the trustworthiness of the data. Throughout the research process, I met regularly with graduate student colleagues and dissertation committee members to explore topics such as data collection, data analysis, researcher biases, working hypotheses, and emerging models. Discussions with peers and committee members served to broaden my thinking about the data and to refine the final model. In addition, two graduate student colleagues were asked to code copies of interviews so that the results could be used to compare findings with those of the researcher.

### *Member Checks*

Another strategy that was used to ensure the trustworthiness of the findings was member checks. Member checks entail coding interview data and presenting preliminary interpretations to participants for review and feedback. In the present investigation, member checks were performed simultaneously with secondary interviews and were completed with six participants. These girls were able to provide feedback about interpretations and developing hypotheses. While the majority of the participants

confirmed emerging themes, a few participants clarified interpretations by expanding on the information presented. For example, by sharing my original interpretations about the relationship between specific and non-specific factors and treatment outcome with Olivia Ramirez, a participant that continued to be depressed after treatment, I was able to gather more information about how these variables work independently and interdependently to facilitate or to prevent change. Thus, member checks helped me to validate emerging hypotheses as well as to clarify the relationship between important concepts in the data and, ultimately, to expand the central phenomenon.

### *Reflexive Journaling*

Reflexive journaling was employed throughout the research process in an effort to increase the trustworthiness of the data collection and analysis. Initially, reflexive journaling was used as a way to record thoughts, reactions, and areas for follow-up related to initial and secondary interviews. After each interview, I recorded my general impressions, including ideas about factors that may have contributed to the overall success of the interaction. I also noted ways to check the validity of specific interview data such as reviewing therapeutic homework assignments or speaking with therapists. As the research progressed, my reflexive journal also became a place to record possible biases, track decisions related to methodology, and explore evolving hypotheses related to the unfolding storyline.

## Coding the Data

### *Open Coding*

During open coding, the researcher labels concepts in the data and identifies their properties and dimensions. In the present study, open coding occurred in conjunction with data collection. All of the transcripts were transcribed and coded by the researcher.

In addition, two graduate student colleagues coded four interview transcripts. As interview transcripts were read, the data were broken down into small, meaningful units or concepts and were given a descriptive label. These segments ranged from a single word to a sentence to a paragraph. Each label attempted to capture the central concept in the interview segment. For example, the code *seeking social support* was assigned to following segments: "I would call a friend that I trusted and talk to about it" (Lucia Castillo) and "But when it got really serious, I just talked to (current teacher's name) about it" (Danielle Aiza). Labels were determined by the researcher and, when appropriate, were based on terms used in the relevant literature. In addition, "in vivo" codes were used when a participant's wording seemed to capture the concept nicely. For example, the code **"positive change"** was given to the following interview segment: "Well, for me, it was a positive change 'cause I never used to talk and so, and I never really participated in anything" (Mia Mancini). An example of open coding is provided in Appendix W.

As each interview transcript was subjected to open coding, hundreds of concepts emerged. Codes that were similar to one another were grouped together to form more comprehensive categories. For example, *fight between parents, fight with a friend, death of a loved one, failing a test*, and *too much homework* were grouped together into the category **stressors**. Differences among codes that were collapsed into categories were represented by identifying properties and dimensions. For example, *social withdrawal, emotional release, seeking social support, denial/ignoring, distraction, relaxation, physical release, rumination*, and *problem-solving* were concepts that were all classified as **stressor management strategies**. To understand differences among these concepts, these **stressor management strategies** were grouped by properties and dimensions such as ***domain***, ***approach***, and ***level of helpfulness***. Thus, active, emotion-focused **stressor**

**management strategies** with a high ***level of helpfulness*** included *distraction, relaxation, physical release*, and *seeking social support*, whereas passive, emotion-focused **stressor management strategies** with a low ***level of helpfulness*** included *social withdrawal, emotional release, rumination*, and *denial/ignoring*. Categories were continually re-evaluated to see if they appropriately captured the concept in the data. During this process, memos were used to assist in determining codes and categories as well as a means of conceptualizing the data. Please refer to Appendix X for an example of a memo that was generated during the open coding process.

As open coding proceeded, expected concepts emerged such as unpleasant **emotions** or **coping strategies**. The discovery of unanticipated concepts such as **sense of relatedness** or **"positive change"** influenced further data collection by revising interviews to include questions specific to the unexpected concept. Thus, the connection between the **helpfulness of the ACTION program** and **treatment outcome** (e.g., **"positive change"**) made it clear that the interview needed to be amended to include questions related to how the participants changed over the course of treatment. Thus, data analysis shaped subsequent data collection.

### *Axial Coding*

In the present study, axial coding occurred concurrently with open coding. As significant categories and subcategories were identified in the data, they were explored in a structured manner in which conditions, context, actions/strategies, and consequences were noted. These categories and subcategories were then compared with one another to better understand their relationships. Comparison of categories and subcategories as well as their properties and dimensions was facilitated by grouping them together in a spreadsheet format. Based on comparisons of properties and dimensions, relational statements about categories and subcategories were developed. For example, **stressor**

**management strategy** ***usage*** depends on **stressor** ***controllability*** and **participant characteristics such as** *coping style*. The degree to which a specific treatment skill matched a participant's pre-treatment coping style and seemed likely to solve a specific problem seemed to be a condition that influenced the frequency of specific treatment skill usage. That is, participants that showed a *preference* for emotion-focused **stressor management strategies** prior to **treatment** and/or faced uncontrollable **stressors** tended to ***use*** the **coping strategies** more frequently. As hypotheses about relationships among concepts were generated, they were tested by returning to interview transcripts to determine if they fit the data. An example of axial coding is provided in Appendix Y.

### *Selective Coding*

During the process of selective coding, a core category or central phenomenon is identified and related to all other significant categories in an effort to construct a theory that is grounded in the data. The core category is selected because of its ability to comprehensively represent the central phenomenon around which all other categories and subcategories can be integrated. In the present investigation, different models emerged which described the relationships between major categories. These models were then tested against the data by reviewing interview transcripts to evaluate goodness of fit. If a particular model was not a good fit with the data, then it was either revised or discarded by the researcher. In the present investigation the core category seemed to be the **helpfulness of the ACTION program** since all other categories related to it. The following section will describe the storyline that emerged from the data regarding this core category.

## Storyline

Over the course of **treatment**, the participants experienced **stressors** in both the interpersonal and academic ***domains***. **Stressors** varied in terms of their ***domain***

(interpersonal/academic), ***amount*** (many/few), ***duration*** (chronic/acute), and ***controllability*** (controllable/uncontrollable). Interpersonal **stressors** were further classified by ***type***: conflict- or loss-oriented. Before **treatment**, participants had many, conflict-oriented interpersonal **stressors** that were mostly chronic and uncontrollable.

The girls used several different pre-treatment **stressor management strategies** to cope with these difficulties. **Stressor management strategies** varied with regard to ***amount*** (many/few), ***domain*** (emotion-/problem-focused), ***approach*** (active/passive), and ***level of helpfulness*** (high/low). Prior to **treatment**, participants used predominantly emotion-focused **strategies**, including *social withdrawal, emotional release, seeking social support, denial/ignoring, distraction, relaxation*, and *rumination* to cope with **stressors**. Some of the girls also used problem-focused **strategies** such as *problem-solving*. Specific **stressor management strategy *use*** seemed to depend on **participant characteristics** (e.g., *knowledge*, *coping style*). Before **treatment**, most of the participants demonstrated a *preference* for emotion-focused **strategies**; however, since many girls lacked *knowledge* of effective **coping techniques**, they tended to use predominantly passive **strategies** with a low ***level of helpfulness***. These **strategies** were seen as unhelpful because they did not successfully manage unpleasant **emotions**, decrease rumination, or solve problems.

Given the fact that the participants were not able to adequately cope with their **stressors**, many of the girls experienced frequent and fairly severe **emotions**. Pre-treatment **emotions** varied in terms of ***amount*** (many/few), ***frequency*** (high/low), ***severity*** (high/moderate), and ***quality*** (pleasant/unpleasant). None of the girls reported experiencing pleasant **emotions** prior to **treatment**. The most common unpleasant **emotion** was *sadness*, and the most common **combination of feelings** was *sadness and*

*anger*. These unpleasant **emotions** were generally the direct **consequence** of an identifiable **stressor**.

**Stressors** were also associated with the participants' pre-treatment **outlook**, which tended to be quite bleak. Most of the girls experienced negative **ways of thinking**, which included negative self-directed **thoughts** about their ability or worthiness. In addition, many of the girls experienced negative **thought patterns** (e.g., *minimizing the positive and maximizing the negative*). None of the participants seemed to experience positive **thoughts** or **thought patterns** prior to **treatment**. Thus, as a result of not being able to adequately cope with chronic, interpersonal **stress** the girls developed dysphoric **affect** and distorted **thought patterns**. These factors worked together to produce a high ***level of depressive*** **symptoms** and significantly impaired **functioning**, which resulted in the participants being selected for **treatment**.

The participants' initial **treatment experience** was somewhat negative. At the beginning, most of the girls experienced a moderate ***level of apprehension*** due to a low ***level of familiarity*** with the other **group members**. This low ***level of familiarity*** resulted in a low ***level of trust***, which influenced the ***amount*** of **problem-sharing** in which the girls engaged in the early stages of **treatment**. In the first group meeting, the participants learned about **confidentiality**, which seemed to decrease ***level of apprehension*** by increasing ***level of trust***. Building **trust** increased the ***amount*** of **problem-sharing** in which the participants engaged. As the girls began to open up to each other, they discovered that the other **group members** had problems too. This realization, in addition to certain **group characteristics** (i.e., *diagnoses, gender-specific, same-aged peers*), helped the participants develop a **sense of relatedness**, which seemed to facilitate even more **problem-sharing** as well as build group **support**. Group **support** facilitated **skill-building** and **problem-solving**, and it increased social **support** in **group members** that

had a low ***level of support*** prior to **treatment**. Thus, several factors related to the **structure of treatment** worked together to produce **"positive changes"** in the girls. For a few girls, the **structure of treatment** was the most helpful ***aspect of*** **treatment**.

By engaging in **problem-sharing**, the participants were able to help each other learn and practice skills in group. Thus, the ***acquisition*** and ***application*** of the **treatment components** depended, in part, on group **support**. Other factors that influenced **treatment component** ***acquisition*** were the **activities, rewards**, and therapeutic **homework**. In addition, the ***level of enjoyment*** associated with learning each skill also seemed to influence **treatment component** ***recall***. Skills that were taught using enjoyable **activities** were better ***recalled***, and the girls were more likely to ***practice*** skills when they received **support**, **encouragement**, and positive **reinforcement** for their efforts via **praise** and **rewards**.

Overall, the participants demonstrated a high ***level of recall***, ***comprehension***, and ***application*** of the core **treatment components**: *affective education, coping strategies, problem-solving,* and *cognitive restructuring*. Other, less core **treatment components** (i.e., *self-monitoring, goal-setting, building a positive self-schema*) were less frequently ***recalled*** or ***used*** by the girls. ***Level of helpfulness*** of the **treatment components** seemed to influence ***level of recall*** since the **treatment components** that were most frequently ***recalled*** were also the most helpful skills.

Three core **treatment components** (i.e., *coping strategies, problem-solving, cognitive restructuring*) were rated as the most helpful by the girls. These skills were highly regarded because they were directly related to several **"positive changes"** that the girls made over the course of **treatment** in relation to **stressors, stressor management strategies, emotions,** and **outlook**. *Coping strategies* helped participants to manage unpleasant **emotions** in better, safer, and more **ways**, *problem-solving* provided girls with

an organized **process** with multiple **ways** of solving problems, and *cognitive restructuring* helped the participants to develop more positive **outlooks** and **self-schema**. Since these "**positive changes"** were directly attributed to learning and using new skills, the majority of participants indicated that the **treatment components** were the most helpful ***aspect of*** **treatment**.

At the end of **treatment**, the participants experienced fewer **stressors**. **Stressors** continued to be predominantly interpersonal in nature; however, they were less chronic. The participants coped with these **stressors** using more active **techniques** that resulted in a much higher ***level of helpfulness***. Post-treatment **stressor management strategies** included *distraction, relaxation, seeking social support, thinking positive, physical release, denial/ignoring, social withdrawal,* and *problem-solving*. Being able to manage unpleasant **emotions** and to resolve **stressors** directly affected the **mood** of the participants by increasing their experience of pleasant **emotions** and decreasing unpleasant **emotions**. The girls also experienced an increase in positive self-directed **thoughts** and, many of the participants, acquired more positive **outlooks**. Thus, by the end of **treatment**, most of the girls were no longer **depressed** and their **functioning** improved significantly. As a result, most of the participants rated **the ACTION program** as **very helpful**.

A few participants did not experience as many **"positive changes"** as their fellow **group members**. For these girls, **participant characteristics** (i.e., *expectations, readiness for change, comfort with* **problem-sharing**) seemed to prevent them from benefiting from **treatment**. Participants that had unrealistic *expectations*, had *difficulty* engaging in **problem-sharing**, or were *not open or willing to change* did not make as many **"positive changes."** These girls tended to rate **treatment** as less helpful since they

were not able to resolve their **problems** or eliminate their depressive **symptoms** by the end of group.

In sum, the majority of participants found **the ACTION program to be a highly helpful intervention**. Several factors contributed to the ***overall helpfulness*** of **treatment**, including specific **variables** (i.e., the **treatment components**) and non-specific **variables** (i.e., **treatment structure, participant characteristics**). These factors worked together to produce **"positive change"** in several areas. For most participants, the **treatment components** were the primary **mechanism of change** since they provided specific and direct **ways** to cope with **stress**, elevate **mood**, and improve **outlook**. The **structure of treatment**, however, was also quite important since it provided some girls with increased social **support** and it facilitated the ***acquisition*** and ***application*** of the **treatment components**. Both of these factors were seen as the most helpful ***aspects*** **of treatment** because they contributed to positive **treatment outcomes**. Finally, other non-specific **factors**, such as **participant characteristics**, facilitated and hindered **"positive change,"** and contributed to the ***overall helpfulness*** of **treatment**. Participants found **treatment** less helpful when it did not meet their *expectations*, they felt *uncomfortable* **sharing problems**, or they were *not open or willing to change*.

# CHAPTER SIX

# PRE-TREATMENT FUNCTIONING

As discussed previously, a large proportion (approximately 88%) of the participants no longer met criteria for a depressive disorder at the end of treatment. Thus, the ACTION program appears to have been highly efficacious in reducing depressive symptoms in most of the participants. Although the results of the post-treatment data provide important information regarding treatment outcome, one of the goals of the present investigation was to determine if the intervention provided benefits from the perspective of the participants. Thus, in addition to symptom reduction or remission, it was important to understand if the participants saw the intervention as producing positive changes in their lives.

To understand if and/or how the ACTION program produced positive changes in the girls, it is important to capture how the participants functioned before treatment. To this end, participants were asked to describe their primary stressors, their methods of managing stressors, their emotional experience, and their outlook before treatment. The following chapter will provide a detailed picture of how the girls functioned in each of these areas.

## Stressors before Treatment

Typically, stressors are described as events or situations that impair functioning in one or more life domains. Stressors can be both major life events and minor daily hassles, and they can be characterized as acute or chronic in nature. As discussed previously, stressful life events have been associated with depression in children and adolescents (Compas, 1987); however, this relationship appears to only account for a

small percentage of variance (Johnson & McCutcheon, 1980) and does not explain individual differences in responses to stress (Compas, 1987).

In the present investigation, stressors were considered events that were perceived by the participants as stressful or upsetting. In order to obtain a broad understanding of stressor experiences prior to treatment, the participants were asked to describe "problems" that they were having before or at the beginning of the ACTION program. Consistent with previous research on child and adolescent stressors (Compas et al., 1988), the participants identified stressors in primarily two domains: interpersonal and academic. Interpersonal stressors were generally characterized as conflict- or loss-oriented and included experiences such as fights with family members or peers, death of a loved one, uninvolved or absent parents, and inadequate social support. Academic stressors included concerns about passing a subject or grade, pressure to improve grade performance, managing workload, and navigating the transition from elementary school to middle school.

Although stressors were identified in both the academic and the interpersonal domains, the participants endorsed experiencing interpersonal stressors at much higher rates than academic stressors. In fact, of the 48 pre-treatment stressor experiences that were discussed by the participants approximately 81% were interpersonal in nature. Thus, the girls reported very high rates of interpersonal stress prior to treatment.

The amount of pre-treatment stressor experiences varied from one to seven discrete problems. On average, the girls reported experiencing three stressors prior to treatment. Pre-treatment stressors varied in terms of their duration and controllability. In terms of duration, stressors appeared to be either acute or chronic. Acute stressors included events that occurred once or that had a definite beginning and end (e.g., failing a test). Chronic stressors were defined as events or situations that were recurrent or on-

going (e.g., being bullied). Approximately 70% of all pre-treatment stressor experiences were classified as chronic in nature. Thus, before treatment, participants experienced a high rate of recurrent or on-going stressors. Stressors also varied in terms of controllability, and were classified as controllable or uncontrollable. Controllability was defined as having the ability to change or control the stressor. Thus, if a participant could change the stressor, then it was defined as controllable. If, however, there was absolutely nothing that a participant could do to change the stressor, then it was classified as uncontrollable. Slightly more than half of stressors described were uncontrollable in nature. Please refer to Table 4 for examples of pre-treatment stressors categorized by stressor characteristics.

### ***Interpersonal Stressors***

Prior to treatment, the girls reported experiencing a very high rate of interpersonal stressors. These stressors seemed to be characterized as either conflict- or loss-oriented, and varied in terms of their duration and controllability. Conflict-oriented interpersonal stressors included peer, sibling, and parent conflict. Death of a loved one, social isolation, or uninvolved/absent family members were common types of loss-oriented interpersonal stressors reported by the girls. For more examples of conflict- and loss-oriented stressors, please refer to Table 4.

Although both types of interpersonal stressors were reported, the participants seemed to experience conflict-oriented stressors at much higher rates than loss-oriented stressors. In fact, approximately 68% of interpersonal stressors were classified as conflict-oriented. The most common conflict-oriented interpersonal stressor was conflict with peers, with nine participants reporting that this was a problem for them. The majority of peer conflicts involved controllable fights with friends or other peers. For example, Lucia reported that one of her main sources of stress before treatment was the

fact that she was "always getting into problems with other girls." Similarly, Jamilla talked about having "arguments with friends" on a fairly regular basis. Olivia identified fights with friends as a major source of stress for her, indicating that she was struggling with friends being mad at her for spending too much time with a boyfriend. Since her boyfriend and male best friend did not get along and got into fights, this compounded things for her. When asked what was going on at the beginning of treatment, Olivia said, "Like a lot of fights. Oh my god, the fights! It would make me cry."

Other forms of conflict with peers included being bullied or being the object of rumors or gossip. These conflicts were uncontrollable and produced a high degree of distress. This was the case for Sophie: "I guess it was just, like, you know, in middle school, all the, like, rumors and, like, friends back-stabbing and all that stuff or, you know, just things all together so much it, like, stresses you." Paris also had "rumors" spread about her and Sarah identified "gossip" as a significant pre-treatment stressor. In addition to experiencing forms of relational aggression such as rumors, the participants also reported experiencing more direct forms of bullying. For example, Mia identified "getting picked on" by a peer as an on-going source of stress.

Another significant source of interpersonal stress was conflicts with family members. Five of the girls described experiencing on-going conflict with a parent or step-parent prior to treatment. In many cases these conflicts were controllable in that they were a result of the participant's actions. For example, Lydia disclosed that many of the fights with her mother were her fault: "I wasn't very nice with my family. Like if my Mom told me, "Go do that," I would be like "I don't want to do that," and then we would have a discussion and fights and stuff like that, so I was mean." In addition to fighting with parents, the girls in the study disclosed that they often had conflict with their siblings. For Jamilla and Devora this was the case. In both instances, these girls

described experiencing on-going conflict with a sister that was characterized as uncontrollable because they could do nothing to change it.

Table 4

*Characteristics of Pre-Treatment Stressors*

| | Interpersonal | | Academic | |
|---|---|---|---|---|
| Duration | Conflict-oriented | Loss-oriented | | Controllability |
| Chronic | Being bullied<br>Rumors<br>Parents arguing | Absent parent<br>Depressed parent<br>Incarcerated sibling | Too much schoolwork<br>Academic pressure | Uncontrollable |
| Chronic | Sibling conflict<br>Getting in trouble | Not having friends | Failing class/grade<br>Balancing schoolwork and other activities | Controllable |
| Acute | Fight between parents | Death of relative<br>Parents divorce | Changing schools | Uncontrollable |
| Acute | Fight with friend<br>Fight with parent | Ending friendship<br>Romantic break-up | Failing test | Controllable |

Three of the girls reported that a major source of stress for them was chronic conflict between their parents. For example, Lucia reported "…my parents were always arguing and wanted to get a divorce…" Paris also experienced chronic stress related to conflict between parents. When asked about her pre-treatment stressors, she indicated "My parents argue a whole lot…They would argue almost every night." Alexandra was also dealing with conflict between parents before treatment. She reported that she felt "pretty bad" because her parents were getting a divorce. In all of these instances, it was

clear that the participants had no control over the stressful situations. Thus, these stressors were classified as uncontrollable.

In addition to experiencing conflict-oriented interpersonal stressors prior to treatment, many of the participants also reported significant loss-oriented interpersonal stressors. These types of stressors fell into three main categories: (1) death or loss of a loved one, (2) lack of social support, or (3) an uninvolved/absent parent. Paris, Angelina, and Mia all experienced a major, uncontrollable loss prior to being in the ACTION program. For Mia, a close relative that lived with her for over a year had to move away. Mia responded to this loss with a lot of sadness because she saw this person as a "good sister" that had provided her with a lot of support.

Paris and Angelina experienced actual deaths of loved ones prior to treatment. When asked about her life before the ACTION program, Angelina reported "I was, like, feeling, like, sad because, like, two people died, like, within, like, a few, like, months, like, two people that were really close to me and I was sad about that." Similarly, Paris reported that one of her biggest stressors was the loss of her grandfather. She stated "My grandfather died and I was actually really close to him…I would spend summers with him and whenever he passed away, it was a big trouble for me. I started crying and wouldn't stop."

Another loss-oriented stressor that was commonly described by many of the participants was lack of social support or not having friends. This was a major problem for Lydia, Devora, Courtney, and Alika at the beginning of treatment. For the most part, this stressor seemed to be acute and controllable since not having friends was temporary and depended on either circumstance (e.g., being on summer vacation) or participant characteristics (e.g., shyness, irritability).

Two of the participants reported that a major source of uncontrollable, loss-oriented interpersonal stress for them was having an uninvolved/absent parent. Lucia reported that she rarely spent time with her mother because she "didn't really put any effort into anything." Thus, Lucia's mother was uninvolved in her life because she did not make an effort to spend time with Lucia. Mahina also had an uninvolved/absent parent, which was a major source of stress. When asked about pre-treatment stressors, Mahina reported:

> My dad, he, um, I haven't seen in about four years and there's a lot of times where I'll get happy 'cause he'll call and say he was going to pick us up or do things with us, but he never followed through with it.

### *Academic Stressors*

Only about 19% of pre-treatment stressor experiences that were described by the participants were classified as academic stressors. In fact, only 6 out of the 17 girls that were interviewed reported that academic stressors were a significant source of distress prior to being in the ACTION program. Most of the academic stressors that were described were chronic, yet controllable in nature. These problems included getting bad grades, not getting work done, or failing a class or grade. For example, Mahina reported that she was getting a bad grade in math and stated that she "wanted to pick up (her) grades more." Mia and Sarah reported that they were also having difficulties related to school. Mia stated that she "wasn't really focusing on schoolwork" and Sarah reported that she was "not getting homework done." Thus, each of these experiences was on-going, but controllable. Another academic stressor that was faced by some participants was failing a grade. Neither Danielle nor Alika thought that they would pass their current grade, which caused both of them to experience feelings of fear and anxiety. For

Angelina, a major source of uncontrollable stress in her was the transition from elementary to middle school and the increased workload:

> I was, like, stressed because it was, like, 6th grade and I went from switching between, like, two classes and not a time period to get there, but just, like, you know, because it goes from having two classes to having it change between nine classes or something… It's, like, lots of work and a lot of stress because each teacher just thinks that they're the only person that's, like, teaching you and so they give you all this homework...And then there's that class and all the homework, so you're all stressed out.

Thus, for Angelina the transition to from elementary to middle school was a significant source of acute, uncontrollable, academic stress.

Although most of the girls reported a significant amount of interpersonal stressors prior to treatment, some participants also indicated that they were having difficulties in the academic domain. These problems, for the most part, were on-going; however, many of them were controllable.

## Stressor Management before Treatment

Prior to being in the ACTION program, most of the participants responded to stressors in a variety of ways. Pre-treatment stressor management strategies included emotional release, denial/ignoring, seeking social support, distraction, social withdrawal, relaxation, rumination, and problem-solving. The average number of strategies used by the participants was two; however, this varied considerably. Some participants reported using one stressor management strategy, whereas other girls indicated that they used up to five different techniques to cope with stressful events.

Consistent with the extant literature on coping in children and adolescents (see Compas et al., 2001 for a review), the stressor management strategies that were identified

by the participants were characterized as being either emotion- or problem-focused. Emotion-focused strategies involved attempts to regulate unpleasant emotions associated with a stressful event, whereas problem-focused strategies involved direct attempts to control the stressor. Examples of emotion-focused strategies included emotional release, social withdrawal, seeking social support, distraction, relaxation, denial/ignoring, and rumination. Problem-focused stressor management strategies included problem-solving. The participants employed emotion-focused stressor management strategies at a much higher rate than problem-focused techniques. In fact, only five out of forty-two strategies that were described by the girls were problem-focused. Thus, approximately 88% of pre-treatment stressor management strategies were emotion-focused.

Stressor management strategies varied in terms of their approach and level of helpfulness. With regard to approach, stressor management techniques were classified as active or passive. Active strategies were defined as direct attempts to control the stressor or to manage the unpleasant emotions associated with the stressor. On the other hand, passive strategies were seen as attempts to avoid or simply succumb to the stressor or to the feelings that it evoked. The main distinction between the two categories was whether or not the participant attempted to act on their feelings or the situation, or allowed their emotions or the situation to act upon them. Prior to treatment, the participants reported using approximately an equal number of active and passive stressor management strategies.

Stressor management strategies also varied in terms of their level of helpfulness from high to low. Level of helpfulness seemed to depend on two factors: (1) successful emotion management or (2) successful problem resolution. Stressor management strategies had a high level of helpfulness when they effectively managed unpleasant emotions associated with a stressor or when they solved the problem. In addition,

stressor management strategy approach was also associated with level of helpfulness since active strategies were rated as more helpful than passive ones. Finally, specific stressor management strategy use depended on participant characteristics (e.g., knowledge). Participants that lacked knowledge of effective ways of coping tended to use stressor management strategies that were not very helpful. For a summary of properties and dimensions of pre-treatment stressor management strategies, please refer to Table 5.

Table 5

*Characteristics of Pre-Treatment Stressor Management Strategies*

| Strategy | Participants | Domain | Approach | Level of Helpfulness |
| --- | --- | --- | --- | --- |
| Emotional Release | 8 | Emotion-focused | Passive | Low |
| Denial/Ignoring | 7 | Emotion-focused | Passive | Low |
| Seeking Social Support | 5 | Emotion-focused | Active | Moderate |
| Distraction | 4 | Emotion-focused | Active | Moderate |
| Social Withdrawal | 3 | Emotion-focused | Passive | Low |
| Rumination | 2 | Emotion-focused | Passive | Low |
| Relaxation | 1 | Emotion-focused | Active | Moderate |
| Problem-solving | 5 | Problem-focused | Active | Low |

*Note.* Participants = Number of participants that reported using a specific strategy.

## *Emotion-Focused Pre-Treatment Stressor Management Strategies*

### *Emotional Release*

The pre-treatment emotion-focused stressor management strategy that was most commonly employed by the participants was emotional release. This technique was used

by over half of the girls, including Courtney, Angelina, Lydia, Alexandra, Lucia, Paris, Devora, and Sarah. Emotional release involved expressing unpleasant emotions (e.g., sadness, anger) through activities such as crying, writing in a journal, yelling, or cutting.

For the most part, emotional release was characterized as a passive stressor management strategy that had a low level of helpfulness. Emotional release seemed to be passive because it did not involve active attempts to manage the unpleasant emotions related to the stressor. In general, this strategy was seen as having a low level of helpfulness since it rarely resulted in the participant feeling better and, oftentimes, made the situation worse. For instance, four participants indicated that they screamed or yelled at other people in order to express their feelings, which resulted in negative consequences such as social isolation or getting into trouble. In only one instance was emotional release labeled as a helpful strategy. When asked how she managed stress prior to treatment, Lucia indicated that she "would just go write in my diary, my journal." In this case, she was able to express her feelings in a way that did not result in negative outcomes and the use of the strategy improved her mood.

***Denial/Ignoring***

Another common pre-treatment emotion-focused stressor management strategy that was discussed by the girls was denial/ignoring. This strategy was employed by seven participants. Examples of denial/ignoring included denying the importance of, forgetting about, or not paying attention to problems or stressors. For example, Olivia stated that she "wouldn't really pay attention to" problems with her family. Similarly, Danielle said that she "wouldn't pay attention to" problems prior to being in the ACTION program. When discussing her problems with her father, Mahina reported "I would give up and I really wouldn't care." Denial/ignoring also included attempts to suppress unpleasant emotions related to a stressor. For instance, when faced with teasing from

peers, Mia reported: "I would just keep everything that I, like, all my emotions inside. I wouldn't tell nobody."

Denial/ignoring was characterized as a passive stressor management strategy with a low level of helpfulness. It was classified as passive since it did not involve attempts to manage unpleasant emotions. When asked about her stressors prior to treatment, Alexandra reported "I would, like, ignore them and sometimes it would make it worse by just ignoring them." Thus, denial/ignoring was seen as having a low level of helpfulness because it did not resolve the stressors.

***Seeking Social Support***

Seeking social support was another commonly employed pre-treatment emotion-focused stressor management strategy. Examples of this strategy included talking to friends, family members, or teachers or seeking comfort from pets or loved ones. Seeking social support sometimes depended on the gravity of the problem. For example, Danielle stated that she only engaged in this strategy when problems "got really serious." Similarly, Mia said that she only sought out her mother for support when the problem "got to a point where I needed to tell somebody."

Overall, seeking social support was an active stressor management strategy since it involved a direct attempt to manage unpleasant emotions that resulted from a specific stressor. This strategy seemed to have an inconsistent level of helpfulness. At times, participants indicated that talking to someone about a problem helped them to feel better; however, at other times, the girls indicated that it did not help. For example, when Angelina talked to friends about the death of a loved one, she indicated that this helped her to feel better. Danielle, on the other hand, reported that despite talking with her mother about a problem, she did not feel better because the issue was not resolved. Thus, level of helpfulness seemed to be influenced by the goal of the participant. When

participants were looking for a way to express their feelings, seeking social support was helpful; however, when they wanted to solve a specific problem, this strategy was not as effective.

### *Distraction*

Four participants reported using distraction in the face of stressful events. This pre-treatment emotion-focused stressor management strategy included activities like having fun with someone, watching television, listening to the radio, or playing a game.

Distraction was characterized as active because it involved direct attempts to manage unpleasant emotions associated with a stressor. Thus, participants that reported using distraction were actively attempting to make themselves feel better in the face of stress. Level of helpfulness associated with distraction seemed to depend on the goal of the participant. If the participant wanted to improve mood, then distraction was very helpful. For example, Angelina indicated that distraction helped her to stay busy after the death of a loved one, which improved her mood. If, on the other hand, the goal of the strategy was to solve the problem or end rumination, then distraction had a low level of helpfulness. Although Lucia reported that she often used distraction techniques such as watching television, listening to the radio, or playing a game when her parents were arguing, she stated that they did not help because her parents continued to have conflicts. Thus, since it did not solve her problem, Lucia found distraction to be less helpful. For Jamilla, distraction was not powerful enough to end her rumination. When asked about the helpfulness of different distraction techniques, she stated: "Yeah, sometimes they didn't work. Sometimes I just couldn't get it out of my head."

### *Social Withdrawal*

Social withdrawal was another pre-treatment emotion-focused stressor management strategy that was employed by participants. This strategy was defined as

attempting to remove oneself from others and/or the stressor. A typical example of social withdrawal was going to one's bedroom in an effort to be alone. When faced with an upsetting situation, Courtney, Lydia, and Danielle said that they would go to their rooms. For example, Courtney reported "When I'd feel bad, I might go in my room...and nobody could bother me or anything like that."

Uniformly, social withdrawal was characterized as a passive stressor management strategy since it did not involve attempts to manage the unpleasant emotions associated with the stressful event. In addition, this strategy seemed to have a low level of helpfulness since it rarely improved the participants' moods or the situation that caused their unpleasant emotions.

***Relaxation***

Another pre-treatment emotion-focused stressor management strategy that was discussed during the interviews was relaxation. Only one participant reported that she employed a relaxation technique in the face of stress. Jamilla indicated that when she was upset about something, she would "go in the restroom and just wash my face or take a shower."

Relaxation was characterized as active since it involved attempts to regulate unpleasant emotions. For Jamilla, level of helpfulness was moderate. She indicated that it "sometimes" helped her to feel better, but stated that it was not always useful because it could not always decrease rumination about a stressful event.

***Rumination***

Only two participants discussed engaging in rumination prior to treatment. Rumination involves thinking or worrying about a problem in a repeated manner. When faced with problems, Sophie indicated that she tended to "dwell" or ruminate: "I think I pretty much…I, like, dwelled on my problems."

This strategy was classified as passive because it did not involve attempts to resolve the problem or to manage the unpleasant emotions associated with it. Rumination had a low level of helpfulness according to Sophie. When encouraged to discuss the helpfulness of this strategy, she reported "I'd just dwell on (the problem) and never fix it and it would always just be, like, there." Thus, rumination was not viewed as an effective strategy because it did not make Sophie feel better and it did not solve her problem.

### ***Problem-Focused Pre-Treatment Stressor Management Strategies***

#### ***Problem-Solving***

Prior to treatment, five participants reported that they used or attempted to use problem-solving when faced with situations that resulted in unpleasant emotions. Problem-solving was defined as generating one or more plans for solving a specific problem.

This strategy was characterized as active since it involved direct attempts to manage or solve a stressful situation or event. Overall, problem-solving had a low level of helpfulness, which seemed to depend on a few factors, including ability to generate solutions, successful resolution of the problem, and the controllability of the stressor. For Danielle, problem-solving was not a helpful strategy because she was not able to come up with a plan. When asked about how she managed stressors prior to being in the ACTION program, she reported "Just think about it and then try to make a solution and when I couldn't, I just, um, wouldn't pay attention to it that much." Thus, when she was unable to utilize problem-solving effectively, she reverted to an emotion-focused strategy: denial/ignoring. For Lucia, problem-solving had a low level of helpfulness because her plan did not resolve the problem. When Lucia tried to resolve a conflict with a friend by "confronting" her, the girls just ended up in an argument.

The controllability of the stressor also seemed to affect level of helpfulness. For example, both Mahina and Paris attempted to use problem-solving to resolve uncontrollable stressors and had little success. Paris was not able to make her parents argue less by calling the police and Mahina was not able to make her absent father more involved in her life by making plans with him. Thus, for these participants, problem-solving was not a helpful skill.

### ***Pre-Treatment Stressor Management Strategy Use***

Prior to treatment, the participants seemed to employ a high number of stressor management strategies with a low level of helpfulness. As noted earlier, use of stressor management strategies seemed to be related to having knowledge of effective ways of coping. For example, when asked how she managed pre-treatment stress, Sophie stated "I didn't know what to do when I was upset. I was just upset and I didn't know how to fix it." Because Sophie did not know how to manage problems, she simply ruminated about them. Alexandra had a similar experience: "When I, like, got really mad, I couldn't think of anything to do." Her lack of knowledge led Alexandra to use denial/ignoring and emotional release to cope with pre-treatment stressors. Neither of these strategies was very effective in managing her emotions or solving her problems. Paris also indicated that she had difficulty knowing how to manage pre-treatment stress, which resulted in her using ineffective strategies. For example, Paris stated "Well, really, I didn't know what to do...I would just forget about it. I didn't know what to do because I didn't know nothing about ACTION." Thus, pre-treatment stressor management strategy use seemed to depend on participant characteristics such as having knowledge of helpful coping techniques. Not knowing how to manage stress effectively led many participants to employ stressor management strategies with a low level of helpfulness.

## Emotional Experience before Treatment

Many of the participants were asked to describe their emotional experience prior to treatment. To elicit a broad range of responses, the girls were usually asked a general question such as "How did you feel before you started the ACTION program?" Of the ten girls that were asked this question, all of them described experiencing a range and, sometimes, a number of unpleasant emotions.

Specific types of unpleasant pre-treatment emotions included anger, loneliness, anxiety, sadness, and stress. Sadness was the most commonly experienced type of unpleasant pre-treatment emotion among the girls. In fact, approximately 80% of participants reported that they felt sad. For example, when asked how she felt prior to being in the ACTION program, Sarah said "I was feel blah, like, really down in the dumps, and I, like, kind of didn't really want to participate in anything or, you know, like that." The next most common type of unpleasant emotion was anger. This emotion was experienced by four of the girls. Two of the girls experienced anxiety and two more reported experiencing loneliness or stress prior to treatment. None of the participants discussed experiencing pleasant emotions.

Unpleasant emotions varied with regard to their amount, frequency, and severity. In terms of amount, on average, the participants endorsed experiencing 1.5 unpleasant emotions. The most common combination of unpleasant emotions was sadness and anger. For example, when asked about her pre-treatment feelings, Jamilla stated "I was, I was kind of sad and mad."

The frequency of unpleasant emotions varied from moderate to high. For example, when asked how often she felt unpleasant emotions prior to treatment, Jamilla stated "Well, not all the time, but when I felt bad sometimes, yeah." Not many of the

girls specified frequency of their unpleasant emotions; however, those that did reported that they experienced these feelings at a moderate rate.

Unpleasant emotions also varied in terms of their severity. According to the participants, their unpleasant emotions tended to have a moderate to high level of severity. For some girls, they felt "kind of" or "sort of" sad or mad prior to being in treatment. For other girls, their unpleasant emotions were experienced as more intense. Danielle endorsed feeling "really lonely" and Devora reported that she felt "really, really bad." Overall, the level of severity of unpleasant emotions seemed to be equally divided between moderate and high.

Experience of unpleasant emotions before treatment seemed to be related to an identifiable stressor. Many of the girls reported that their unpleasant emotions were the result of a specific stressor such as the death of a loved one or academic difficulties. For example, Angelina reported that she felt sad prior to treatment because "…like two people died like within like a few like months, like two people that were really close to me and I was sad about that." The girls' ability to manage these stressors seemed to influence the experience of unpleasant emotions. That is, girls that demonstrated a low ability to manage specific stressors reported experiencing more unpleasant emotions.

## Outlook before Treatment

In order to gain insight into the participants' pre-treatment outlook, the girls were encouraged to talk about how they viewed themselves and their lives before being in the ACTION program. A pattern emerged among the data that suggested that the participants demonstrated consistent negative ways of thinking. When talking about their thoughts, the girls identified several negative self-directed thoughts. In addition, some of the participants seemed to exhibit negative thought patterns such as minimizing positive

events and maximizing negative events. None of the participants talked about positive thoughts or thought patterns.

Similarly to their pre-treatment emotions, the girls indicated that their negative thoughts usually corresponded with an identifiable stressor. For example, Courtney reported that she had the negative self-directed thought "I'm alone" because she did not have "many friends" prior to treatment. Olivia also reported a negative self-directed thought associated with a specific stressor. When asked about how she viewed herself prior to treatment, she indicated "I would have the thought sometimes I was a, slut and stuff, or a ho, or something like that." This negative thought seemed to stem from the fact that many of Olivia's friends were calling her names because they did not like the fact that she was spending more time with her boyfriend than with them. Thus, specific stressors seemed to trigger many of the participants' pre-treatment negative thoughts or negative thought patterns.

### *Negative Self-Directed Thoughts*

Several of the participants endorsed having negative self-directed thoughts prior to treatment. These negative thoughts seemed to correspond to either beliefs about worthiness or ability. Thoughts about worthiness tended to focus on personal flaws such as not being attractive or likeable, whereas thoughts about ability focused on the participants' capabilities in areas such as school or other activities.

One of the most common negative thoughts about worthiness held by the participants was "I'm ugly." This thought was expressed by four girls, including Alexandra, Lucia, Sarah, and Jamilla. For example, when asked how she thought about herself prior to treatment, Sarah replied "I (thought) I was ugly and fat." The next most common negative self-directed thought was "I hate myself." For example, when asked about how she felt about herself prior to treatment, Lucia replied "I just didn't like myself

period." Angelina also had this thought prior to treatment: "I didn't really like myself a lot." Other negative self-directed thoughts reported by the participants included "I'm alone," "No one likes me," and "I'm different." All of these pre-treatment thoughts seemed to imply that the participants believed that they were unworthy in some way.

Some of the girls described having negative self-directed thoughts that corresponded to beliefs about ability. The most common thought in this category was "I'm stupid." Paris, Lydia, and Jamilla had this negative thought. For example, when talking about her negative thoughts prior to treatment, Lydia reported "Like math, I don't know, like, I don't understand it really well, so sometimes when I did my homework, I'm (was) like, "Oh, I hate math. I'm dumb because I can't do it."

Other girls had negative thoughts about not being able to measure up or to fix things in their lives. For example, Courtney reported "Well I felt that I couldn't fix things…It made me feel like I was, I wasn't useful and had much of a purpose. That I should be able to be, be doing more than this." Thus, many of the girls appeared to believe that they lacked abilities.

### *Negative Thought Patterns*

When discussing their pre-treatment outlook, some of the participants reported that they had specific negative thought patterns such as minimizing the positive and maximizing the negative. For example, when describing how she viewed things before treatment, Sophie stated "I was really negative, like, constantly putting myself down and just everything I thought about was just not happy…nothing good went through my mind and I just always focused on the bad things before I looked at the good things." Alexandra had a similar experience. When asked about her outlook on life, she explained "I couldn't look at mostly anything in the bright side." Thus, a predominantly negative

though pattern of not being able to attend to positive events seemed to be a common experience for some of the girls.

## Chapter Summary

Overall, the data suggest that the participants had significantly impaired pre-treatment functioning. Prior to being in the ACTION program, the participants experienced stressors in two domains: interpersonal and academic. Interpersonal stressors were either conflict- or loss-oriented. Stressors varied in terms of their amount, duration, and level of controllability. Overall, the participants reported experiencing a high rate of pre-treatment, conflict-oriented interpersonal stressors that were predominantly chronic and uncontrollable in nature.

The girls attempted to cope with these difficulties by employing several different stressor management strategies, including emotional release, social withdrawal, seeking social support, denial/ignoring, distraction, relaxation, rumination, and problem-solving. These techniques varied in terms of their domain, approach, and level of helpfulness. Prior to treatment, the participants tended use predominantly emotion-focused strategies that were generally passive and unhelpful. Use of specific pre-treatment stressor management techniques depended, in part, on the participants' knowledge of effective ways of coping. Since most of the girls did not know how to successfully manage unpleasant emotions and/or stressors, they tended to utilize coping strategies with low levels of helpfulness.

Not being able to effective cope with difficulties resulted in the experience of several, unpleasant pre-treatment emotions such as sadness, anger, loneliness, and stress. Sadness was the pre-treatment emotion most often experienced by the participants. Unpleasant, pre-treatment emotions seemed to occur somewhat frequently and they tended to high a moderate to a high level of severity. None of the girls reported

experiencing pleasant emotions prior to treatment. The participants experienced these emotional reactions in relation to identifiable stressors over which they lacked the ability to manage successfully.

These difficulties also seemed to contribute to the development of negative ways of thinking. Many of the participants reported that their pre-treatment outlook was characterized by negative thoughts and negative thought patterns. Negative thoughts tended to be self-directed, associated with specific stressors, and about worthiness or ability. In terms of negative thought patterns, many of the girls reported that they frequently minimized positive events in their lives while simultaneously maximizing negative events. Thus, the participants' pre-treatment outlook was extremely bleak.

Taken together, the data suggest that the combination of high levels of stressors with low levels of knowledge and ability to manage difficulties contributed to the experience of unpleasant emotions and negative ways of thinking prior to treatment. That is, the participants were unable to cope effectively with the significant amount of stress in their lives and, therefore, felt extremely sad and angry. In addition, since they could not successfully resolve their difficulties, the participants began to view themselves as worthless and/or incapable, and they developed a cognitive bias in which they exaggerated the negative and ignored the positive aspects of their lives. These factors seem to have resulted in the development of depressive symptoms (e.g., chronic sadness or irritability, loss of interest or pleasure in most activities, appetite changes, insomnia, fatigue, impaired concentration, suicidal ideation). As the participants became depressed, their emotional, social, and academic functioning deteriorated. Thus, the girls entered treatment with significantly impaired functioning.

The next chapter will explore how the girls responded to being in a gender-specific group CBT treatment for depression. It will discuss the participants' reactions to

treatment as well as their perceptions of the helpfulness of the intervention. Particular attention will be paid to the participants' experience of the structure of treatment.

# CHAPTER SEVEN

# TREATMENT STRUCTURE

Given their significantly impaired pre-treatment functioning, it was interesting to hear how the participants experienced treatment. At the beginning of each interview, the girls were asked "What was the ACTION program like for you?" This question was intentionally broad to elicit many possible answers. In response to this question, the participants consistently discussed aspects of treatment that contributed to the overall helpfulness of the ACTION program. One of these aspects was the structure of treatment (e.g., group therapy). After several interviews, it became clear that this was an important concept that was not originally expected. Thus, in order to elicit more information about this phenomenon, the participants were also asked "What was it like being in a group with other girls?"

As a pattern began to emerge among the data that suggested that the group format of treatment was strongly related to the overall helpfulness of the intervention, the interviews were modified once more to gather additional information. This modification involved having the girls that participated in secondary interviews compare the group and the individual meetings in terms of their level of helpfulness. The following chapter will explore how the participants experienced being in a group intervention for depressed, pre-adolescent girls.

## Characteristics of the Group

As described earlier, the ACTION program is a gender-specific group intervention for depressed, pre-adolescent girls ages 9 to 13. Each group contains two to four participants. Since the intervention is school-based, each group is situated at an

elementary or a middle school. The elementary school groups contain 4th and 5th graders and the middle school groups contain 6th and 7th graders. Thus, the girls in the group are usually close in age and grade. The groups tend to reflect the ethnic diversity of the areas in which the schools are located. Since the participants are randomly assigned to the groups, no consideration is given to ethnic backgrounds, specific ages, or specific grades of the girls. In addition, participants can be assigned to groups in which they know none, some, or all of the other members. The following section will discuss how the participants responded to being in a treatment group for depressed, pre-adolescent girls.

## Experience of Group Treatment

### *Level of Familiarity and Initial Apprehension*

In discussing their initial reaction to treatment, many of the girls (10 out of 17) reported that they felt a moderate level of apprehension. Some of the participants reported that they were acquainted with one another; however, most of the girls did not know each other prior to treatment. For example, when talking about her fellow group members, Sophie reported "Like, at the beginning, (one group member) and I talked, but we weren't like friends. We were just like acquaintances." Shaneika had a similar experience. She reported that she "sorta" knew the other girls in her group because she had "seen them a lot" and she knew their names; however, she stated that they did not know her. Only one participant indicated that she was friends with a group member prior to treatment. Jamilla reported that she and one of her group members knew each other well, indicating that this girl already "knew all of her secrets." However, Jamilla reported that she did not know the other girl in her group, therefore, "didn't really trust her" at the beginning of treatment.

In general, the participants had a low level of familiarity with one another at the beginning of the ACTION program. For some girls, level of familiarity influenced initial

treatment reaction by increasing level of apprehension. That is, participants that did not know each other well had a higher level of apprehension in the early stages of treatment. For example, when asked what it was like being in a group with other girls, Shaneika reported "Mmm…it seemed weird at the start of it." She elaborated on her level of initial apprehension by stating

> Like you don't know (the other group members), but you've seen them a lot. Like you know their name, but they don't know yours. It's kind of weird. I didn't know (other group member's) name. I'd seen her sometimes, but not actually a lot. So it was kinda weird that you didn't know them, but you sorta did.

Thus, for Shaneika the fact that she had a low level of familiarity with the other girls in her group resulted in a moderate level of apprehension at the beginning of treatment. Paris had a similar experience: "Kinda scared me a little because I didn't know the other girls." Thus, many of the participants experienced initial apprehension about being in a group treatment due to the fact that they had a low level of familiarity with the other participants.

Over time, the participants' level of apprehension declined. Many of the girls indicated that they began to feel more comfortable as treatment progressed because they started to learn more about their fellow group members. As participants increased their level of familiarity with one another, they became less apprehensive about being in a group intervention. For example, Shaneika indicated that, after a few meetings, she began to feel less apprehensive: "Like it felt kinda weird, but then I just started getting along with it. I felt comfortable with it." When asked how her level of apprehension decreased, she explained that she became more comfortable by "…getting to know (the other girls) and being around 'em more." Thus, as Shaneika's level of familiarity increased, her apprehension decreased.

### *Level of Familiarity and Trust*

Level of familiarity with group members also influenced level of trust and initial reaction to the structure of treatment. Since many of the girls did not know each other well at the beginning of treatment, they experienced a low level of trust, which increased their feelings of apprehension about being in a group with other girls. For example, since Paris did not know the other girls in her group, she reported "I thought they were going to pick on me and stuff after the group was over or something. Be like, "Hey, you're stupid with the – your story is stupid and I didn't like it. Why did you even tell it? Nobody even cares about it." Lucia also had initial concerns about trust based on level of familiarity. When asked about her specific concerns, she replied "Them girls going and telling stuff that happened in (group)." Jamilla also had a low level of trust for some of the other group members at the beginning of the treatment. She reported "And I really, at first I really didn't trust (the other group member) 'cause I really didn't know if she could go home and call somebody and tell them (what she had shared in group)." Thus, since many of the participants had a low level of familiarity with their fellow group members, they experienced a high level of initial apprehension about the structure of treatment because they did not know if they could trust the other participants.

### *Level of Trust and Confidentiality*

The data suggest that a factor that seemed to significantly influence level of trust among group members was confidentiality. The concept of confidentiality is introduced in the first group meeting. The therapists facilitate a discussion among group members about its definition and limitations. Usually, the participants do not know what confidentiality means, so they are told that it means that what is discussed in the group is private and must be kept in the group (i.e., "What we talk about in here, stays in here."). The girls are also told that they cannot share the names of group members with anyone

outside of the group. After explaining this to the girls, the therapists generate a discussion of how each participant would feel if confidentiality was broken. Most participants are able to identify that they would not feel safe engaging in self-disclosure and would not trust the other group members if their secrets were shared with others.

The therapists also discuss the limits of confidentiality with the participants, including the fact that they have to tell an adult if any of the girls state that they are going to hurt themselves either on purpose or through dangerous behavior, that someone else is hurting them, or that they are going to hurt someone else. It is explained to the girls the therapists must break confidentiality under these circumstances in order to protect them.

After introducing confidentiality and discussing it limits, each group member signs a "confidentiality contract," which states "I agree to follow the rule that everything that is said during our meetings will stay in the meeting. I won't tell anyone else what someone said during a meeting. I won't even tell others who is in the group." After each group member signs the contract, the therapists also sign it. The girls are given a copy of the contract to keep in their ACTION program workbooks.

Several of the girls spontaneously discussed confidentiality when describing their experience of treatment during the interviews. Most of the girls that discussed it, recalled that they signed a "contract" that said that "what was said in group should stay in group." A couple of the girls further defined confidentiality as a way of keeping group members' secrets. Both Mahina and Sarah talked about it in this way. Mahina reported

> In the group, they had, uh, a certificate…it was one for all of us and, um, we signed off on it, every group member, including the counselors…it's this thing where whatever stays in the group, whatever is being said or done in the group, stays in the group… So, it's really like keeping a secret.

Sarah also saw confidentiality as a contract that meant that she and the participants would keep each others' secrets. She reported "…we, we signed a contract of confidentiality and we couldn't tell anyone's secrets or anything. We would have to keep them and no one would ever know."

Confidentiality appeared to be a helpful aspect of treatment since it increased level of trust among group members. For example, Mahina reported

> It helped me to understand that our people in the group were going to be able to keep it to themselves. 'Cause I didn't really want everyone knowing that I was in the ACTION program, so really it just helped to…make me feel like no one was going to know.

Alexandra also found that confidentiality increased feelings of group safety: "…you can just talk about whatever and, like, nobody would, like, know about it." For Jamilla, confidentiality increased her trust in the group member that she did not know well prior to treatment. She reported "I started trusting her and she started trusting me." When asked to explain why her level of trust for this particular participant increased, Jamilla indicated "I found out that I could trust her 'cause she didn't tell nobody (what she had shared in group)." As Jamilla realized that the other group member kept confidentiality, she began to trust her. Thus, confidentiality seemed to significantly increased level of trust among participants by helping them to realize that the other girls would not share their secrets with people outside of the group. As level of trust increased, the participants' apprehension about the structure of group decreased and the girls became more open to sharing their feelings, thoughts, and problems.

### *Problem-Sharing*

Many of the participants talked about problem-sharing as an important aspect of treatment. For the purposes of this study problem-sharing will be defined as sharing

feelings, thoughts, and specific problems with group members. Level of familiarity and level of trust interacted to affect the girls' level of problem-sharing. The girls that reported that they did not know or trust the other participants at the beginning of treatment also reported that they engaged in lower levels of initial problem-sharing. For example, Lucia reported "…at first, I was kind of, like, I didn't want to say anything to them because I didn't know them at all in the group, like if they would go out there and say stuff. So, for a while I didn't say anything." Thus, some girls were apprehensive about the structure of treatment because they were initially uncomfortable with engaging in problem-sharing with individuals that they did not know well or trust.

Confidentiality seemed to directly influence level of problem-sharing for several of the participants. When asked why she felt comfortable sharing problems with other group members, Jamilla indicated "Because (the primary therapist) said that…whatever goes on in there is going to stay in there, so I just thought, "I might as well just say it."" Mia had a similar experience. During her interview, she reported that she was very "shy" at the beginning of the treatment; however, Mia stated that she became more open over time and now she has difficulty with talking too much. When asked what contributed to this change, she stated "Well 'cause they taught us confidentiality and so they told me to be open and not to be shy and so…I stopped being shy, I stopped trying to be shy and now I'm crazy I guess." Thus, for both of these girls, confidentiality directly influenced their level of problem-sharing.

For other participants, level of problem-sharing increased as level of familiarity and trust increased. That is, as the girls attended more group meetings, got to know each other better, and realized that the participants could be trusted, they began to open up and share problems with the group. This was the case for Lucia. She explained "We just started just coming in there and just started talking about stuff and trusting each other that

we wouldn't go and say anything, so it got easier each time." Thus, as the girls became more comfortable with the structure of treatment, they were able to engage in more problem-sharing.

Most of the girls began to view problem-sharing as a positive aspect of treatment. For example, although she was initially hesitant to engage in problem-sharing, Alexandra reported that, eventually, it was "nice to talk about (problems)." Sarah also discovered that problem-sharing was a positive aspect of treatment: "It was great. I could share my feelings and no one would judge me and I felt like it was a safe place to tell my secrets." Thus, for many participants, initial apprehension about the structure of treatment declined as the girls learned that the group provided a "safe place" in which to engage in problem-sharing. Problem-sharing was also influenced by the fact that, over time, the participants began to understand that they had a lot in common with the fellow group members.

***Sense of Relatedness***

In addition to wanting to know how the girls responded to being in treatment, it was important to understand how they responded to being in a gender-specific, same-aged peer group treatment for depression. Thus, an understanding of how the characteristics of group influenced participants' reactions to the structure of treatment became an additional aim of the study. Thus, during the interviews, participants were asked to discuss their experience of being in a group for girls. One of the significant concepts that emerged during this discussion was the idea that the girls experienced a sense of relatedness with their other group members. This concept seemed to imply that the girls realized that they had a lot in common in terms of their feelings and experiences. Several group characteristics seemed to influence sense of relatedness, including the diagnoses, gender, and age of the participants.

The data suggest that sense of relatedness was influenced by the fact that treatment targeted depressed youth. The fact that the other girls were experiencing similar (or in some cases more severe or more frequent) symptoms and stressors influenced sense of relatedness. That is, as the participants discovered that the other group members were also facing difficulties (which contributed to symptoms of depression), their sense of relatedness increased. For example, Sophie reported that she quickly learned that she and the other participants "had a lot in common" because they were all experiencing problems at the beginning of treatment:

> One of the girls, like, she had…lots of problems at home, like, with her parents and her sisters and then another, I think two of the girls had, like, most of their problems were, like, at home because, like, their cousins live with them…and they didn't have enough attention…they needed attention because there were so many little kids…And then (one girl), I think it was just more like, she was still, like, breaking into middle school…trying to get over all the stuff that people say about you and just like let it go, you know let it pass. Me and her had a lot of the same problems.

Mia's sense of relatedness also increased when she learned that her fellow group members had similar problems. In fact she stated that seeing that "there's other girls that have the same problems and they're going through the same things" is one of the benefits of the group intervention. Shaneika agreed. As she listened to the problems that the other girls were facing, she felt a stronger sense of relatedness: "I felt, like, more actually related to the group and so I understanded what they were talking about."

Sense of relatedness resulted in group members thinking that they were not alone in terms of their experiences and their feelings. This was a very positive experience for the girls. For example, Lydia stated "I was pretty excited to, um, to know about the other

girls and not know that it was just me having problems." Angelina agreed. She also felt less alone because of being in treatment: "It was cool to know that like...someone else feels bad…They, like, know, ah, that, like, it's happening to them too." Mia had a similar experience. When describing her initial impressions of being in a group treatment for girls, she stated "'Cause at first I felt like I was alone on some things, but when I started ACTION I kinda realized, "Yeah, some people are going through this too."" As the girls realized that they faced similar difficulties and experienced similar feelings, their sense of relatedness increased. Thus, being in a group with other depressed participants seemed to influence the experience of the structure of treatment by increasing feelings of relatedness among group members.

Another factor that seemed to influence the experience of treatment structure was the fact that the participants were the same gender. Many of the participants indicated that they liked the fact that the ACTION program was only for girls. Being in a gender-specific group treatment seemed in increase the participant's sense of relatedness. For example, when asked about her experience of being in a group with other girls, Mahina stated "It's was kinda cool though, knowing that they were all girls and we could all share the same thing, like, if it was just a girl thing." Gwendolyn agreed. She noted that the gender-specificity of the group contributed to her feelings of relatedness with the other participants. In describing what she liked about being in a group with other girls, Gwendolyn said "Mmm…mmm…well that there's other girls to help you in group that may have been feeling exactly the way that you feel." Sarah also liked the fact that the group contained only female members: "I liked that it was a girls only program because boys don't usually want to talk about their feelings." Thus, the gender-specificity of the group seemed to influence the experience of the structure of treatment by increasing sense of relatedness among group members.

Another factor that seemed to influence the experience of the structure of treatment by increasing sense of relatedness among group members was the similar age of the group participants. That is, being with same-aged peers appeared to make participants feel a higher degree of relatedness for each other. For example, Gwendolyn explained

> Sometimes (the therapists), they have had that feeling, but they forgot, so maybe, maybe it's like something happening to you because you're younger or whatever. Well, there's younger girls in there with you so they can help you a little bit.

Sophie agreed. She enjoyed the group meetings more than the individual meetings because "I guess it was more comfortable with people my age around and just easier to talk about stuff." Thus, being with same-aged peers increased the girls' sense of relatedness.

In sum, characteristics of the group including the diagnoses, gender, and age of the participants seemed to influence the experience of the treatment structure by increasing sense of relatedness among group members. The structure of treatment was perceived positively by the participants since the group characteristics facilitated the girls' ability to understand and to relate to one another. The next section will discuss how sense of relatedness influenced problem-sharing.

### *Problem-Sharing and Sense of Relatedness*

Problem-sharing and sense of relatedness seemed to have a reciprocal relationship in which engagement in problem-sharing led to a higher degree of sense of relatedness and sense of relatedness led to increased problem-sharing. For example, as some girls began to talk about their problems with the group, the other participants felt like they could relate to the girls that engaged in problem-sharing. For example, Sophie indicated that, as the other girls in her group opened up about their problems, she realized that she

had "a lot in common" with them. Thus, Sophie's sense of being related to the girls in her group increased as they shared their problems with her.

The reverse was also true. For some participants, sense of relatedness facilitated problem-sharing. For example, Danielle reported that she was initially hesitant to engage in problem-sharing because she did not know the other girls in her group very well. Eventually, however, she was able to open up to the group and "share (her) feelings" with the other girls. When asked what facilitated problem-sharing for her, she indicated that it was "being with a lot of girls that could understand how I feel." Thus, the fact that the treatment was gender-specific increased Danielle's sense of relatedness with the other girls in her group, which made her more comfortable with problem-sharing.

### *Sense of Relatedness and Group Support*

Sense of relatedness also increased the support of the group. That is, the more the girls felt that they could relate to each other, the closer they became over the course of treatment. Jamilla summarizes this phenomenon:

> Well, 'cause, in there we get to tell our private stuff that other people don't know and when (a group member) tells those things, I was thinking "Sometimes that stuff happens to me too." And that we really had a lot in common, so that's, I think that's what made us closer.

Although many of the girls reported some initial apprehension about being in a group treatment with other girls, almost all of the participants reported that, over time, their groups became a safe and supportive place in which they could share problems, build skills, and receive encouragement. In fact, when asked to compare the group meetings with the individual meetings, the participants overwhelmingly indicated that they preferred the group meetings. No participants indicated that they preferred the

individual meetings and only one participant, Sarah, indicated that she "…liked them both equally."

Overall, the group meetings were rated as more helpful than the individual meetings because they offered support and encouragement as well as more ideas, opinions, and solutions to problems. In addition, the group provided the participants with a place to learn and practice new skills. Thus, the group structure of treatment seemed to provide members with support in three ways: (1) it increased social support through the development of friendships among group members, (2) it facilitated the acquisition and application of new skills, and (3) it provided participants with increased solutions to specific problems.

***Increased Social Support***

Over the course of treatment, level of familiarity, level of trust, and sense of relatedness continued to increase. These factors contributed to the development of friendships among many of the group members. In fact, by the end of treatment, many of the participants (12 out of 17) reported that they developed friendships with the other girls in their groups. For example, Olivia reported that in her group, "We all became good friends and we used to, we'd talk about anything. We would trust each other and everything, so we became good friends." Lydia also made friends with the girls in her group. When asked about her experience of the ACTION program, she recalled feeling "excited" because she got to "meet new friends." For Lydia, this aspect of treatment was very important because she "didn't really have that many" friends before treatment. Thus, the group provided many participants with increased social support.

***Help Building New Skills***

According to the participants, the other way in which the group provided support to its members was the fact that the group members helped each other practice new skills.

For example, when Gwendolyn came to the group one day after experiencing unpleasant emotions related to an uncontrollable stressor, the girls in her group helped her to practice the coping strategies in order to improve her mood:

> This one day, I just wasn't feeling very good, that week where, you know, I had that whole bunch of tests. They helped me, you know, they played games with me and what I liked about that week in ACTION was when they wanted me to feel better, so we played coping strategies.

The other girls in Gwendolyn's group encouraged her to use the coping strategies to improve her mood. Thus, the group served as a place in which the participants supported each other in learning and practicing new skills.

***More Solutions to Problems***

In describing their reasons for preferring the group meetings, several participants cited the fact that the group setting allowed for more ideas, opinions, and solutions to problems. In addition to helping each other practice new skills, the participant also helped each other generate solutions to specific problems. For example, when discussing her experience of treatment, Lydia indicated that she enjoyed "sharing problems" with the group because "maybe (the other participants) had experienced it and could tell me tips about it." For Gwendolyn, the group also offered more ideas for solving problems than the individual meetings: "Because there were more, um, thoughts and there were more ideas and stuff for you to think about and choose which one. Now if you're just talking to one person, all they have is, maybe, a couple ideas." This was also true for Mahina. She preferred the group meetings because "I actually have…not only one person's opinion…I have, like, a whole group's opinion to really help me better." Thus, being in a group treatment helped the participants to have a broader range of solutions to problems since there were multiple people offering ideas and advice.

## Chapter Summary

Most of the girls indicated that they experienced some initial apprehension related to being in a group intervention. Initial apprehension was influenced by level of familiarity with other group members. Since many of the girls did not know each other, they felt apprehensive about being in group. In addition, the girls experienced a low level of trust at the beginning of treatment. Some of the girls were worried that the other participants would make fun of them or share their secrets with others. The introduction of confidentiality into the group reassured most girls that the other group members could be trusted, which facilitated problem-sharing.

As the girls began to open up to each other, they developed a sense of relatedness. Sense of relatedness was facilitated by group characteristics (e.g., diagnoses, gender-specific, same-aged peers) and interacted with problem-sharing in a reciprocal manner. That is, as the girls shared problems, they felt more related and as they felt more related, they shared more problems. Sense of relatedness helped the girls realize that they were not alone, and it helped increased group support.

The group provided support to its members in a variety of ways, including increasing social support, providing assistance with the acquisition and application of new skills, and providing multiple solutions to specific problems. All of these factors contributed to the participants rating the group meetings as more helpful than the individual meetings. In fact, when asked if the treatment would be as helpful if it were converted into an individual program, most of the participants that completed secondary interviews (5 out of 7) indicated that it should remain a group intervention. Thus, the girls' experience of the structure of treatment was very positive, and it was rated as highly helpful by the participants.

Overall, the structure of treatment (i.e., group therapy) appears to have been strongly related to the helpfulness of the ACTION program. Being in a group with other girls, although initially daunting, allowed participants to receive help with problems in a supportive and encouraging manner, which contributed to the development of friendships and, ultimately, new skills.

Another important aspect of treatment that the participants discussed in relation to the helpfulness of the ACTION program was the specific treatment components (i.e., skills). The next chapter will discuss which treatment components were most frequently recalled, understood, used, and evaluated as helpful by the participants.

# CHAPTER EIGHT

# TREATMENT COMPONENTS

As discussed previously, the ACTION program consists of several treatment components. One of the main goals of the present investigation was to gain an understanding of which treatment components are best recalled and understood by the participants. An additional aim of this study was to determine which treatment components are most frequently used and rated as most helpful. In order to elicit spontaneous recall of different treatment components, the interviewers did not cue the participants by asking questions about specific skills or activities. Instead, the girls were asked to describe their experience of treatment: "What was the ACTION program like for you?" As the participants mentioned specific treatment components in response to this broad question, the interviewers asked the girls to discuss each one in detail. The participants were encouraged to describe specific examples of using each skill as well as to discuss how often it was used, its level of difficulty, and its level of helpfulness. Participants were also encouraged to discuss anything that hindered the use of a particular skill. After discussing all of the specific treatment components that the girls spontaneously recalled, the participants were then asked to talk about which components, if any, were the most and least helpful.

Overall, the participants demonstrated good spontaneous recall of the skills and activities in the ACTION program. The following section will begin by exploring the treatment components that were most commonly recalled by the participants. After discussing each component as well as its frequency of use, level of difficulty, and level of helpfulness, the components that were perceived as most helpful will be discussed. Finally, the treatment components that were perceived as least helpful will be presented.

## Core Treatment Components

The ACTION program is comprised of several different treatment components that attempt to reduce depressive symptoms by targeting specific skill deficits. Some of the treatment components are more central to the intervention than others since they target areas that are known to be impaired in depressed individuals. The core treatment components are affective education, coping strategies, problem-solving, and cognitive restructuring. These components encourage the development of skills such as identifying, labeling, and managing unpleasant emotions, solving problems, and changing negative thoughts and negative thought patterns. The following section will discuss the participants' recall, understanding, and frequency of use of the core treatment components. In addition, perceived level of difficulty and level of helpfulness will also be described. Please refer to Table 6 for a summary of the characteristics of the core treatment components as well as the number of participants that spontaneously discussed each skill during the interviews.

### *Affective Education*

A central component of the treatment is affective education. As discussed previously, this consists of teaching the participants both a simplified version of the cognitive model of depression as well as how to recognize and label unpleasant emotions. In terms of recognizing and labeling emotions, the girls are taught the 3 Bs: brain, body, and behavior. Using this technique, the participants are encouraged to become aware of and to label their emotions in order to know when to use the different therapeutic skills to cope with unpleasant feelings.

Table 6

*Characteristics of the Core Treatment Components*

| Component | Participants | Recall | Comprehension | Frequency | Difficulty | Helpfulness |
|---|---|---|---|---|---|---|
| Affective Education | 3 | Good | High | Unknown | Easy | High |
| Coping Strategies | 15 | Good | High | High | Easy | High |
| Problem-Solving | 15 | Good | High | Moderate | Easy | High |
| Cognitive Restructuring | 11-13 | Good | High | High | Easy | High |

*Note.* Participants = Number of participants that discussed a specific component.

### *Definition and Recall of Affective Education*

Only three participants spontaneously discussed recognizing and labeling emotions. Of the girls that talked about this aspect of affective education, all of them referred to it as the 3 Bs. One of the participants named the 3 Bs (i.e., body, brain, behavior), but stated that she did not remember how or why to use them. The other two girls defined the 3 Bs as a way to identify feelings. For example, Sarah reported: "The 3 Bs – body, brain, behavior. It tells you how you're feeling." Mia also agreed that the 3 Bs help "…identify what you are feeling;" however, she expanded the definition of this skill to include the fact that the 3 Bs also help one to know when to take action to feel better. Thus, Mia's definition included the idea that the identification of unpleasant emotions is a precursor to engaging in coping strategies, problem-solving, or cognitive restructuring techniques.

### *Level of Difficulty and Level of Helpfulness*

Both of the participants that discussed the 3 Bs in detail stated that it was an "easy" skill to use; however, Sarah reported that level of difficulty sometimes depends on level of comfort with self-observation. For instance, she stated that "Well, it was easy 'cause I knew how I could, um, figure out what I'm feeling, but it was hard 'cause, like, I didn't really want to observe what I was doing and stuff." Thus, Sarah's low level of comfort with self-observation made using the 3 Bs more difficult.

In terms of level of helpfulness, this skill was seen as highly helpful. Sarah said that the 3 Bs helped her "a lot" because "…then I knew how I was feeling and I knew how I could change it." Mia agreed. She indicated that "It pretty much tells you what you're feeling, so, yeah, it does help, a lot." Thus, overall, these two participants found recognizing and labeling emotions to be a very helpful component of treatment.

## *Coping Strategies*

One of the most commonly discussed treatment components was the coping strategies. As discussed previously, participants are taught to use this skill to manage unpleasant thoughts or feelings that are related to stressors that cannot be controlled or changed. The five general categories of coping strategies are (1) do something fun and distracting, (2) do something soothing and relaxing, (3) do something that uses energy, (4) talk to someone, and (5) think about it in a more positive way.

### *Definition and Recall of Coping Strategies*

During the interviews, the majority of participants (15 out of 17) recalled and described situations in which they utilized the coping strategies. In terms of defining the coping strategies, most of the girls describe them as a way to make them feel better or a way to manage unpleasant emotions. Some of the girls took this definition one step further, explaining that the use of coping strategies is dependent on the controllability of

the stressor. That is, coping strategies are to be used for uncontrollable stressors. The girls, on average, recalled three of the five general coping strategy categories. Only two girls recalled all five. Thus, the participants demonstrated good recall and understanding of the coping strategies.

***Coping Strategies and Stressors***

Consistent with what the girls are taught in the ACTION program, the participants used identification of unpleasant emotions or identification of an uncontrollable stressor as cues to engage in coping strategies. When asked to provide specific examples of using the coping strategies, the participants described using them for both interpersonal and academic stressors; however, the ratio of interpersonal stressors was much higher (i.e., 3 to 1) than academic stressors. Thus, coping strategies were mostly employed in the face of interpersonal stressors. Academic stressors typically included too much homework, "high stakes" testing, or falling grades. Interpersonal stressors included conflict with peers, siblings, or parents, conflict between parents, or a troubled sibling.

Contrary to what is explicitly taught in treatment, participants used coping strategies for both controllable and uncontrollable stressors. For the most part, participants described using coping strategies for uncontrollable stressors such as arguments between their parents or someone stealing something from them; however, they also described using the skills for controllable stressors too. For example, Sophie described a situation in which she got into a fight with her mother because she was not willing to be flexible:

> I think…it was like last weekend. Me and my mom got into a big fight over…something about the cruise...I don't remember what it was about…it was something that we were going to do on the cruise and I was like, "No, I don't want to do it."

This situation was classified as a controllable stressor since Sophie had the ability to control or change it. Thus, despite being explicitly taught to use coping strategies for uncontrollable stressors, many of the participants also employed this skill in the face of controllable stressors.

***Type, Level of Difficulty, Frequency of Use, and Level of Helpfulness***

The coping strategies that were used by the participants in the ACTION program varied in terms of their type, level of difficulty, frequency of use, and level of helpfulness. With regard to type, the category that was most commonly employed by the participants was doing something fun and distracting (e.g., playing outside, watching TV, playing a game). The next most commonly used category was doing something soothing and relaxing (e.g., listening to music). Two participants endorsed using coping strategies that were categorized as doing something that uses energy (e.g., running, playing volleyball) and two other girls reported that they used the category of talking to someone (e.g., a friend). None of the participants indicated that they used the category of think of it in a more positive way.

Frequency of use varied across participants. The majority of participants that described using coping strategies endorsed using this skill at a high rate. For example, Mahina reported "Really, I used them all the time. Sometimes I wouldn't even notice that I am using them when I was. Either everyday or every other day." A couple of participants indicated that they used the coping strategies at a moderate rate and a few noted that their frequency of use was low. Frequency of use seemed to depend on how often the participant experienced unpleasant emotions. For instance, Gwendolyn noted that she used the coping strategies at a moderate rate (i.e., "half and half") because she "wasn't mad very often." Thus, a low level of unpleasant emotions resulted in a low level of coping strategy use.

The coping strategies also seemed to vary in terms of level of difficulty. The majority of girls that used the coping strategies rated them as "easy" to use. For example, Paris noted "Those were real easy to use because you just had to do something." Level of difficulty seemed to depend on a few factors, including complexity of the problem, motivation of the participant, and type of unpleasant emotion experienced. For example, Mahina reported that she tried to use a soothing and relaxing coping strategy when her father would continuously disappoint her by not spending time with her; however, she said that it did not help because it was not a "simple" problem, like conflict with a friend. For Mia, the coping strategies were "…easy, but sometimes it was difficult 'cause sometimes you just don't feel like doing it." Thus, her level of motivation influenced the level of difficulty of this skill. Finally, Gwendolyn indicated that the coping strategies were easy, for the most part, except when she felt angry: "They were pretty easy to use, but they were kinda difficult to do when you're in an angry mood…You're just so mad. You just want to sit down and just gripe at the wall." In this case, Gwendolyn's type of unpleasant emotion (i.e., anger) influenced her perception of the level of difficulty.

All of the girls that discussed using the coping strategies rated them as helpful. The level of helpfulness varied from low to high; however, only one participant rated the coping strategy that she used as unhelpful. Thus, overall, the girls found the coping strategies to be very helpful.

The girls were also asked if there were times when the coping strategies would not be considered helpful. Overall, level of helpfulness seemed to be influenced by participant characteristics such as degree of the emotional reaction to the stressor. Stressors that produced extreme emotional reactions were less well-managed by use of a coping strategy. Mia, for example, stated that a coping strategy may not be helpful if "…you're real, real sad or something. I guess. It will kind of make you feel better, but it

won't completely make you feel better." Devora agreed. Coping strategies were less helpful for her if she was "really, really sad."

Another factor that influenced the helpfulness was the type of stressor for which a coping strategy was employed. For instance, a couple of participants noted that unpleasant emotions associated with the death of a loved one were not well-managed by the use of a coping strategy.

### *Problem-Solving*

Another treatment component that was frequently discussed by the participants was problem-solving. As discussed previously, participants are taught to use problem-solving as a way to manage unpleasant emotions that stem from undesirable situations that can be controlled or changed. Thus, in the face of controllable stressors, participants are encouraged to engage in problem-solving strategies. Problem-solving is referred to as the 5 Ps and is presented to as a five-step procedure: (1) problem identification, (2) goal identification, (3) multiple solution generation, (4) prediction of solution outcomes, and (5) evaluation of solution effectiveness.

#### *Definition and Recall of Problem-Solving*

Out of 17 girls, 15 spontaneously recalled and defined problem-solving during the interviews. Most participants defined problem-solving as a way to solve problems, with several girls stating that problem-solving involved five steps. Two girls identified problem-solving as a skill that is used with controllable stressors and one girl noted that it is used in place of the coping strategies. In addition to defining problem-solving, most of the participants also named or described how to use the specific problem-solving steps. On average, the participants recalled four out of the five problem-solving steps, with six girls recalling all five steps. Thus, overall, the participants demonstrated a very good recall and comprehension of this particular skill.

### ***Problem-Solving and Stressors***

The participants described using problem-solving with stressors in both the interpersonal and academic domains. One participant described using problem-solving with a physical stressor (i.e., allergies). Most of the girls used problem-solving with conflict-oriented interpersonal stressors such as peer, sibling, and family conflict. Three participants described using it for academic stressors (e.g., managing homework). Problem-solving was most often employed with controllable stressors.

Interestingly, a few girls described using problem-solving with uncontrollable interpersonal stressors (e.g., being bullied). For example, Mahina attempted to use it to "gain a relationship" with her father who had been absent from her life for several years: "You could call him, like, one of them was you could call him and ask him or you could try to spend time with him or invite him to eat lunch with you, things like that." Thus, despite being instructed to use problem-solving with controllable stressors, some participants employed this skill with uncontrollable stressors.

### ***Level of Difficulty, Frequency of Use, and Level of Helpfulness***

Similar to the coping strategies, problem-solving varied in terms of its level of difficulty, frequency of use, and level of helpfulness. Overall, the participants described the problem-solving steps as "easy" to use. A few participants rated the skill as both easy and difficult. Level of difficulty seemed to depend on two factors: controllability of the stressor with which it was used and ability to generate plans for solving the problem. If a participant attempted to employ problem-solving with an uncontrollable stressor, then she perceived this skill as difficult to use. For example, Mahina stated that problem-solving was easy when it is used with a "…a problem that really you know you can fix easy." However, she expressed that it was difficult to use with more complex problems such as the situation with her absent father. Level of difficulty also seemed to depend on the

participant's ability to generate plans for solving the problem. For instance, Paris reported "Sometimes (problem-solving is) difficult because sometimes I can't come up with plans to do." Thus, if a participant could not think of different plans, then she perceived problem-solving as a difficult skill to use.

Frequency of use of problem-solving varied from low to high, and depended on a couple of factors, including whether or not the participants were experiencing controllable or uncontrollable stressors and the preference of the skill when compared with other skills. The girls were fairly evenly divided in terms of how often they used problem-solving. Some girls, like Mahina, Devora, Sarah, and Lydia, stated that they used problem-solving very often. On the other hand, Shaneika, Gwendolyn, Paris, and Sophie indicated that they hardly used this skill. For the most part, the participants with a low frequency of use indicated that they were either not experiencing many controllable stressors or that they preferred a different skill (e.g., coping strategies).

In terms of helpfulness, problem-solving varied from low to moderate to high. Most of the participants described problem-solving as a helpful skill. For example, Danielle described it as "a big help." Only one participant, Mahina, indicated that it was not a helpful skill: "It really just, it doesn't really do a lot." It is interesting to note that Mahina attempted to use problem-solving with an uncontrollable interpersonal stressor (e.g., absent parent) with little success. Despite her efforts to "gain a relationship" with her father by calling him and inviting him to do things with her, Mahina's father continued to be uninvolved in her life. Participants that used problem-solving with uncontrollable stressors such as Mahina, Olivia, Gwendolyn, and Paris rated this skill as less helpful. For these girls, it was not able to resolve issues such as parents getting divorced, being bullied, being hated by someone, or a having a sibling that was using drugs. Thus, level of helpfulness appeared to depend on controllability of the stressor

with which problem-solving was used. When problem-solving was used with uncontrollable stressors, it was not effective and, therefore, not perceived as helpful by the participants.

### *Cognitive Restructuring*

Another core treatment component is cognitive restructuring. As discussed previously, the girls are taught various strategies to identify, challenge, and modify negative thoughts. In order to externalize negative thoughts, the participants are instructed to think of their negative thought as a "Muck Monster" or a negative voice in their heads that wants them to feel bad or be "stuck in the muck." The girls are taught to identify their Muck Monster thoughts and to challenge them with two questions: (1) "What is the evidence?" and (2) "What's a different way of looking at it?" By applying these techniques to test the validity of negative thoughts, the participants become "Thought Judges." If it is evident that a negative thought is not valid, then the girls are encouraged to construct a more positive or more realistic thought.

#### *Definition and Recall of Cognitive Restructuring*

Eleven of the girls that were interviewed talked about the process of identifying negative thoughts in the ACTION program. The girls consistently used the term Muck Monster and defined it as either an internal voice that says negative things about the self or, simply, negative thoughts about the self. For example, Mia reported "We call the negative thoughts in our head the Muck Monster." A few of the girls also noted that the negative thoughts are not true and that you have to challenge them. Cognitive restructuring was discussed by 13 participants and was consistently described as either talking back to the Muck Monster or using the Thought Judge questions. In terms of talking back to the Muck Monster, participants described cognitive restructuring in three ways: (1) saying the opposite of the negative thought, (2) providing evidence for why the

negative thought is not true, or (3) finding an alternative way of looking at the situation related to the negative thought. An example of saying the opposite of the negative thought was provided by Shaneika. She reported "When (the Muck Monster) tells me something about myself, I always say the opposite of that thing."

Six participants talked about the Thought Judge questions when attempting to explain cognitive restructuring. When asked to describe the Thought Judge, most of the girls simply stated that it was two questions and provided an example of one of the questions. Two participants elaborated on this basic definition by stating that the questions are used to change thoughts. On average, these girls remembered one of the two cognitive restructuring questions. Interestingly, this question was always "What's the evidence?" Thus, none of the participants recalled the question "What is a different way of looking at it?" Despite having not recalled the specific question, participates did give examples in which they clearly used this cognitive restructuring technique. For example, Olivia reported that she had a negative thought that one of her friends "hated her." In order to challenge this negative thought, she told herself ""Maybe she doesn't hate me. She's just playing around with me," or something like that." Clearly, Olivia was attempting to find an alternate explanation for her friend's behavior. Thus, overall, most of the girls demonstrated a good recall and understanding of cognitive restructuring.

***Cognitive Restructuring and Negative Thoughts***

The participants that discussed cognitive restructuring during the interviews provided several examples of negative thoughts that they experienced during the ACTION program. According to J. S. Beck (1995) negative thoughts in depressed individuals tend to correspond to negative core beliefs that can be categorized in two realms: unlovability or helplessness. Themes of unlovability core beliefs include unworthiness, undesirability, and the inability to merit the love or attention of others

(Beck, 1995). Helplessness core beliefs are characterized by themes of powerlessness, vulnerability, or failure to achieve (Beck, 1995).

Consistent with this theory, the participants described negative thoughts that corresponded to negative core beliefs of unlovability and helplessness. Negative thoughts associated with unlovable core beliefs included thoughts like "I'm different," "No one loves/likes me," "I'm ugly," "I'm not a good person/friend," and "I'm not good enough." Negative thoughts related to core beliefs of helplessness included thoughts such as "I never do anything right," "I'm stupid," and "I will be bullied." Overwhelming, the girls endorsed core beliefs of unlovability at much higher rates than core beliefs of helplessness. Of the twenty-one negative thoughts that were described, fifteen were related to core beliefs of unlovability.

Participants' negative thoughts also varied in terms of their focus. The focus of the negative thoughts was on the self, others, and the future. The vast majority of negative thoughts were self-focused (approximately 86%). In other words, they related specifically to a personal character flaw such as not being a good friend, being ugly, or being stupid. Only one negative thought that was described was other-focused or described a negative situation that involved another person. This thought was described by Olivia. She stated that she had a negative thought that her friend "hated" her. Three negative thoughts were focused on the future and these included thoughts like "I will be bullied," "I am never going to make friends," and "My problems will never go away."

***Level of Difficulty, Frequency of Use, and Level of Helpfulness***

Cognitive restructuring varied in terms of its level of difficulty, frequency of use, and level of helpfulness. Level of difficulty varied from low to moderate to high, and depended on the girls' grasp of the skill. Most of the participants stated that cognitive restructuring was an "easy" skill to use; however, several girls noted that it was initially

difficult because they did not fully understand it or they had little experience with it. For example Jamilla reported "At first, it was kind of difficult. Then sort of easy. It was difficult because you really didn't, at first, you didn't really understand who (the Muck Monster) was until (the therapist) told you and really explained it."

Overall, the girls that discussed employing cognitive restructuring endorsed using this skill at a very high rate. In fact, only one participant said that her frequency of use was low. Frequency of use seemed to depend on the frequency of negative thoughts. For example, Gwendolyn reported that she did not engage in cognitive restructuring very often: "I didn't really have many negative thoughts." Thus, for participants that had frequent negative thoughts, cognitive restructuring was employed at a high rate.

Cognitive restructuring appeared to be a very helpful skill. Almost all of the participants rated it as helpful. Furthermore, most of the girls indicated that its level of helpfulness was high. In fact, only one participant reported that cognitive restructuring was only "a little bit" helpful. For this participant, level of helpfulness seemed to depend on not being able to fully eliminate her negative thought. For example, Mahina rated cognitive restructuring as "a little bit" helpful because despite trying to "fight back" her negative thoughts about herself, she "would always know that that one part of me that I don't like is still there." Thus, she was unable to completely eliminate her negative belief about herself and, therefore, she did not perceive this skill as highly helpful.

Another factor that influenced level of helpfulness seemed to be whether or not the negative thought that was being restructured was true. Several of the participants indicated this skill was not helpful when it was employed with a true rather than a distorted thought. For example, Courtney reported, "If, if the Muck Monster isn't telling lies, then there…there's really no way to fix it." Thus, level of helpfulness of cognitive

restructuring seemed to depend on whether or not it was used with true or distorted thoughts.

## Less Central Treatment Components

In addition to the core treatment components, the ACTION program also contains treatment components that are important but less central. These components attempt to encourage skills such as engaging in pleasant activities, noticing pleasant events, building a positive sense of self, and setting personal goals. The following section with discuss the recall, comprehension, frequency of use, level of difficulty, and level of helpfulness of these non-core treatment components. Please see Table 7 for a summary of the characteristics of these skills as well as the how many participants recalled each one.

### *Self-Monitoring*

As discussed previously, self-monitoring encourages participants to notice positive events and engage in pleasant activities as a way to elevate mood. The participants are instructed to create a list of activities in which they can engage on a regular basis (i.e., TAL). Each day, the girls are supposed to track the number of activities that they are able to complete as well as identify how completing the activities affected their overall mood. The goal of this process is to teach the participants that there is a link between positive mood and pleasant events, and that they are capable of affecting their mood by choosing to engage in fun activities.

Another piece of the self-monitoring treatment component is the CPD (i.e., "Catch the Positive Diary"). The participants are given notebooks in which they are instructed to record positive events that occur each week. The goal of the CPD is to have the participants shift their focus from the negative to the positive, and to understand that choosing to focus on pleasant events rather than on unpleasant events can enhance mood.

Thus, using the self-monitoring techniques, the participants learn to "catch" pleasant events and to "do" fun activities in order to decrease feelings of depression.

Table 7

*Characteristics of the Less Central Treatment Components*

| Component | Participants | Recall | Comprehension | Frequency | Difficulty | Helpfulness |
|---|---|---|---|---|---|---|
| Self-monitoring | | | | | | |
| TAL | 2 | Good | Low | High | Easy | Moderate |
| CPD | 5 | Good | Moderate | High | Difficult | High |
| Self-Map | 0 | N/A | N/A | N/A | N/A | N/A |
| Goals | 0 | N/A | N/A | N/A | N/A | N/A |

*Note.* Participants = Number of participants that discussed a specific component.

### *Definition and Recall of the TAL*

During the interviews, only two participants discussed the TAL. These participants defined it as a list of things to do, with one participant adding to the definition by saying that it was connected to coping because it was a list of things to do that you "like" or enjoy. Both participants gave examples of specific activities that were on their list, including "playing basketball," "going to the park," "playing outside," "having parties for no reason," "jumping rope," and "playing on the computer." The girls also talked about how the lists were completed, indicating that they checked off the activities that they completed each day. Although Sophie talked about how she would share her list with the group and they would talk about how the activities made her feel, neither of the girls explicitly described the connection between doing pleasant activities

and enhancing mood. Thus, it was not clear if these participants truly understood the underlying theory behind this particular skill.

***Definition and Recall of the CPD***

Five participants described the CPD during the interviews. The most common explanation of the CPD was that it was a way to "catch" or notice positive things. This definition was consistent with what the girls are explicitly taught. Besides using the CPD to record pleasant events, a couple of the girls also indicated that they used it for other purposes, including working through other skills such as cognitive restructuring and problem-solving. For example, Angelina indicated that she used it as an "Evidence Journal" too and that she would record evidence against her negative thoughts in it. Paris reported that she used the CPD as a "diary" and that she worked through the problem-solving steps in it. Thus, a couple participants expanded the purpose of the CPD to include using it as a place to practice other skills. Thus, the participants seemed to have a somewhat incomplete understanding of this aspect of self-monitoring.

***Level of Difficulty, Frequency of Use, and Level of Helpfulness of the TAL***

With regard to level of difficulty, the participants that discussed the TAL indicated that it was an "easy" thing to do. Both of the girls also indicated that their frequency of use of the TAL was high. One of the participants, Shaneika, indicated that she still uses this skill; however, she only uses it "like twice a week" now.

With regard to level of helpfulness, Sophie stated that the TAL was a helpful skill. She reported that she enjoyed talking about it with the other girls in group. Shaneika reported that she was unsure if the TAL was helpful or not helpful. She indicated that level of helpfulness depended on whether or not she was already engaged in fun activities. When she was already having fun, the TAL was not as helpful. Thus, the TAL appeared to be an easy skill to use that was employed at a rate high during treatment;

however, it was only moderately helpful for the two girls that discussed it during the interviews.

### *Level of Difficulty, Frequency of Use, and Level of Helpfulness of the CPD*

Most of the five girls that reported using the CPD rated their frequency of use of this skill as high. Two of the participants indicated that they continue to use this skill; however, they reported that they employ it less frequently than they did when they were in treatment. Only one participant, Olivia, talked about the level of difficulty of using the CPD. She indicated that it was a "difficult" skill to use because it required a lot of mental effort. Olivia described how she would have to go back and think about the "whole entire day" in order to use the skill effectively.

In terms of level of helpfulness, most of the girls indicated that it was a helpful skill, with a few participants reporting that the CPD had a high degree of helpfulness. Level of helpfulness seemed to be influenced by how using it made the girls feel (i.e., better). All of the girls indicated that it made them "feel better," with one participant stating that using the CPD made her feel better about herself, her life, and her future. Thus, for this participant, the CPD was highly helpful because it resulted in positive feelings in multiple domains.

## *Building a Positive Self of Sense*

Another aspect of treatment is its focus on building a positive sense of self through the self-map activity. As described previously, the self-map is a diagram on which the participants write down personal strengths in several areas of their lives. The purpose of the activity is to replace negative self-schema with a more positive, realistic view of the self.

None of the girls discussed the self-map activity. One participant, Sophie, talked about learning to "like herself" over the course of treatment; however, she stated that this

was accomplished through the encouragement of the therapists. When asked to describe what she meant, Sophie said: "And then like, liking myself, it would be, like, I guess just, like, focusing more on me 'cause when (the therapists) taught us that, you know, you have to love yourself too, don't always put people first." Thus, it does not appear that she acquired a more positive sense of self as a result of completing the self-map activity.

### *Setting Goals*

In the ACTION program, each participant is encouraged to set specific goals that she works on over the course of treatment. Only one participant discussed setting goals. When explaining cognitive restructuring, Jamilla stated that she "accomplished a goal to stop believing the Muck Monster." However, in reviewing the therapist's notes for Jamilla's goals, this was not one of her actual goals. Thus, it seems that she meant that she accomplished a personal goal rather than a goal that was part of the treatment.

## Aspects of Treatment that Facilitate Skill Acquisition and Application

The treatment components are presented to the participants using a variety of activities. After the girls learn the initial concepts, they acquire the skills by practicing them both inside and outside of the group. In order to encourage practice of skills outside of the group, the participants are given therapeutic homework assignments that they are expected to complete each week. To encourage completion of therapeutic homework assignments and practice of new skills within group, participants are given small, tangible rewards such as beads or nail polish. Thus, skill acquisition and application is facilitated through the use of activities, therapeutic homework assignments, and rewards. Please refer to Table 8 for a summary of the characteristics of these aspects of treatment as well as the number of participants that spontaneously discussed them during the interviews.

When asked to describe their experience of treatment, many of the participants indicated that the ACTION program was "fun." In fact, 14 out of 17 girls gave this reply.

When prompted to elaborate on this idea, a pattern emerged among the data that suggested that the participants perceived two aspects of treatment as very enjoyable: the activities and the rewards. Since these aspects of treatment are related to the acquisition and application of the treatment components, they will be discussed in the following section. In addition, this section will also discuss the participants' recall, comprehension, completion, and perceived level of helpfulness of therapeutic homework since this aspect of treatment also encourages acquisition and application of the treatment components.

Table 8

*Characteristics of the Other Aspects of Treatment*

| Aspects | Participants | Recall | Comprehension | Frequency | Difficulty | Helpfulness | Enjoyment |
|---|---|---|---|---|---|---|---|
| Activities | 16 | Good | High | N/A | Easy | High | High |
| Rewards | 5 | Good | High | N/A | N/A | High | High |
| Homework | 7 | Fair | Moderate | Moderate | Easy | Moderate | N/A |

*Note.* Participants = Number of participants that discussed a specific component.

### ***Activities***

In the ACTION program, most of the treatment components are taught to the participants using several different structured activities. These activities are meant to be a fun and engaging way for the girls to learn and to practice the therapeutic strategies in the group. Some activities involve physical experiences such as doing hula hoops or jumping rope. Other activities involve mental experiences such as modeling and role-playing. During the interviews, several of the participants discussed the activities. In fact, 16 out of 17 girls mentioned the group activities when describing their experiences of the treatment. Approximately equal numbers of physical and mental activities were

recalled. The recall of these activities seemed to be influenced by level of frequency, timing, enjoyment, and helpfulness.

***Recall of Specific Activities***

Across the interviews participants recalled almost all of the specific group activities; however, some activities were more frequently discussed than others. The three activities that were most frequently recalled by the participants were "Shredding Negative Thoughts," "Talking Back to the Muck Monster," and the "Web." Frequency of activity did not seem to influence recall. For example, the Web activity is completed four times over the course of treatment, whereas Shredding Negative Thoughts is completed only one time. Despite being completed more frequently, the Web activity was only recalled by four participants. Shredding Negative Thoughts, on the other hand, was recalled by six of the girls. Timing of an activity may have influenced recall since Shredding Negative Thoughts, the very last activity completed in the ACTION program, was recalled by the most participants. However, only one participant recalled the "Sunglasses" activity, which is completed in the first meeting. So, timing could not fully account for frequency of activity recall. Level of helpfulness and level of enjoyment seemed to influence activity recall. That is, the more helpful and enjoyable the activity, the more likely it was to be recalled by the participants. This point will be illustrated in the next section with a specific activity: Shredding Negative Thoughts.

***Shredding Negative Thoughts***

In the last meeting, the participants are instructed to write down the negative thoughts, unpleasant emotions, and problems that troubled them the most at the beginning of treatment. They are then told that they will be placing all of these things into a paper shredder. The therapists explain that since the girls have acquired the skills to manage negative thoughts (i.e., cognitive restructuring), they no longer have to believe them and

will now be letting them go. The participants are also told that since they now know how to manage unpleasant emotions by using coping strategies and how to solve problems by using problem-solving, they can let these things go too. After discussing this, each participant shreds her pieces of paper. As she shreds them, the participant is encouraged to explain why she is letting go of these things. For example, if her negative thought is "I'm stupid," then she is encouraged to talk about her more positive, realistic thought (e.g., "I'm not stupid because I am passing all of my classes."). At the end of the activity, a poster of the Muck Monster is also shredded.

*Recall of Shredding Negative Thoughts.* Shredding Negative Thoughts was recalled by six participants. Most of the girls that discussed this activity recalled shredding both their negative thoughts and the Muck Monster poster. For example, Paris reported

> We actually wrote down all these negative problems with the Muck Monster, um, writing down things that the Muck Monster had told us and, um, at the end…on the last day we got those sheets of paper and…we had a paper shredder and, um, before we shredded it, we had to read the card and then say something positive – that it's not true or anything and…you had to say something positive about it and then after that you had to shred it and then, um, for the Muck Monster, the piece of paper that had the Muck Monster, we tore it and we each gotta, um, all three of the girls each got a piece and, um, we said our goodbyes to the Muck Monster and, um, we shredded it.

Sarah also recalled the activity in conjunction with discussing the Muck Monster: "…we took a shredder and we shredded (the Muck Monster) and then we shredded him again and then again and again and again…" When asked more about the activity, she

explained its rationale: “Because we wanted to get rid of those thoughts.” Thus, the girls demonstrated good recall of both the activity and its purpose.

*Level of enjoyment.* For Paris, Shredding Negative Thoughts was a very positive experience. As she talked about it in the interview, she had a big grin on her face and she would frequently laugh. Shredding Negative Thoughts also appeared to be an enjoyable aspect of treatment for Sarah. When discussing it, she indicated “…we killed the Muck Monster. Yeah. We shredded him.” She was also smiling and laughing when explaining this activity. Shredding Negative Thoughts was also an enjoyable aspect of treatment for Gwendolyn. In describing the activity, she said

> I thought was so fun. It was, we had, like, written negative thoughts…on a piece of paper, and then we’d, so we got the piece of papers and (the therapist) gave us some more, it was, like, she’d write some more negative thoughts on there and then we’d put it through the shredder. It was funny.

When asked to explain why the activity was “fun,” Gwendolyn replied “Because, well, it was just funny to see—I don’t know. I do not know why it was so fun, but, it was. I’ll just say that.” For Sophie, completing this activity was also a positive experience. While describing it to the interviewer, she smiled repeatedly. Thus, Shredding Negative Thoughts appeared to be a very enjoyable aspect of treatment for the girls that recalled it.

*Level of helpfulness.* Shredding Negative Thoughts was also a powerful experience for participants. For example, Paris explained that because of the activity, her Muck Monster was “gone” and that when he does come back, she completes the activity on her own: “I think about what we did and I actually get a piece of paper and I write the, and I write in capital print Muck Monster and I tear it into thousands of little, tiny pieces and I throw it in the trash.” Sarah also indicated that the activity was highly effective.

She stated that it successfully rid her of her Muck Monster, reporting “I gave him a lifetime supply of, supply of first class tickets to Hawaii.” Shaneika agreed that the activity was very helpful. She indicated that her Muck Monster was also gone as a result of shredding him. Jamilla had a similar experience. After completing the activity, she indicated that her Muck Monster “was gone.” Sophie also indicated that this activity was very helpful. She reported that it was a helpful activity “Because (my negative thoughts) pretty much went away…’cause you don’t like think like that anymore.” Thus, all of the participants saw this activity as very helpful.

In sum, Shredding Negative Thoughts was the most frequently recalled activity. Two factors seemed to influence recall: level of helpfulness and level of enjoyment. Activities that were perceived as more helpful and more enjoyable seemed to be better recalled by the girls.

### *Rewards*

Another aspect of treatment that influences the acquisition and application of the treatment components is rewards. Beginning in the first meeting, participants are introduced to a within-group incentive system. The girls are shown two bags of prizes that include inexpensive items. One bag contains less desirable rewards (e.g., pencils, stickers), whereas the other bag contains more desirable rewards (e.g., bracelets, nail polish). The types of rewards that are included in the bags are based on gender and developmental considerations as well as feedback from former group participants. At the end of the first group meeting, participants are told that they can choose a less desirable reward for attending each meeting and a more desirable reward for completing their therapeutic homework assignments. Thus, rewards indirectly influence the acquisition and application of the treatment components by encouraging completion of the therapeutic homework assignments.

Later in treatment, the participants are also rewarded for identifying their own and other people's negative thoughts as well as for challenging these thoughts. The girls receive a small incentive (e.g., a bead) to engage in an activity that helps them to practice a specific skill (i.e., cognitive restructuring). Once again, rewards serve as a means of encouraging the acquisition and application of the treatment components.

***Recall of Rewards***

When asked to recall their experience of treatment, five participants mentioned the rewards. Three girls referred to the rewards as "prizes." For these participants, the rewards were related to the within-group incentive system. Alika discussed how she would receive a prize for completing therapeutic homework: "you get to do worksheets and you turn them in the next day and you get a prize." Danielle also talked about receiving rewards for doing assignments: "I was good at doing my homework, so I got a lot of prizes." Thus, receiving rewards seemed to influence the completion of therapeutic homework.

***Level of Enjoyment***

For Alika, receiving rewards was a very positive experience. In fact, she said that this was one of the best aspects of treatment. When asked about the strengths of the ACTION program, she replied "You get a prize." Danielle agreed. When asked about her favorite aspects of treatment, among other things she indicated "And the prizes too." Thus, receiving rewards was one of the most enjoyable aspects of treatment for these girls.

The other two girls that discussed rewards during the interviews were Gwendolyn and Angelina. Both of these participants talked about how they received beads for catching and challenging negative thoughts. For example, Angelina stated "…we'd say "That's a negative thought!" And so we'd, like, get, like a bead or something 'cause we

got beads for that." For her, getting beads was an "enjoyable" aspect of treatment. Thus, for Angelina the reward contributed to the treatment being fun.

***Level of Difficulty***

For Gwendolyn, getting rewards influenced the level of difficulty and level of enjoyment of a specific treatment component: cognitive restructuring. When asked to rate the level of difficulty of challenging negative thoughts, Gwendolyn indicated "Well, kinda hard, kinda easy…but then it got easier when (the therapist), she hands us these little purses or whatever…And whenever you talk back to the Muck Monster, then you get a bead and you put it inside your little purse." When the interviewer asked Gwendolyn if getting a bead made the activity easier, she stated "Yeah, it was funner, actually." Thus, being rewarded for her efforts seemed to influence Gwendolyn's perception of the difficulty and the enjoyment of a group activity that taught a specific treatment component.

## ***Therapeutic Homework***

Therapeutic homework is another aspect of treatment that encourages the acquisition and application of the treatment components. It gives the participants a chance to review and practice therapeutic strategies outside of group. Beginning in the first meeting and continuing throughout the treatment, participants are asked to complete "practice" assignments. On average, the girls are asked to do three assignments per meeting, with each assignment requiring approximately five minutes or less to complete.

The most frequent therapeutic homework assignment is the CPD (see Appendix I), which the girls are asked to complete in 17 of the 20 meetings. The least frequent assignment is the 3 Bs worksheet (see Appendix B), which is only assigned in two meetings. Although most assignments are given without participant input, starting in Meeting 11 and continuing until Meeting 19, the girls are able to choose between

completing a coping strategies worksheet (see Appendix C) or a problem-solving worksheet (see Appendix D). This option is given to the girls so that they can utilize the skill that is most relevant to their current concerns.

***Definition and Recall of Therapeutic Homework***

Seven participants discussed therapeutic homework during the interviews. Almost all of these participants described this treatment component as "worksheets" or "homework" despite the fact that it is purposely referred to as "practice" rather than homework by the therapists. Only Paris referred to the therapeutic homework as practice. None of the participants described specific assignments in detail or talked about how these assignments were given to increase acquisition and application of skills. Thus, the girls seemed to have a somewhat basic recall and understanding of this aspect of treatment.

***Frequency of Use, Level of Difficulty, and Level of Helpfulness***

Frequency of use seemed to depend on external reinforcement. For example, both Danielle and Alika discussed receiving rewards for completing therapeutic homework assignments. Thus, rewards seemed to have influenced therapeutic homework completion for these participants by providing them with a tangible incentive.

The completion of therapeutic homework was also influenced by academic and interpersonal obligations. For example, Sophie indicated that she and the other group members were supposed to complete "worksheets" for each group meeting. Although she reported they were "pretty easy" and that she completed them "most of the time," she indicated that she and the other group members were not always consistent about completing the worksheets because "real homework" and "friends" got in the way. Alika had a similar experience. She reported that "sometimes (she) didn't get a chance to (complete the assignments)," indicating that academic "homework" came first. Thus,

participants that had other interpersonal or academic obligations demonstrated a lower completion rate of therapeutic homework.

The helpfulness of the therapeutic homework appeared to be mixed for participants. Sophie stated that it was helpful in terms of reviewing and understanding what was discussed in group: "I mean it was just, like, trying to review so it, like, gets in your head…I think it helped us understand like what we were talking about." For Lydia, completing the therapeutic homework assignments was "really helpful" because it gave her an opportunity to solve specific problems: "Like (the therapist) gave us, um, a binder full of worksheets…so if I had a problem, I would write it down… I would go to my binder and write about what the problem was and then problem-solve it." In fact, she reported that she still uses "some of the worksheets." For Paris, the therapeutic homework was also helpful: "I liked that because whenever you do the sheets, um, uh…like you think about it and you just let it all out." Thus, for these participants therapeutic homework was seen as a helpful component of the treatment.

For Mahina, however, the therapeutic homework was not helpful because it was experienced as an additional stressor. When asked about aspects of treatment that were not helpful, she said "Like we would have to go home and do homework about it. 'Cause I already have a lot of pressure about homework already and that would put more on me." Although Alika did not report that completing the therapeutic homework was stressful, she rated it as "just okay" in terms of its helpfulness. Thus, for these girls, the therapeutic homework was not perceived as a helpful treatment component.

**Most Helpful Treatment Component**

One of the goals of the present investigation was to determine which aspects of treatment were perceived as most helpful by the participants. Therefore, during the interviews, participants were asked to discuss which treatment component helped them

the most. To allow for as many different responses as possible, this question tended to be broad, such as "Out of all the things that you learned in the ACTION program, which was the most helpful for you?" By not asking about skills specifically, the participants were able to talk about other aspects of treatment such as the group structure or the activities.

Interestingly, when asked this general question, all of the participants except one described a core treatment component. The following are the most helpful treatment components according to the participants: coping strategies, problem-solving, cognitive restructuring, and affective education. Only one participant, Angelina, was unable to rate a specific aspect of treatment as most helpful. She stated that she could not decide between coping strategies, problem-solving, and cognitive restructuring because they were all important. One participant indicated that a skill summary sheet that was unique to her group was the most helpful aspect of treatment. Since this sheet was not something that was used across treatment groups, this response was not included in the analysis of the most helpful treatment component. The following section will discuss each of the treatment components that were rated as most helpful by the participants.

### *Coping Strategies*

The coping strategies were most commonly rated as the most helpful treatment component. In fact, when asked what helped them the most approximately 46% of participants (7 out of 15) said it was the coping strategies. The helpfulness of the coping strategies seemed to depend on several factors including providing better, safe, and multiple ways to manage unpleasant emotions as well as providing a way to decrease rumination.

The coping strategies provided participants with a way to manage unpleasant emotions. For example, Gwendolyn reported that she found them to be the most helpful aspect of treatment "because they, they lifted my spirits. They didn't dampen them or

whatever that word is. So, you know, they made me have a good time when I was sad sometimes." Thus, the coping strategies helped improve Gwendolyn's sad mood.

For some participants the coping strategies not only helped them to manage unpleasant emotions, but they also provided a better way of dealing with stress compared with how they managed it before treatment. This was the case for Sarah. Prior to being in treatment, Sarah used the emotion-focused stressor management strategy emotional release to cope with stress, which did not help her to feel better. She found the coping strategies extremely helpful because "Like I knew how to handle my problem. Like better. So, I don't have to be…so I didn't have to be sad and I could change my thinking." Thus, the coping strategies provided Sarah with a better way to manage her unpleasant emotions.

This was also the case for Lydia. Prior to being in the ACTION program, she used social withdrawal and emotional release to deal with stressors; however, after treatment, she used distraction. Using this specific coping strategy allowed her to manage her unpleasant emotions in a way that produced better results.

For Alexandra, the coping strategies were the most helpful aspect of treatment because they provided her with a safe way to deal with her unpleasant emotions. Prior to treatment, Alexandra reported that she would cut herself when she was upset in order to achieve an emotional release. After learning the coping strategies, Alexandra realized "if I felt that I was going to cut myself, I can look at some things, if I can do that, I can go play with my cousins." Thus, Alexandra discovered that she could replace her pre-treatment behaviors with ways of coping that were safer.

Alika rated the coping strategies as the most helpful treatment component because they provide multiple ways of managing unpleasant emotions. When asked why she found these strategies to be the most helpful aspect of treatment, she replied "…because

there's a lot of things that you can do. You can talk to your friends and use your energy." Thus, the coping strategies gave Alika multiple options for managing unpleasant emotions.

In addition to helping participants manage unpleasant emotions in better, safer, and multiple ways. The coping strategies also decreased rumination. For many participants this is the reason that the coping strategies were rated as the most helpful treatment component. This was the case for Olivia and Sophie. When asked why she rated the coping strategies as the most helpful treatment component, Olivia replied "'Cause it would help me, like, get my mind off stuff. Even if it would come back later, I could get it off again." Sophie had a similar response. She stated "At the beginning (of treatment), I didn't know what to do when I was upset. I was just upset and I didn't know how to fix it, so I think coping, like, it gave me something, like, to do to, like, get my mind off of things." Thus, for these participants the fact that the coping strategies decreased rumination is the reason why they found them to be the most helpful component of treatment.

### ***Problem-Solving***

After coping strategies, problem-solving was the treatment component that was rated as most helpful. Four participants (approximately 26%) rated problem-solving as the most helpful treatment component. For these girls, problem-solving helped them to solve specific problems by providing choices. In addition, this treatment component was perceived as most helpful because it was an organized process.

Both Devora and Lucia rated problem-solving as the most helpful treatment component because it helped them to solve specific problems. Devora did not have any friends at the beginning of the ACTION program. By learning and using problem-solving, she was able to generate plans for making friends. At the end of treatment, she

became friends with her "whole class." Thus, problem-solving was a very useful skill because it helped her to solve a specific problem. Similarly, Lucia was having problems with her friends at the beginning of treatment, and she was not sure how to cope with them. By learning problem-solving, she was able to find ways to cope with a specific stressor.

For Mahina, problem-solving was the most helpful treatment component because it gave her choices and it was an organized process. When asked why she found it to be the most helpful aspect of treatment she stated: "Mmm…because I have choices. I can pick which plan I want…And there's so, like, the steps that there are, they help you to kinda, they kinda lead you through the way." Shaneika also liked having choices. She chose problem-solving as the most helpful treatment component "because, um, you got more than one choice of what to try to make it be better." Thus, for these girls, having an organized process that provided different choices was a very helpful way of managing their stressors.

### *Cognitive Restructuring*

Cognitive restructuring was rated as the most helpful treatment component after coping strategies and problem-solving. Three participants (approximately 20%) indicated that "talking back to the Muck Monster" or cognitive restructuring was the most helpful component of treatment. For these participants, this skill was the most helpful because its use resulted in a more positive outlook or self-schema and it was easy to use.

Talking back to the Muck Monster was the most helpful treatment component for Courtney because "…it made me think good things about myself." Prior to treatment, Courtney endorsed having a lot of negative self-directed thoughts; however, after learning to use cognitive restructuring, she developed a much more positive self-schema. For Jamilla, cognitive restructuring was the most helpful treatment component because

she "…started thinking positive things." Thus, for both of these girls the consequence of using cognitive restructuring (i.e., improved self-schema and outlook) was the reason why this skill was particularly helpful for them.

According to one participant, cognitive restructuring was easy to use. For example, Paris reported: "… you didn't have to write anything down, it didn't take that long for you to get over something, you just do it right then and there." Unlike some of the other treatment components, which require planning or having access to resources, cognitive restructuring can be used immediately in almost any situation. Thus, its ease of use rendered this skill the most helpful treatment component for Paris.

### *Affective Education*

Affective education was the final treatment component to be rated as most helpful by participants. Only one participant reported that the 3 Bs or affective education was the most helpful component of treatment. For Mia this skill was the most useful aspect of treatment because "…if you don't have the 3 Bs you won't know what to do." She went on to explain:

> Like at first I wouldn't know if I was upset, angry, mad and then I would, then I started using the 3 Bs and now I know how I'm feeling and then I would kinda go back and see why I'm feeling and then it would help me like that. I would, then I would see why I was feeling that way and then I would try to do a coping, one of the coping skills, like listen to music.

Thus, for Mia, affective education was the most helpful component of treatment because it helped her to identify her feelings, which prompted her to engage in coping strategies to manage unpleasant emotions.

## Least Helpful Treatment Component

In addition to describing the treatment component that was most helpful, participants were encouraged to discuss the component of treatment that was the least helpful for them. The only consistent pattern among answers to this question was that four participants indicated that they found "nothing" to be least helpful. For example, when asked which aspect of treatment was least helpful, Courtney replied "I'm not sure there is one." Mia agreed. When asked if there was something in treatment that was the least helpful, she indicated "Um, no, 'cause I pretty much use almost everything they taught me." Thus, several participants seemed to find no aspect of treatment unhelpful.

Some of the participants did report that specific skills were not helpful to them; however, these ratings almost always depended on personal preference, limited comprehension of a particular concept, or both. For example, Paris indicated that the 3 Bs were the least helpful treatment component because she did not comprehend this skill: "I didn't really like (the 3 Bs) because I didn't really understand it." Olivia rated problem-solving and the "Thought Judge" as the least helpful treatment components because she "didn't like them." Lucia rated cognitive restructuring as the least helpful aspect of treatment, stating "The Muck Monster. What was the point of the Muck Monster? I didn't get it. I never understood that." Thus, helpfulness of a particular treatment component seemed to be strongly influenced by the participant's level of understanding of the skill as well as by their personal preference for it.

## Chapter Summary

One of the main goals of the present investigation was to understand which of the treatment components that comprise the ACTION program were best recalled and comprehended by the participants. An additional aim of the study was to determine the level of frequency, difficulty, and helpfulness of these skills. When discussing their

experience of the ACTION program, the participants recalled most of the core treatment components at a very high rate.

Only a few participants discussed one of the core treatment components: affective education. Of these participants, each of them talked specifically about learning to recognize and identify feelings using the 3 Bs. For the most part, this skill was rated as “easy” to use; however, one participant felt that its level of difficulty was dependent on her comfort with self-observation. Although it was sometimes challenging to use, recognizing and identifying feelings was deemed a highly helpful skill because it assisted the participants in knowing that they were experiencing unpleasant emotions and that they should try to use a therapeutic skill to improve their mood. Thus, the 3 Bs seemed to be a very helpful component of the ACTION program for some girls.

Overall, most of the girls seemed to understand, employ, and benefit from learning coping strategies. When faced with unpleasant emotions or uncontrollable stressors, the girls engaged in emotion-focused coping. Interestingly, the girls also utilized coping strategies with controllable stressors as a precursor to engaging in problem-solving strategies. The participants cited examples of using two general categories of coping strategies most frequently: doing something that is fun and distracting and doing something that is soothing and relaxing.

Many participants recalled and understood problem-solving. Consistent with what is taught in the program, the girls appeared to use this skill mostly in the face of controllable stressors. Controllability of the stressor influenced level of difficulty of the skill as well as level of helpfulness. The participants perceived problem-solving as more difficult and less helpful when they attempted to use it with uncontrollable stressors. Overall, most of the girls found problem-solving to be a helpful skill.

In general, the participants seemed to understand how to identify and how to challenge negative thoughts using the specific strategies taught in the ACTION program. Most of the girls seemed to hold negative core beliefs of unlovability prior to treatment that produced negative self-focused thoughts. When faced with these thoughts, the participants reported using cognitive restructuring at a high rate of frequency. Most of the participants found cognitive restructuring to be "easy" to use; however, some endorsed initial difficulty with it based on their understanding of the skill. Overall, the girls found it to be a highly helpful skill. Level of helpfulness depended on being able to fully eliminate a negative thought and on whether or not the negative thought was true. If they could not rid themselves of the thought completely or if the thought was realistic, then the participants found this skill to be less helpful.

Very few participants spontaneously discussed treatment components that were less central to the treatment. In fact, self-monitoring was the only non-core treatment component that was discussed by the participants. With regard to this treatment component, the participants tended to discuss focusing on pleasant events (i.e., the CPD) more than engaging in pleasant activities (i.e., the TAL). The girls seemed to understand the purpose of these two self-monitoring activities; however, their level of comprehension was somewhat basic. The TAL was rated as an "easy" skill to use by the participants; however, it helpfulness received mixed reviews. With regard to the CPD, level of difficulty seemed to depend of the amount of mental effort needed to complete it. When it required a lot of mental effort, it was seen as a difficult skill to use. Most of the girls that described using the CPD rated it as a helpful skill. Level of helpfulness seemed to depend on whether or not using the skill made the participants feel better.

During the interviews, participants also discussed aspects of treatment that facilitated the acquisition and application of the treatment components such as activities,

rewards, and therapeutic homework. Almost all of the participants recalled doing specific activities. Recall of activities did not seem to depend on the frequency or the timing of the activity. Instead, activities that were rated as having a high level of helpfulness and a high level of enjoyment were recalled more frequently.

Some of the participants also recalled receiving rewards for completing therapeutic homework and for participating in specific group activities. Receiving rewards was a positive experience that facilitated the acquisition and practice of different treatment components.

Approximately half of the participants discussed the therapeutic homework. The girls seemed to have a basic understanding of the purpose of this treatment aspect; however, its frequency of use and level of helpfulness were somewhat mixed. Receiving rewards encouraged participants to do therapeutic homework, whereas other interpersonal or academic obligations hindered its completion. Homework assignments were viewed as helpful by participants that saw them as a way to practice and learn treatment components; however, they added additional stress for other girls, which made them less helpful.

Out of everything that the girls did or learned in treatment, the coping strategies were rated as the most helpful component of treatment by the majority of the participants. This skill was seen as most helpful because it provided better, safer, and multiple ways to manage unpleasant emotions and to decrease rumination. The next most helpful treatment component was problem-solving. This skill was viewed as most useful because it provided participants with an organized process for solving specific problems in multiple ways. Cognitive restructuring was the third most helpful treatment component. This skill helped participants to develop more positive outlooks and self-schema. Affective education was rated as the most helpful treatment component by one participant

because it helped her to identify unpleasant feelings, which prompted her to engage in coping strategies.

The participants were unable to come to a consensus regarding the least helpful treatment component. Many of the girls indicated that no aspect of treatment was unhelpful. For other participants, level of comprehension and personal preference rendered some skills less helpful.

Overall, the helpfulness of the ACTION program seems to be strongly related to the treatment components. The core treatment components such as coping strategies, problem-solving, and cognitive restructuring appear to have been most helpful to participants. Learning new ways of managing unpleasant emotions, solving problems, and developing a more positive outlook appears to have been a very positive experience for the participants. The acquisition and application of these new skills seems to have been facilitated through the use of structured activities, rewards, and therapeutic homework assignments.

Given the fact that the participants found both the structure of treatment and the treatment components helpful, the next chapter will explore which aspects of treatment were most strongly related to the overall helpfulness of the ACTION program.

# CHAPTER NINE

# HELPFULNESS OF THE ACTION PROGRAM

As discussed in the previous chapters, the data suggest that both the structure of treatment and the treatment components were helpful aspects of the ACTION program. This chapter will explore how these factors contributed to the overall helpfulness of treatment from the perspective of the participants. It will begin with a presentation of the participant's overall evaluation of the ACTION program. This discussion will be followed by an overview of the changes that were made by the girls as a result of participating in treatment. After detailing participant changes, the factors that both facilitated and hindered positive change will be presented.

## Overall Evaluation of Treatment

During the interviews, the participants were encouraged to discuss whether or not they perceived the treatment as helpful. Many of the girls spontaneously evaluated the ACTION program while discussing their experience of treatment, making statements such as "It really helped me." When participants did not make unprompted evaluations, they were directly encouraged to assess the helpfulness of treatment. Of the 17 girls that participated in the study, all of them indicated that the ACTION program was helpful. This is an interesting finding given the fact that two of the participants were still depressed at post-treatment.

Although all of the participants found treatment to be helpful, the level helpfulness varied from high to low. Ten participants, or approximately 59%, described the ACTION program as being very helpful. For example, Alexandra reported "Yeah...it really helps you a lot. It helped me a lot." Paris agreed. When discussing her experience

of the ACTION program, she reported "It really helped me." Danielle also had a very positive evaluation of the ACTION program. When asked about the strengths of the intervention, she replied "Everything." Danielle reported that there was "nothing" bad about the treatment and that she would not change any aspect of it. Other participants that perceived the treatment as highly helpful included Mia, Angelina, Devora, Sarah, Lydia, Jamilla, and Sophie. All of the participants that rated treatment as a highly helpful no longer met criteria for depression by the end of the program.

For other participants, treatment was less helpful. Five girls, or approximately 29%, indicated that it was only mildly helpful. For example, Mahina reported that she had a mixed experience. When asked if the treatment helped her, she replied "Um…yeah, it did. But it did and then it wouldn't." Olivia had a similar experience, she indicated that the ACTION program was helpful, but said that it only helped "a little bit." Courtney, Gwendolyn, and Lucia also saw the ACTION program as only mildly helpful. Lucia, Courtney, and Mahina no longer met criteria for a depressive disorder at the end of treatment. Olivia and Gwendolyn, on the other hand, continued to experience depression at the time of the post-treatment assessment.

Given the fact that two of these participants did not recover from their depressive episodes by the end of treatment, level of helpfulness of treatment seemed to depend, in part, on symptom remission. That is, girls that did not recover from their depressive symptoms, found the treatment to be less helpful. However, since the remaining three participants that rated the ACTION program as less helpful did experience a full remission of depressive symptoms, level of helpfulness of treatment seemed to depend on additional factors.

One of these factors seemed to be perceived level of positive changes. Some of the participants that perceived the ACTION program as less helpful indicated that they

made fewer positive changes over the course of treatment compared with participants that perceived treatment as highly helpful. For example, when asked if she changed as a result of being in the ACTION program, Gwendolyn replied “Mmm…kind of…not exactly.” Olivia had a similar experience. She reported that she made “some” changes, but not many during the course of treatment. Thus, for these participants, treatment was less helpful because it did not help them to make positive changes.

Some girls did make positive changes over the course of treatment, yet they still evaluated the ACTION program as less helpful. For these girls, treatment seemed to be less helpful because it was less responsible for their positive changes. For example, Courtney reported that she did make positive changes over the course of treatment; however, she viewed the ACTION program as only mildly helpful because these changes were not directly related to being in treatment. When asked if the ACTION program helped her, Courtney replied “A little bit, but, uh, I know that part was just because I was making more friends. During the summer I didn’t have many friends, but I made two new friends this school year.” Thus, Courtney attributed some of the positive changes that she made to factors that were external to the ACTION program (e.g., making friends outside of group). Since these changes were not produced by treatment, Courtney viewed the intervention as less helpful. Factors that may have affected these girls’ ability to make positive changes will be discussed in detail later in this chapter.

Two participants, Alika and Shaneika, did not specify the degree of helpfulness of treatment when asked to evaluate the ACTION program. These girls simply stated that the treatment was helpful without indicating if it helped them a little or a lot. Both of these participants no longer met criteria for a depressive disorder at the end of treatment. Information provided in the interviews gave clues as to whether or not these participants found the ACTION program mildly, moderately, or highly helpful. For example, when

asked how she would change the ACTION program, Shaneika indicated that she would not change it in any way. She also indicated that if she had not been in the program, then she would "probably still be having problems." Alika had a similar experience. She indicated that being in the ACTION program made "all of (her) problems go away." Thus, although they did not specify the degree of helpfulness of the ACTION program in their interviews, it seems that the intervention was fairly helpful for both of these participants.

In sum, the ACTION program was perceived as helpful by all of the participants. The majority of participants (approximately 59%) evaluated the treatment as highly helpful. Some participants (approximately 29%) found it to be only mildly helpful, and other participants (approximately 12%) seemed to view it as highly helpful despite not having explicitly stated a degree of helpfulness. Thus, most participants (12) perceived treatment as highly helpful. The following section will discuss why the majority of participants rated the ACTION program in this manner.

## Changes Associated with Treatment

Since all of the participants indicated that the ACTION program was helpful in some way, it was important to determine what it was about the treatment that contributed to this evaluation. Therefore, the participants were asked to discuss how the treatment helped them. In response to this inquiry, most of the girls talked about the ways in which the treatment produced "positive changes" in their lives. A pattern emerged among the data that suggests that the treatment helps participants by producing positive changes in several areas of functioning. The following section will present the changes that were experienced by the participants over the course of treatment in the following areas: stressors, stressor management, emotions, outlook, and social support.

### *Stressors after Treatment*

Throughout the interviews, participants were encouraged to describe experiences before and after treatment. Many of the girls indicated that the ACTION program was helpful because it produced positive changes related to stressors. That is, as a result of being in treatment, several of the girls experienced an overall decrease in the amount of problems or stressful events. For example, Mahina reported "It helped me in a lot of ways to solve my problems." The following section will describe how stressors changed over the course of treatment according to the participants.

#### *Amount*

Most of the participants indicated that they continued to experience stressors at the end of treatment. Overall, the amount of problems that the girls reported decreased. Prior to treatment, the participants reported experiencing an average of three stressors. After treatment, the girls indicated that they experienced an average of one stressor. Thus, the amount of stressors declined substantially over the course of treatment.

#### *Domain*

The participants continued to experience stressors in both the interpersonal and academic domains. As seen with the pre-treatment stressors, stressors experienced at the end of treatment were disproportionately in the interpersonal domain. In fact, approximately 83% of stressors described by participants as occurring after treatment were characterized as interpersonal. The vast majority (approximately 70%) of these interpersonal stressors were conflict-oriented in nature. Only one participant reported experiencing a loss-oriented stressor after treatment. Specific interpersonal stressors included rumors, bullying, getting into trouble, and conflict with or between parents.

### *Duration*

In terms of duration, the participants' post-treatment stressors were less chronic compared with their pre-treatment stressors. Prior to treatment, approximately two thirds of the stressors that were reported by the participants were chronic. After treatment, the girls reported an equal number of chronic and acute stressors. Thus, stressors became less chronic over the course of treatment.

### *Controllability*

The controllability of stressors also seemed to change over the course of treatment. Before being in the ACTION program, the participants reported experiencing slightly more uncontrollable than controllable stressors. Interestingly, after treatment, the girls reported experiencing a much higher rate of uncontrollable stressors. In fact, approximately 90% of the post-treatment stressors reported by the participants were characterized as uncontrollable. Thus, over the course of treatment, stressors became less controllable in nature.

### *Stressor Changes and the Treatment Components*

According to some participants, positive stressor changes were related to learning and using core treatment components such as coping strategies and problem-solving. This was the case for Lucia. When discussing how she changed over the course of treatment, she replied "Yeah, like, it was easier for me to deal with problems." Lucia stated the ACTION program was helpful because many of the stressors in her life had improved as a result of learning problem-solving and using it for specific issues (e.g., fights with other girls). Thus, acquiring and applying specific skills to specific problems helped many of the participants resolve these issues and, therefore, experience an overall decrease in stressors over the course of treatment.

### *Stressor Management after Treatment*

Another area of functioning that was affected by treatment was stressor management. As discussed previously, prior to being in the ACTION program, the majority of participants utilized emotion-focused stressor management strategies to cope with difficulties. These strategies were equally divided in terms of their approach with approximately half being active and half being passive, and most techniques had a low level of helpfulness since they either did not resolve the problem or they did not make the participant feel better.

To better understand how stressor management strategies changed as the result of being in treatment, participants were asked to describe how they coped with stress, problems, and/or unpleasant emotions after having completed the ACTION program. Once again, participants responded to stressors in a variety of ways; however, the stressor management strategies that they employed after treatment were somewhat different than those used before treatment. For a summary of the characteristics of post-treatment stressor management strategies as well as the number of participants that used each technique, please refer to Table 9.

#### *Type*

In terms of strategy type, the post-treatment stressor management techniques described by the girls included seeking social support, distraction, positive thinking, relaxation, denial/ignoring, physical release, social withdrawal, and problem-solving. Seeking social support, distraction, positive thinking, relaxation, and physical release were grouped together under the category coping strategies since these five skills are specifically taught in the ACTION program and the participants often referred to them in this way during the interviews. Two new strategies emerged from pre- to post-treatment: positive thinking and physical release. These techniques are explicitly taught in the

ACTION program. It is interesting to note that emotional release, the pre-treatment stressor management strategy that was most commonly used by participants, was not discussed by any of the girls after treatment. In addition, the participants no longer used rumination after treatment.

Table 9

*Characteristics of Post-Treatment Stressor Management Strategies*

| Strategy | Participants | Domain | Approach | Level of Helpfulness |
|---|---|---|---|---|
| Seeking Social Support | 9 | Emotion-focused | Active | High |
| Distraction | 8 | Emotion-focused | Active | High |
| Positive Thinking | 4 | Emotion-focused | Active | High |
| Relaxation | 3 | Emotion-focused | Active | High |
| Physical Release | 2 | Emotion-focused | Active | High |
| Denial/Ignoring | 3 | Emotion-focused | Passive | Low |
| Social Withdrawal | 2 | Emotion-focused | Passive | Low |
| Problem-solving | 10 | Problem-focused | Active | High |

*Note.* Participants = Number of participants that reported using a specific strategy.

### *Amount*

With regard to the amount of strategies used after treatment, participants described using approximately two and a half stressor management techniques to cope with stress. This varied considerably across participants, with some girls stating that they consistently used one strategy for managing stress, whereas other girls reporting that they used up to five different techniques. It is interesting to note that prior to treatment, the girls reported using an average of two strategies. Thus, the amount of stressor

management strategies used by the participants did not increase significantly over the course of treatment.

### *Domain*

Post-treatment stressor management strategies continued to be classified by two distinct domains: emotion- and problem-focused. Emotion-focused techniques included the five coping strategies, denial/ignoring, and social withdrawal. Problem-focused strategies included problem-solving. As with pre-treatment stressor management strategies, the techniques used by participants after the ACTION program were predominantly emotion-focused. Of the 45 strategies that were described by the participants as being used after treatment, approximately 73% were emotion-focused. Thus, the girls continued to utilize emotion-focused stressor management strategies at a much higher rate compared with problem-focused strategies after treatment.

### *Approach*

Stressor management strategies continued to vary in terms of their approach and level of helpfulness after treatment. Once again, strategies were seen as active or passive. The approach of stressor management strategies changed significantly from pre- to post-treatment. Before treatment, participants used active stressor management strategies approximately 50% of the time. After being in the ACTION program, the girls reported that they used active stressor management strategies approximately 89% of the time. Thus, from pre- to post-treatment, the girls increased their use of active stressor management strategies by approximately 39%.

### *Level of Helpfulness*

Level of helpfulness of stressor management strategies continued to vary from high to low over the course of treatment, and continued to depend on whether or not use

resulted in an improved mood or a less stressful situation. Over the course of treatment, the overall level of helpfulness of specific stressor management strategies increased, with more girls reporting that their post-treatment stressor management techniques helped manage unpleasant emotions or resolve stressful situations. Thus, stressor management strategies became more helpful by the end of treatment.

***Emotion-Focused Post-Treatment Stressor Management Strategies***

The most commonly employed emotion-focused post-treatment stressor management strategies were the coping strategies. These techniques were specifically taught in the ACTION program and included seeking social support or "talking to someone," distraction or "doing something fun and distracting," positive thinking or "thinking about it in a more positive way," relaxation or "doing something soothing and relaxing," and physical release or "doing something that uses energy." Some of the participants continued to use other emotion-focused stressor management strategies after treatment such as denial/ignoring and social withdrawal.

*Seeking social support.* Seeking social support was the most commonly employed coping strategy after treatment. Nine participants indicated that they used this technique when faced with stressful situations. Seeking social support involved talking with friends or family members about feelings associated with a stressor. This emotion-focused strategy was seen as active because it involved direct attempts to manage unpleasant emotions related to stressful events. Seeking social support was rated as a helpful post-treatment strategy since it often resulted in an improved mood. Despite having an inconsistent level of helpfulness before treatment, several participants continued to use this strategy after treatment. In fact, four out of five girls (Angelina, Mia, Danielle, and Gwendolyn) used seeking social support before and after treatment.

*Distraction.* Another coping strategy that was used by many of the participants (8 out of 16) after treatment was distraction. This strategy involved attempts to improve mood by decreasing rumination about a stressor through activities such as playing with friends, doing a fun activity, watching television, or counting to ten. Distraction was classified as an active strategy because it was used to directly manage unpleasant emotions related to a stressor. Overall, the participants rated it as a very helpful stressor management strategy.

*Positive thinking.* Four participants reported using positive thinking as a means of managing unpleasant emotions related to a stressor after treatment. This strategy involves shifting attentional focus from a stressful event to a positive event in an effort to improve mood. For example, Courtney reported that she attempts to think about positive things to circumvent feelings of sadness: "But, you know, now, if I feel sad, I just think about something happy and something good. It keeps me from being sad." Positive thinking was characterized as an active stressor management strategy since it involved direct attempts to influence mood. Overall, it was rated as very helpful by the participants that described using it because it successfully improved mood.

*Relaxation.* Three of the participants described using relaxation as a stressor management strategy after treatment. One of these girls, Jamilla, had reported using it prior to treatment. All of the participants that used relaxation after treatment indicated that they listened to music in an effort to manage unpleasant emotions related to a stressful situation or event. This coping strategy was classified as active since it involved direct attempts to improve mood. The girls that reported using it, rated relaxation as a helpful skill. They indicated that it helped to "calm them down."

*Physical release.* Physical release was defined as doing some form of physical activity in an attempt to manage stress. Two participants reported using physical release

as a post-treatment stressor management strategy: Jamilla and Alika. Jamilla indicated that she "played basketball with friends" when she was experiencing unpleasant emotions and Alika reported that she went running with her dog when she was upset. Physical release was classified as an active coping strategy since it involved direct attempts to manage stress. For both Jamilla and Alika, physical release was a useful strategy because it decreased their feelings of stress.

*Denial/ignoring.* Three participants reported using denial/ignoring as a post-treatment emotion-focused stressor management strategy. It is interesting to note that two of the three girls, Olivia and Mahina, had reported using this strategy prior to treatment. For Mahina, denial/ignoring involved trying to "not care" about the situation with her absent father: "I really don't bother. My dad or trying anything 'cause I mean, nothing's really going wrong anymore just 'cause I don't care." For Olivia and Sarah, denial/ignoring involved attempts to "ignore" problems or stressors. Denial/ignoring continued to be a passive strategy with a low level of helpfulness.

*Social withdrawal.* Two participants reported using social withdrawal as a post-treatment emotion-focused stressor management strategy. Once again, this technique involved withdrawing to a bedroom in the face of stress. Although the strategy itself was rated as passive, once in the bedroom, one of the participants actually engaged in more active strategies such as thinking positive. Thus, in this one instance social withdrawal was seen as helpful because it set the stage for more active coping strategies that resulted in improved mood. Overall, however, social withdrawal continued to be a passive strategy with a low level of helpfulness.

***Problem-Focused Post-Treatment Stressor Management Strategies***

*Problem-solving.* The number of participants that reported using problem-solving as a problem-focused stressor management strategy doubled from pre- to post-treatment.

After treatment, ten participants indicated that they used this technique to cope with stress. It is interesting to note that, despite its low level of helpfulness prior to treatment, all of the participants that used problem-solving before treatment continued to use it after treatment. After treatment, problem-solving was used for academic and interpersonal stressors such as trying to improve grades and trying to resolve conflicts with friends. Once again, problem-solving was seen as an active strategy since it involved direct attempts to solve a problem that was producing stress.

Overall, problem-solving had a higher level of helpfulness after treatment than it did prior to treatment. Level of helpfulness seemed to depend on stressor characteristics. When used with controllable stressors, problem-solving was seen as a very helpful stressor management technique. Interestingly, only one participant reported using problem-solving with an uncontrollable stressor. Mia reported that she used this skill when rumors were being spread about her at school. In this instance, she was not able to solve the problem; however, she reported feeling better because she had taken action to change it. Thus, problem-solving appears to be helpful even when it is used with uncontrollable stressors if it results in an improved mood.

***Coping Style***

It is important to note that stressor management preference or coping style did not change significantly across treatment. The participants tended to have emotion-focused, problem-focused, or mixed emotion- and problem-focused coping styles. Although some of the specific stressor management strategies changed from pre- to post-treatment, many of the girls continued to use techniques from the same domain. In other words, coping style remained fairly consistent across treatment.

Seven of the participants were classified as having an emotion-focused coping style across treatment. Included in this category were Sophie, Alika, Courtney, Jamilla,

Olivia, Gwendolyn, and Lydia. Courtney is a good example. Prior to treatment, she used two emotion-focused strategies to cope with stress: emotional release and social withdrawal. After treatment, she replaced these specific strategies with positive thinking, which is another emotion-focused strategy. Thus, although the specific skills changed across treatment, Courtney's coping style remained consistently emotion-focused.

Only one participant held a problem-focused coping style across treatment. Shaneika reported that she used problem-solving in the face of pre-treatment stress and she continued to employ this strategy after treatment. It is interesting to note that Shaneika was the only participant that used problem-solving correctly before treatment. Most of the other girls either did not generate multiple solutions for their pre-treatment problems or they attempted to use it with an uncontrollable stressor. Shaneika, on the other hand, used this strategy with a controllable stressor and she came up with several solutions for her problem. After treatment, she continued to use this strategy correctly.

Across treatment, four participants endorsed using a mixed coping style that included strategies that were both emotion- and problem-focused. For example, Danielle reported that, prior to treatment, she used problem-solving, denial/ignoring, social withdrawal, and seeking social support when faced with stressful events. After treatment, she continued to utilize a mixed coping style, which included distraction, seeking social support, and problem-solving. Other participants that used a mixed coping style across treatment included Lucia, Mahina, and Paris.

About one third of the girls expanded their coping style by adding problem-solving. For example, Mia reported that prior to being in the ACTION program she coped with stressful events by seeking social support and through denial/ignoring. Thus, her coping style was emotion-focused. After treatment, Mia stated that she preferred distraction, relaxation, and seeking social support; however, she also reported that she

used problem-solving. Over the course of treatment, Mia's coping style change from emotion-focused to mixed. This was the case for Angelina, Alexandra, Devora, and Sarah.

Overall, the majority of participants seemed to have a specific coping style that remained consistent from pre- to post-treatment. In fact, the data suggest that 12 out of 17 girls (approximately 70%) held the same coping style over the course of treatment, with seven having emotion-focused coping styles, one having a problem-focused coping style, and four having mixed emotion- and problem-focused coping styles. Thus, only five participants broadened their emotion-focused coping style as a result of being in the ACTION program by incorporating problem-focused strategies. Despite the fact that many participants did not change their coping style across treatment, almost all of the girls used more active and more effective emotion- and problem-focused stressor management strategies.

### *Emotional Experience after Treatment*

According to the participants, one of the ways in which the ACTION program helped them to feel better was that it produced positive changes related to their emotional functioning. As discussed in Chapter Six: Pre-Treatment Functioning, the participants' pre-treatment emotional experience was characterized by moderate to high levels of fairly severe, unpleasant emotions. By the end of treatment, the majority of participants described their emotional functioning in positive terms. Overall, many of the girls stated that treatment was helpful because it improved their mood. This improvement in mood seemed to be related to either an increase in pleasant emotions (e.g., happiness, enthusiasm) or a decrease in unpleasant emotions (e.g., sadness, anxiety), and seemed to be facilitated by acquiring and applying specific treatment components.

### *Increase in Pleasant Emotions*

Many participants indicated that they felt an increase in pleasant emotions at the end of treatment. For example, when asked how she felt at the end of the ACTION program, Mia stated "I feel kind of happy now." Devora agreed. In describing her emotional state at the end of treatment, she said "Really, really happy." As is evident from these statements, the degree of happiness experienced by the participants seemed to vary from moderate to high.

For these participants, the ACTION program was perceived as helpful because this increase in pleasant emotions led to an overall improvement in mood. This was the case for Paris: "I think that my opinion was that it's a good program that you can go through if you're having bad things going on and if you want to be happy – er – happier. And that's why it helped me." Thus, for Paris, the program was helpful because it made her feel happier. Alexandra had a similar experience. When asked why she felt that the ACTION program was helpful, she indicated "I'm kinda mostly all the time happy." Thus, for these girls, treatment was perceived as helpful because it led to an increase in pleasant emotions, which resulted in an overall improvement in mood.

### *Decrease in Unpleasant Emotions*

Experiencing a decrease in unpleasant emotions was another reason that some of the participants perceived the ACTION program as helpful. This was the case for Mia. For Mia, the treatment was helpful because it decreased her unpleasant emotions, which improved her performance in school. She explained this experience by saying:

> I think that it's helped me because now I feel better and I guess making me feel better is having less stress on me and now, 'cause at the beginning when I first started the program I was feeling kind of sad and a little upset and then when, I

> was getting kind of bad grades 'cause I wasn't really focusing on schoolwork, but then after I started doing this, it started to help me feel better and calm down and now, I'm getting As.

Thus, for some participants the positive emotional change that resulted from being in the ACTION program was a decrease in unpleasant emotions, which contributed to an overall improvement in functioning.

***Emotional Changes and the Treatment Components***

The positive emotional changes that many of the participants experienced over the course of treatment seemed to be related to learning specific treatment components such as coping strategies and affective education. For example, when explaining why she found treatment helpful, Mia said "Because it helped me identify how I was feeling and it, it also helped me because when I knew what I was feeling, I knew what I could do to help and not feel like that again." Thus, learning how to identify (i.e., affective education) and cope (i.e., coping strategies) with unpleasant emotions is the primary reason that Mia made positive emotional changes. Devora had a similar experience. When discussing how the ACTION program helped her, Devora suggested that learning how to manage her emotions by acquiring and using coping strategies resulted in an increase in pleasant emotions and a decrease in unpleasant emotions:

> Mmm, I feel better. Mmm, (the therapists) helped me feel better about things when I'm sad and that I can do to make me feel better when I'm mad or so I don't have to be sad. Like when people are mad at me or I'm sad or make me sad, I can do stuff to make me feel better so I can be happy. Like I play with my sister or I play in my room.

Thus, helpfulness of treatment seemed to be related to an improvement in mood that is achieved by acquiring and utilizing specific skills.

## ***Outlook after Treatment***

One of the ways in which participants indicated that the ACTION program was helpful is that it produced positive changes with regard to outlook. At the beginning of treatment, many of the participants indicated that they tended to see the world and themselves in a negative light. The girls' pre-treatment outlooks were characterized by negative ways of thinking that included negative thought patterns (e.g., minimizing positive events and maximizing negative events) and negative self-directed thoughts. Over the course of treatment, the ways in which the girls viewed themselves and their worlds changed significantly. The participants developed more positive ways of thinking that included more positive self-directed thoughts and more positive thought patterns. These changes appeared to be related to treatment components such as cognitive restructuring and self-monitoring.

### ***Positive Self-Directed Thoughts***

Many of the participants reported that they experienced frequent negative self-directed thoughts at the beginning of treatment. These thoughts seemed to correspond to beliefs about worthiness (e.g., "I'm ugly") or ability (e.g., "I'm stupid"). Over the course of treatment, the participants' self-directed thoughts appeared to become more positive. The girls seemed to develop more self-acceptance and self-confidence. They began to see themselves as more worthy and more capable.

Some of the participants experienced an increase in positive self-directed thoughts about worthiness over the course of treatment. For example, at the beginning of treatment, Sophie reported that she tended to sacrifice her own needs in order to help others. She attributed this to not seeing herself as important. Over the course of treatment, Sophie discovered that she is important, worthy, and loveable. When asked how she changed, she reported

> I would always put people's problems before mine, and so I would just leave mine and they would just keep getting bigger and bigger and I would try and fix everybody else's problems. That was, like, a big thing for me, and now I guess I'm learning to let, I learned to, like, put myself first sometimes – it's okay to put yourself first sometimes…you have to love yourself too, don't always put people first – I mean it's okay to sometimes, but I guess that helped me a lot...I guess it's just, like…I just know I like myself now and I think that helps because I know I do and I know that there's certain things about my personality that I don't like and there's things that I do and that's just part of life.

Thus, over the course of treatment, Sophie's view of herself became more positive. She learned that she is loveable, and that her needs are important.

Angelina also experienced an increase in positive self-directed thoughts by the end of treatment. At the beginning of the ACTION program, Angelina reported that she "didn't really like" herself; however, at the end of treatment, she reported she saw herself as more worthy and likeable. When asked how she changed as a result of being in the ACTION program, she stated

> Yeah, I just, like, I mean I'm not like a 100%, I mean I don't think anybody is 100% okay with themselves and I, like, learned that and that helped because, you know, like, nobody's perfect and I just, like, try to do the best that I can with, like, what I am and stuff like that...just because you're not perfect doesn't mean that people won't like you.

Thus, by the end of the ACTION program, Angelina experienced an increase in positive self-directed thoughts about her level of worthiness. She gained self-acceptance and began to see herself as loveable despite not being perfect.

In addition to gaining more self-acceptance over the course of treatment, some participants experienced an increase in self-confidence. At the beginning of treatment, many participants reported that they were not confident in their abilities. Over the course of treatment, however, some participants experienced an increase in positive self-directed thoughts that corresponded to beliefs about ability. For example, when asked how she changed as a result of being in the ACTION program, Mahina reported “It made me feel more confident and happier…I felt a little more confident in myself.” Courtney had a similar experience. At the beginning of the ACTION program, she had several negative-self-directed thoughts about her ability to affect change in her life; however, by the end of treatment, Courtney held a more positive view of herself. When asked how she viewed herself at the end of treatment, Courtney replied “That I’m getting better and better at things that I used to be pretty horrible at.” Thus, some participants experienced an increase in positive self-directed thoughts about their ability over the course of treatment.

***Positive Thought Patterns***

Many of the participants developed more positive thought patterns over the course of treatment which resulted in a more positive outlook. This positive outlook varied in terms of its degree from moderate to high, and seemed to depend on the ability to increase focus on positive events while simultaneously decreasing focus on negative events. For example, when asked how she changed as a result of being in the ACTION program, Sophie reported “I think I became, like, a lot more, like, positive about my outlook. Like the way I look at things. Rather than, like, looking at the bad part of things, I would focus more on the good things and try and keep my mind set on the good things instead of the bad.” Mia had a similar experience. When asked how her mental state changed over the course of treatment, Mia reported

> Um, 'cause sometimes…I would think negative and then, so it would put me in a negative direction where I was negative all day. And then, when I started ACTION and they told me that I shouldn't think negative, I kinda thought positive and it was kinda awkward because I didn't really think positive a lot, so it kinda, that kinda changed.

Alexandra also agreed that being in the ACTION program helped her to have a more positive outlook: "Like I can look at a lot of things in the bright side." Thus, many of the participants gained more positive outlooks over the course of treatment.

***Outlook Changes and the Treatment Components***

Acquiring a more positive outlook over the course of treatment seems to have resulted from learning how to identify and challenge negative thoughts and negative thought patterns as well as learning how to shift attentional focus to the positive. That is, positive cognitive changes were related to learning cognitive restructuring techniques and self-monitoring skills. For example, Courtney reported that her outlook improved over the course of treatment as a result of learning how to restructure her negative thoughts: "Well, if I, like, think about bad things, then I would change it into good things. Change that bad into good things…I'm talking about the Muck Monster and that would make you feel bad and you change that thought around and make you feel good." Jamilla also acquired a more positive outlook by learning cognitive restructuring skills. When asked what it was about the ACTION program that helped her to make positive changes, she replied "I stopped believing in the Muck Monster. I started thinking positive things." Thus, the ACTION program was seen as a helpful intervention for several participants because learning a core treatment component (e.g., cognitive restructuring) helped these girls acquire a more positive outlook over the course of treatment.

### *Social Support after Treatment*

As discussed previously in Chapter Seven: Treatment Structure, the helpfulness of the ACTION program also seemed to depend on the ways in which the group facilitated increased social support for the participants. Prior to being in treatment, many of the girls seemed to lack social support. Several of the participants reported that they had high levels of conflict-oriented interpersonal stress and/or a lack of friendships at the beginning of treatment. However, over the course of treatment, the participants acquired more social support. Several of the participants indicated that the characteristics of group (e.g., gender-specific, same-aged peers) facilitated factors such as a sense of relatedness, trust, and problem-sharing, which increased social support. Thus, one of the main changes that occurred as a result of being in a group treatment with other girls was that many of the participants experienced an increase in social support. The structure of treatment, therefore, also contributed to the overall helpfulness of the ACTION program by producing positive changes in the lives of the girls.

### *Summary*

Over the course of treatment, the participants made positive changes in several areas. First, they experienced a decrease in stressors that seemed to be related to learning and using more active and helpful stressor management strategies. Next, they evidenced in an increase in pleasant emotions and a decrease in unpleasant emotions as well as an improvement in outlook. These emotional and cognitive changes also seemed to be related to acquiring and applying specific treatment components or strategies. Finally, some participants experienced an increase in social support. This change seemed to be related to the structure of treatment in that being in a group with other girls facilitated a sense of relatedness and support. The following section will explore the factors that contributed to as well as hindered the positive changes discussed by the participants.

## Factors that Facilitate Positive Change

The data suggest that several of the participants experienced many positive changes over the course of treatment. These changes seemed to be related to the treatment components and the structure of treatment. In order to capture how change was facilitated from the perspective of the participants, the girls were asked to identify what it was about treatment that helped them to make positive changes over the course of treatment. As expected, the participants' responses produced two specific patterns. The girls indicated that it was either the specific skills that were taught in the treatment or that it was the support of the group that helped them to feel better. Some of the participants indicated that it was both factors. The following section will discuss the participants' perspective of the aspects of treatment that facilitated positive change.

### *Treatment Components*

Many of the girls (11 out of 17) indicated that the treatment components or the specific skills were the most helpful aspect of the ACTION program because they facilitated positive change. For example, when asked what it was about the treatment that helped her, Alexandra responded "Like it, like, since we had, like, different things that you could do, like, strategies, it kinda helped me out not to think, like, negative about things that I did or about myself." Thus, for Alexandra learning the different skills in the ACTION program produced positive cognitive changes such as decreased negative self-directed thoughts. Lydia also attributed the positive changes that she made over the course of treatment to the specific skills that she learned in the ACTION program. When asked what helped her, she replied "The group, like, the problems that we discussed and the coping strategies." Thus, the majority of the participants attributed the overall helpfulness of the ACTION program to the fact that the intervention provided specific

skills that produced positive change. This finding suggests that the components that comprise treatment are the primary facilitators of positive change.

### *Treatment Structure*

Another factor that seemed to be associated with the overall helpfulness of the ACTION program was the structure of treatment. Some of the participants (2 out of 17) indicated that positive changes were also facilitated by being in group treatment in which group members provided each other with support. For example, when asked what it was about treatment that helped her to change the most, Sophie replied "I think it was, kinda, like, it was definitely the people in it. Like they really just made you feel, like, it was okay to have negative thoughts, but it's not okay to always be, like, dwelling on the negative thoughts." Mia also reported that the structure of treatment was strongly associated with positive change and, therefore, the overall helpfulness of the ACTION program. When asked what it was about the treatment that helped her, she reported

> I think it was just that you kind of, you can actually talk to people that can relate to you and that, instead of talking to people that are just, like, "Oh, I don't know what you are talking about," or something like that and so it kind of make you feel better cause they know where you are coming from and they know what you feel like and all that, so they can talk to you about it.

During her second interview, Mia continued to attribute the positive changes that she made over the course of treatment to the support of the group: "Um, well, it's probably mainly because of the support I had in the group. 'Cause, like, some, like, the girls there, they kinda knew how I was feeling and they knew what I was going through, so they kinda helped." Thus, for Mia, factors associated with the structure of treatment (e.g., support, sense of relatedness) facilitated positive change and, therefore, rendered

the ACTION program a helpful intervention. Thus, the overall helpfulness of treatment was attributed to factors associated with the structure of treatment for some participants.

### ***Treatment Components and Treatment Structure***

Some of the participants (4 out of 17) indicated that it was both the treatment components and the structure of treatment that helped them to feel better. For example, Angelina indicated that the ACTION program was helpful because it provided her with specific skills (e.g., the core treatment components) for managing unpleasant emotions, solving problems, and challenging negative thoughts. When asked why the treatment helped her to make changes, she replied "Um, well we learn, like, skills, like, problem-solving and skills, like, you know, so the skills that they taught us helped a lot." In addition, Angelina indicated that treatment was also helpful because of the support of the group (e.g., the structure of treatment). She reported that "Just getting, like, encouraged and stuff" by the other group members was another reason why she found the ACTION program to be very helpful.

Olivia agreed that the specific skills in the ACTION program as well as the support of the group facilitated positive change. When asked what it was about the treatment that helped her to make changes, she replied "All the skills that they taught us." In addition to the specific skills being a facilitator of positive change, Olivia also reported that the support of the group was helpful. When asked if the support of the group helped her to make positive changes, she said "Yeah. They were always really supportive whenever I had a problem or something." Although both factors were perceived by Olivia as helpful, she indicated that "the skills" or the treatment components were the aspect of treatment that helped her the most. Thus, for some of the participants the helpfulness of the ACTION program depended on the positive changes that were produced by both the treatment components and the structure of treatment.

## Factors that Hinder Positive Change

The data suggest that most of the participants made positive changes over the course of treatment; however, two participants continued to be depressed at the end of the ACTION program. In addition, although all of the participants stated that the intervention was helpful, some of the girls found it to be less helpful than their peers. Therefore, in addition to understanding aspects of treatment that facilitated positive change, it was important to obtain some information regarding factors that may have hindered recovery. To better understand this phenomenon, the participants were asked to discuss any factors that hindered positive change over the course of treatment. Specifically, participants that completed secondary interviews were asked if "anything got in the way of them making changes" over the course of treatment. In addition, several girls were asked to speculate about why the treatment is helpful for some girls, but not for others. The following section will discuss patterns that emerged among the participants' responses to these questions.

### *Amount and Quality of Stressors*

When discussing the factors that may hinder positive change, some of the participants speculated that the helpfulness of the ACTION program may depend on the amount and quality of stressors faced by participants. That is, the girls seemed to believe that participants with a higher number of stressors or more severe difficulties would not benefit as much from treatment as girls with fewer, less severe problems. For example, when asked what prevents some girls from making positive changes over the course of treatment, Sophie reported

> I guess, 'cause I have a friend that went through the ACTION program this past semester, and she just, like, did not like it at all. She just didn't think it helped

> her. And I think her situation was a lot more, like, intense than, like, minor situations just, like, you know, you're kinda just negative opposed to how she's just, like, constantly doubting herself and just she needs self-esteem and she just doesn't know how to deal with it all and she doesn't understand, like, she's, I guess just depending on the situation.

When asked what types of problems her friend was facing, Sophie indicated "She just, she had a lot going on at home and she just…friends, all of that, no trust, nobody trusted her and so nobody wanted to be her friend and she just had a lot of problems put together." Thus for Sophie's friend, the amount and quality of problems that she was experiencing may have influenced the level of positive changes that she made during treatment and, therefore, resulted in a less favorable evaluation of the overall helpfulness of the ACTION program.

Mahina agreed that quality of stressors may influence level of positive changes and, in turn, perceived level of helpfulness of the treatment. When asked to speculate about why the treatment helps some girls but not others, she stated "It depends – because some girls have harder problems than the other girls." Gwendolyn also felt that severity of stressor influenced the amount of positive changes that could be made during treatment. When asked why the ACTION program helps some girls but not others, she replied "Well I think that maybe, sometimes, the other girls are going, the girls that can't be helped, are going through really bad times." Thus, several of the participants speculated that the ACTION program may be less helpful for girls that have a higher number of severe problems at the beginning and over the course of treatment.

It is important to note that several participants that found the ACTION program to be a highly helpful intervention and that made many positive changes faced numerous and/or severe stressors before, during, and after treatment. For example, Paris rated the

ACTION program as highly helpful and indicated that she made several positive changes over the course of treatment despite the fact that she also reported that some of her problems had actually intensified by the end of the program. Thus, since many girls found treatment helpful despite the fact that they experienced significant stress over the course of treatment, it seems unlikely that the amount and quality of stressors can fully account for the fact that some participants did not make positive changes and, therefore, found treatment less helpful.

## *Participant Characteristics*

Other than the amount and quality of stressors, no other factors that were external to the participants were identified as hindering positive change; however, the participants identified several internal factors that were viewed as possibly preventing change. These factors included participant characteristics such as expectations, readiness for change, and comfort with problem-sharing.

### *Participant Expectations*

According to the participants, the treatment does not address all problems equally well. Although the girls are taught to cope with uncontrollable stressors, such an absent parent, this solution does not always work. For Lucia, the helpfulness of the ACTION program depended on its ability to resolve a major uncontrollable stressor in her life: parental conflict. The fact that this issue was not resolved by the end of treatment, led Lucia to rate the program as a "little bit" helpful rather than "a lot." She explained her rating by stating "No, (it's not a lot) because it's kind of still the same at home."

Mahina had a similar experience. When asked if the treatment helped her, she stated "Um…yeah, it did. But it did and then it wouldn't." Mahina explained her ambivalent feelings by saying "Oh because, um, well I remember that everything was sorta the same. Just because you're trying to make yourself feel better doesn't mean

people outside the group is going to comprehend the same way you do." She further clarified that she perceived the treatment as mildly helpful because it did not resolve all of her problems. In particular, it did not help with a major, uncontrollable stressor: an absent parent. Mahina explained "The fact that my – I still have problems to go along with it. Like it wasn't gonna change right then and there. I had to do things about it and not everything was going to be able to change around with my dad, especially."

Gwendolyn agreed that the treatment was only somewhat helpful because it did not resolve all problems. When asked if the ACTION program was helpful, she replied

> Well, it's yes and no because sometimes there were things that couldn't be helped, but sometimes there were things that could be helped just by using a coping strategy or playing a game or something, so, you know, sometimes they couldn't really do anything, so it wouldn't, you know, help.

Although many of the problems that these participants discussed were uncontrollable stressors, the data does not support the idea that stressor type influenced ability to make positive changes since. Many other participants in the study reported that they were able to make positive changes and found the ACTION program to be very helpful despite facing uncontrollable stressors that were not resolved by the end of treatment. Therefore, the key factor in the instances described above seems to be that these participants had the expectation that treatment would resolve all of their problems. When this did not occur, these participants were disappointed, which resulted in a less favorable evaluation of the ACTION program. Thus, participant expectations seemed to influence perception of the helpfulness of the treatment.

***Readiness for Change***

Another factor that seemed to prevent some of the girls from making positive changes was their degree of openness or readiness for change. Readiness for change

seemed to encompass two concepts. First, participants had to be open to change and, second, they had to be willing to put forth effort to change.

*Openness to change.* Participants that were not open to change made fewer positive changes over the course of treatment. As a result, these participants perceived the ACTION program as less helpful. For example, when asked why she felt that some girls make changes and other girls do not, Sophie replied

> I don't know. I, I guess it's just, like, some girls just make the decision that this is going to help me or automatically, "Oh, I just don't like this and it's not going to help me at all." So I guess it's your outlook from the beginning a little. Like, "Oh, I'll give it a chance," you know? Or just not at all. 'Cause at first, when I first got in ACTION I was just, like, "Ah…" like, "Is this really going help?" you know? But I gave it a chance and it really did help.

Thus, in Sophie's opinion, being open or ready for change from the start of treatment is a factor that can facilitate or hinder positive change and, therefore, affect the overall helpfulness of the treatment.

A few of the participants indicated that they had a low degree of openness for change, which resulted in a low level of positive changes. When asked to speculate about why the treatment helps some girls but not others, Olivia reported "…some girls may be, like, too depressed to, like, change at all. They might have their mind set to one thing, so they won't, they can't change it no more." When asked if this influenced her ability to make positive changes, Olivia indicated that it did. She stated

> 'Cause (the therapists and the other participants) would try to change my thinking and I knew that even though they tried and I said "Okay, I changed my mind," but

I still knew that I didn't. So, I still had the same thought. I never changed it. 'Cause I'm so hard-headed.

She went on to clarify that it was not the treatment or the therapist that hindered change for her: "Oh no. It's just…I don't know…I, I just couldn't. There's some things I just couldn't change." When asked to reflect on what got in the way for her, Olivia said

> Probably that if I know, if I know, like, if I know, know, know that it is my fault, but (the therapist and the other participants) keep on telling me that it's not, I'll still have it in mind that it is. If I have my mind stuck on something. If I have my mind, like, saying, "Okay, this is true and this is not," nobody can change it. Yes. I am - I'm hard-headed.

Thus, Olivia attributed the fact that she made few positive changes over the course of treatment to the fact that she was "hard-headed" or not open to challenging some of her fundamental beliefs. Since Olivia was not able to change these beliefs, she continued to experience sadness at the end of treatment and, therefore, perceived the ACTION program as less helpful.

*Effort to change.* Another component of readiness for change that seemed to influence the ability of participants to make positive changes over the course of treatment was their willingness to put forth effort to change. It was speculated by many of the participants that lower levels of effort would result in lower levels of positive change. For example, when asked to explain why some girls in the ACTION program make positive changes while others do not, Alexandra indicated that effort to make changes is a key factor. She stated "Like, if you try to do some of the things that (the therapists) tell you to, then it can help you. But, if you don't try, then it really isn't helping you." Mia agreed. When asked why the treatment helps some girls but not others, she concluded "So, I think it might help some girls because they actually will try stuff and some girls, it

won't help them because they don't want to try anything that they don't, they didn't make up themselves."

Participants that reported fewer positive changes over the course of treatment also thought that effort to change was an important prerequisite of positive change. For example, Mahina had an ambivalent evaluation of the ACTION program and reported that she made fewer positive changes over the course of treatment than she had hoped. When speculating about why the treatment is more helpful for some girls, Mahina concluded "So (it helps) the ones who try hard." She admitted that there were times when she "didn't try" during the ACTION program. Mahina reported that, sometimes, she did not put forth effort to participate in treatment. She stated "Like I would be, sometimes, I would be mad and I'd just be sitting here and I wouldn't' try to answer the questions." Not putting forth effort had a significant impact on Mahina. When asked about factors that cause her to "feel down now," she replied "…that I didn't try hard enough to fix my problems when ACTION was here and now I want to be back in it just to solve my problems." Mahina's level of effort seems to have influenced her ability to make positive changes in the ACTION program and her view of the treatment as helpful. Thus, for some participants, the helpfulness of the ACTION program depended on their level of effort to make positive changes over the course of treatment.

***Comfort with Problem-Sharing***

Some of the participants also believed that comfort with problem-sharing may have influenced the process of change and, therefore, the overall helpfulness of treatment. Girls that were more comfortable with problem-sharing seemed to have shared more unpleasant emotions, stressors, and negative thoughts with their group. These girls were more likely to perceive treatment as helpful. For example, when talking about her friend that participated in the ACTION program but found it unhelpful, Sophie reported that

"Sometimes I think she just doesn't feel comfortable…she can't just, right off the bat, just talk to about anything and she's really hard to get to know, so I think it's definitely just, just the person, depending on the person." Thus, since Sophie's friend was not comfortable engaging in problem-sharing, she was harder to get to know and, therefore, may not have opened up to her ACTION group. By not opening up to her group, Sophie's friend may not have received the help that she needed, which may have caused her to find treatment less helpful.

For Olivia, the ACTION program was only a "little" helpful. One of the reasons that she discussed for why she did not find treatment more helpful was that she was hesitant to engage in problem-sharing, which resulted in her not getting help with her problems. When asked if she did not receive help with her problems, Olivia stated "I didn't really talk about it with (the group). I would talk a lot. Just not about me." Gwendolyn had a similar experience. Therapist reports as well as her own report indicated that she had difficulty with problem-sharing during the course of treatment. When asked what prevented her from making changes during treatment, Gwendolyn indicated that she was not always comfortable sharing "personal" information with her ACTION group. She reported that she had the opportunity to engage in problem-sharing; however, she stated that she did not have the desire to do it: "Ah it wasn't that I never got a chance to talk about (problems), it was that I never wanted to." Thus, participants that were not comfortable with problem-sharing were less likely to talk about their problems during treatment. Not sharing problems resulted in getting less help and in making fewer positive changes over the course of treatment. Since fewer positive changes were made by these participants, they found treatment to be less helpful overall. Therefore, they had less favorable evaluations of the helpfulness of the ACTION program.

## Chapter Summary

The data support that the ACTION program is perceived as a helpful intervention. The majority of the participants found the treatment to be highly helpful because it produced positive stressor, stressor management, emotional, and cognitive changes. By the end of treatment, the participants experienced fewer stressors, acquired and applied more active and effective stressor management strategies, experienced an improvement in mood related to a decrease in unpleasant and an increase in pleasant emotions, and experienced more positive ways of thinking including more positive self-directed thoughts and more positive thought patterns. These changes resulted from the acquisition and application of specific treatment components such as coping strategies, problem-solving, cognitive restructuring, and self-monitoring. Thus, the treatment components were the primary factor that facilitated positive change over the course of treatment and, therefore, rendered the ACTION program helpful in the eyes of the participants.

Some of the participants also reported that treatment facilitated positive change in the realm of support. Many of the girls reported that they lacked friends at the beginning of treatment and/or experienced high levels of interpersonal conflict. For these girls, being able to trust and to share problems with peers that were experiencing similar difficulties was a very positive experience that contributed to increased social support. Thus, for these participants, the structure of treatment facilitated a positive change (e.g., increased support) that contributed to the overall helpfulness of the intervention.

Overall, the participants attributed the helpfulness of the ACTION program to two main factors: the treatment components and the structure of treatment. The data suggest that the treatment components were primarily associated with the helpfulness of the ACTION program because they were responsible for positive change related to stressors, stressor management, emotions, and outlook. The structure of treatment was also helpful

because it increased social support and provided a safe place in which to learn and practice new skills. Thus, both aspects of treatment were important for facilitating positive change and, therefore, influencing treatment evaluation and outcome.

Not all of the participants found the ACTION program to be highly helpful. The participants speculated that several factors may hinder the process of change and, therefore, render treatment less helpful. Some of the girls speculated that the amount and quality of stressors may have influenced change; however, the data do not support this hypothesis. Participants with numerous and severe stressors were able to make positive changes over the course of treatment despite the fact that the intervention did not resolve all of their difficulties.

The data suggest that factors related to participant characteristics were primarily responsible for hindering positive changes over the course of treatment. These factors included participant expectations, readiness for change, and comfort with problem-sharing. Participants that had the unrealistic expectation that the ACTION program would solve all of their problems found the treatment to be less helpful. In addition, participants that were not ready or willing to put forth effort to change made fewer positive changes over the course of treatment and, therefore, rated the ACTION program less favorably. Finally, participants that engaged in low levels of problem-sharing due to discomfort with self-disclosure also found the ACTION program to be less helpful. Thus, participant characteristics seemed to significantly influence treatment outcome and evaluation.

The next chapter will present an integrated discussion of all of the findings from the present study. In addition, it will present a model for the mechanisms of change in the ACTION program.

# CHAPTER TEN

# DISCUSSION

Although current research has demonstrated that some forms of psychosocial interventions for depressed youth are efficacious, studies examining the process of child and adolescent therapy continue to be quite rare. In the quest for streamlined and empirically supported interventions that seek to optimize recovery from psychological disorders, the question of how and why certain treatments work becomes crucial. The present investigation attempted to better understand the mechanisms of change in a group CBT intervention for depressed, pre-adolescent girls. The initial focus of the study was on how participants recalled, comprehended, used, and evaluated the specific treatment components (i.e., specific factors) in relation to the overall efficacy of the intervention. However, as the data collection and analysis process unfolded, it became clear that common factors, or non-specific mechanisms of change, played an essential role in treatment outcome. Therefore, these factors were also explored.

This investigation began with several, broad research questions that attempted to capture treatment experience, evaluation, and outcome from the perspective of the participants:

1. How is a group CBT intervention for depressed girls perceived by the participants? Is the treatment helpful? How effective is the treatment in reducing depressive symptoms, increasing skills, and elevating mood from the perspective of the participants?
2. Are there identifiable stressors that are associated with depression? If so, what are they? How do the participants manage these stressors prior to treatment?

How do their stressor management strategies change as a result of being in treatment?

3. How do the participants experience treatment? Do they change over the course of treatment? What changes do they make? What factors (i.e., specific or non-specific) influence change?
4. How do the treatment components influence change? Which treatment components are most frequently recalled, best understood, most frequently used, and perceived as most helpful? How do these skills help? Which components are least recalled or perceived as least helpful?

These inquiries can be condensed into two main questions: (1) Does the treatment work? and (2) How does the treatment work? These more succinct inquiries will serve as a guide for discussing the study results. First, the following chapter will present a summary of the findings and, where appropriate, will discuss these results in relation to existing research. Next, implications for research and intervention will be explored. Finally, a summary of study limitations and conclusions will be presented.

**Question 1: Does the Treatment Work?**

Prior to treatment, all of the participants were diagnosed with a depressive disorder. In addition, many of the participants had comorbid conditions such as anxiety or behavioral disorders. By the end of treatment, approximately 88% of participants no longer met criteria for depression. In addition, many participants had also recovered from comorbid anxiety disorders. Thus, in this particular cohort of participants, the intervention appears to be extremely efficacious in treating depressive disorders. Furthermore, treatment also seems to be fairly efficacious in terms of reducing symptoms of anxiety. The rate of recovery from depression is consistent with preliminary estimates

of the overall efficacy of the treatment (K.D. Stark, personal communication, June 22, 2007).

In addition to information gathered on pre- and post-treatment assessment measures that suggests that the treatment relieved depressive symptoms at high rates, data gathered via the semi-structured interviews indicate that most of the participants reported significant improvement in functioning over the course of treatment. The following section will attempt to answer the question of whether or not the treatment works by summarizing these changes.

### *Overview of Pre-Treatment Functioning*

At the beginning of treatment, the participants experienced significant psychological distress that led to impairment in several areas. The data suggest that this distress was intimately linked with the inability to cope with multiple stressors, which led to unpleasant feelings and a distorted outlook. The following section will summarize the findings regarding the participants' pre-treatment functioning.

#### *Pre-Treatment Stressors*

As discussed in Chapter Six: Pre-Treatment Functioning, the participants reported experiencing many stressors prior to participating in the ACTION program. These stressors varied in terms of their domain, duration, and controllability. That is, they were classified as academic or interpersonal, chronic or acute, and controllable or uncontrollable.

The majority of stressors experienced by the girls prior to treatment were interpersonal in nature. Given the age and gender of the participants, this finding is consistent with current research which suggests that adolescent girls experience higher rates of interpersonal stress than their male peers (Compas & Wagner, 1991; Larson & Ham, 1993; Leadbeater, Blatt, & Quinlan, 1995; Little & Garber, 2000; Shih et al., 2006).

Furthermore, the fact that the girls reported experiencing numerous interpersonal stressors in the context of the development of depressive disorders is consistent with previous research that has shown that interpersonal stressors are positively correlated with increases in depressive symptoms and decreases in self-esteem in adolescent girls (Leadbeater et al., 1995; Little & Garber, 2000; Moran & Eckenrode, 1991).

With regard to duration, the participants' pre-treatment stressors tended to be somewhat more chronic than acute in nature, which contradicts recent findings in the literature that suggests that depression is more closely related to discrete stressors (Shih et al., 2006). Previous studies, however, have demonstrated a significant link between chronic stressors and depression in adults and adolescents, with some investigations suggesting that chronic stress is a stronger predictor of depressive symptoms than acute stress (see Hammen, 2005 for a review). Thus, findings from the present study, which suggest that there is a link between depression and chronic stress, seem to be supported by past investigations of these variables in adults and youth.

In addition to experiencing more chronic stress, participants also tended to experience slightly more uncontrollable than controllable stressors prior to treatment. This finding is consistent with current research that indicates that depressed children, particularly females, tend to experience higher rates of stressful life events that are uncontrollable or independent of their behavior than anxious or non-depressed children (Williamson, Birmaher, Dahl, & Ryan, 2005). This finding does contrast some previous research, which has demonstrated that late adolescent girls and adult women with histories of depression tend to experience more stress that is self-generated or controllable than independent or uncontrollable (see Hammen, 2005 for a review). These mixed findings may suggest a developmental trend with regard to controllability of stressors and the onset and recurrence of depression in females. That is, in younger girls,

uncontrollable stressors are more closely associated with the development of depression, whereas self-generated or controllable stress is more strongly linked with on-going depressive symptoms and episodes in adolescent and adult women.

***Pre-Treatment Stressor Management Strategies***

In response to these stressors, the participants tended to use mostly emotion-focused stressor management strategies that had low levels of helpfulness. Given the age, gender, and internalizing symptoms of the participants, this finding is consistent with research on age and gender effects on coping as well as with literature on coping and depression. Studies have consistently shown that girls engage in higher rates emotion-focused coping compared with their male peers (Broderick & Korteland, 2002; Compas et al., 1988; Hampel & Petermann, 2005). Furthermore, recent research shows that early adolescent girls, defined as 5th and 6th graders, demonstrate a decrease in adaptive emotion-focused coping strategies (e.g., distraction) and an increase in maladaptive emotion-focused techniques (e.g., rumination) compared with same-aged male peers as well as with younger and older females (Hampel & Petermann, 2005). Finally, use of emotion-focused stressor management strategies has been shown to be associated with depression and other internalizing symptoms in youth (Compas et al., 1988; Rafnsson et al., 2006).

In addition to using mostly emotion-focused techniques, another characteristic of the participants' pre-treatment stressor management strategies is that they were somewhat more passive than active in nature. This finding is consistent with the extant literature which suggests that depressive symptoms in youth are positively correlated with passive, avoidant coping and negatively correlated with use of active, approach strategies (Bokszczanin, 2003; Herman-Stahl et al., 1995; Herman-Stahl & Peterson, 1996; Muris et al., 2001).

With regard to number of strategies employed by participants prior to treatment, the data suggest that the girls used several techniques; however, these strategies had a low level of helpfulness because the participants lacked knowledge of more effective ways of coping. This finding is consistent with a study by Jeney-Gammon and colleagues (1993) that showed that depressed children actually engaged in more, albeit less effective, coping strategies in the face of a major stressor than their non-depressed peers. Similarly, the girls in the present study attempted to resolve the numerous pre-treatment stressful events in their lives in many ways; however, since they lacked knowledge of how to effectively do this, they were unsuccessful.

***Pre-Treatment Emotions***

Given the fact that the participants were unable to cope effectively with the significant amount of stress in their lives, it is not surprising that their pre-treatment emotional state was characterized by a moderate to high level of fairly severe, unpleasant emotions. The most frequently experienced emotion prior to treatment was sadness, and the most common combination of feelings was sadness and anger. Since depression in children and adolescents is characterized by a pervasively sad or irritable mood, this finding is not surprising. It is interesting to note that none of the girls discussed feeling pleasant emotions prior to treatment. Thus, the participants' pre-treatment moods seemed to have been exceptionally bleak.

The data suggest that unpleasant emotions were generally the consequence of an identifiable pre-treatment stressor, which lends support to the theory that depressive symptoms are usually preceded by stressful life events (see Hammen, 2005 for a review). In addition, participant characteristics (e.g., knowledge) in relation to stressor management strategies seem to have also influenced pre-treatment mood. When participants' lacked the ability to successfully manage stressors, they became despondent.

Thus, the participants' dysphoric affect and subsequent depression seems to have resulted, in part, from both the experience of stressful events and the inability to resolve them. Inability to manage stressors successfully seems to have been the consequence of lacking knowledge of effective stressor management strategies as discussed previously.

These findings are consistent with results in the coping and stress literature that suggest that coping mediates psychological well-being following stressful events. According to researchers in this area, effective coping protects against the development of psychological symptoms in the presence of stressors, whereas ineffective coping creates vulnerability to psychiatric disorders (Compas et al., 2001; D'Zurilla & Nezu, 2001). Thus, the girls' inability to manage pre-treatment stressors successfully, which was the result of their lack of knowledge of effective coping, increased their risk for depression in the face of so much chronic, uncontrollable, interpersonal stress.

***Pre-Treatment Outlook***

The data suggest that the participants' inability to effectively manage their stressors affected their pre-treatment outlook in two significant ways. First, they experienced high rates of negative self-directed thoughts about their worthiness and/or ability. Second, the participants developed negative thought patterns in which they disproportionately focused on negative rather than positive events. The ways in which the participants' cognitions changed is strikingly similar to existing theories of depression. As discussed in Chapter Two: Review of the Literature, Beck's (1967; 1979) cognitive theory of depression suggests that adults with depressogenic vulnerability possess underlying maladaptive schema or cognitive representations that trigger the disorder in the face of stressors. The participants' negative self-directed thoughts and negative thought patterns are almost identical to descriptions of consistent negative views

of the self (i.e., core beliefs of worthlessness, helplessness, or undesirability) and typical cognitive errors (i.e., magnification/minimization) proposed by this theory.

Although the participants' pre-treatment cognitions were similar to those posited by Beck and colleagues (1979), results from the present study are somewhat inconsistent with the cognitive theory of depression in that these negative ways of thinking did not seem to be latent. Instead, the data suggest that the participants' negative self-directed thoughts and negative thought patterns developed as a result of experiencing multiple stressors and employing ineffective coping strategies. In fact, recent research has suggested that in children, but not adolescents, negative cognitions may be the effect rather than the predictor of depressive symptoms (McGrath & Repetti, 2002; Timbremont & Braet, 2006).

Furthermore, the finding that the girls' negative cognitions developed after stressful events is consistent with relatively recent longitudinal research that examined the effect of negative life events on cognitions in pre-adolescents. In this study, results suggested that higher levels of negative life events significantly predicted more depressive attributions in the year following the stressors and incremented the prediction of more hopelessness in the subsequent two years (Garber & Flynn, 2001).

Findings from the present study appear to be consistent with these results as well as other studies (e.g., Bruce, Cole, Dallaire, Jacquez, Pineda, & LaGrange, 2006) and support the idea that the pathways to depression in children may be different than in adolescents and adults. Perhaps in childhood, negative cognitions develop from feelings of hopelessness and dysphoric affect that are caused by ineffective coping with stressful events. It is possible that these negative ways of thinking then become ingrained as personality and cognitive capabilities develop and mature, and serve to fuel future episodes of depression in the face of stressors in adolescence and adulthood. Thus, since

Beck's cognitive theory is based on adult depression and the data in this study were collected from pre-adolescents, the discrepancy between these models is most likely the result of a developmental phenomenon.

### *Pre-Treatment Functioning and Developmental Factors*

In the present study, the combination of multiple stressors and ineffective stressor management strategies, therefore, resulted in feelings of sadness and anger. In addition, the participants seemed to begin to view themselves as unworthy and incapable, and they started to maximize the negative events in their lives while simultaneously ignoring the positive ones. This chain of events led to marked distress that developed into depressive disorders, which significantly impaired pre-treatment functioning.

During adolescence, friendships and peer affiliation become particularly meaningful as youth attempt to master a central developmental task of establishing a sense of personal autonomy and identity that is unique from the family (Compas & Wagner, 1991). The need to connect with others seems to be higher in adolescent girls than adolescent boys (Little & Garber, 2000). As a result of this increased emphasis on peer relationships, which results in heightened levels of self-disclosure, adolescent girls may become more vulnerable to loss and rejection in their social relationships (Compas & Wagner, 1991). It has been speculated that adolescent girls are at an increased risk for depression due to a greater investment in interpersonal relationships compared with their male peers (e.g., Cyranowski, Frank, Young, & Shear, 2000); however, this assertion has rarely been supported in empirical investigations (see Nolen-Hoeksema & Girgus, 1994 for a review). Thus, interpersonal investment alone does not seem to be a sufficient risk factor for depression in adolescent girls.

Some researchers (e.g., Beck, 1983; Blatt, 1974) have speculated that specific cognitive-personality styles, such as an interpersonal orientation, can create

depressogenic vulnerability when combined with domain-specific stress. These theories have been merged together to form what is generally referred to as the personality-event congruence hypothesis of depression. Briefly, according to Beck (1983) individuals generally have one of two primary cognitive-personality styles: sociotropric or autonomous. Individuals with a sociotropric style are primarily concerned with interpersonal relationships, whereas autonomous individuals are predominantly invested in matters related to achievement. Beck hypothesized that sociotropric individuals would be more vulnerable to depression when they experienced stress in their interpersonal relationships (e.g., fight with a friend, loss of a relationship) and that individuals with autonomous styles would be more likely to become depressed following stress related to achievement goals (e.g., failing a class, getting fired).

Investigations of the personality-event congruence hypothesis have yield partial support for the theory in adults and youth. Consistently, researchers have found a significant relationship between interpersonal orientation (i.e., sociotropric/dependent), interpersonal/social stressors, and depressive symptoms in cross-sectional investigations (Clark, Beck, & Brown, 1992; Robins, 1990, Study 1; Rude & Burnham, 1993) and prospective studies (Hammen, Ellicott, & Gitlin, 1989; Hammen, Ellicott, Gitlin, & Jamison, 1989; Hammen & Goodman-Brown, 1990; Little & Garber, 2000, 2004, 2005). Support for the hypothesis that achievement oriented individuals (i.e., autonomous/self-critical) experience depression following achievement-related stressors has either not been demonstrated in adults and youth (Clark et al., 1992; Robins, 1990, Study 1; Rude & Burnham, 1993; Little & Garber, 2000), or it has not reached statistical significance (Hammen et al., 1989; Hammen & Goodman-Brown, 1990; Robbins, 1990, Study 2). Thus, at present, only the link between interpersonal-orientation, social stressors, and depression has been supported in the literature.

With regard to adolescent girls, there is some evidence emerging that the relationship between interpersonal investment/orientation and depression is mediated by the experience of interpersonal stressors. For example, Little and Garber (2004) demonstrated that interpersonal orientation was a risk factor for depressive symptoms in a sample of adolescent girls when it interacted with social stressors. That is, girls that reported more investment in interpersonal relationships and experienced more social stressors showed greater increases in depressive symptoms over time compared with their male counterparts or their female peers that had lower levels of interpersonal investment.

Researchers that have examined specific aspects of interpersonal orientation, such as attachment style, have also found links between cognitive-interpersonal factors, stress, and depression in girls. For example, in a recent study, Eberhart and Hammen (2006) found that adolescent females with higher rates of anxious attachment cognitions and poorer family relationship quality were at a greater risk of developing a major depressive episode over a 2-year period compared with peers with fewer attachment concerns and better family relationship quality. Thus, it appears that the combination of investment in interpersonal relationships and difficulties in the interpersonal realm may create depressogenic vulnerability in adolescent girls.

Findings from the present investigation lend partial support to the theory that interpersonal investment and interpersonal stress may lead to depression in early adolescent girls. Given their high rate of interpersonal stressors and their subsequent symptoms of depression in conjunction with these difficulties as well as their reports that treatment helped to increase social support, it appears that many of the girls in the present study held interpersonal orientations that served to create depressogenic vulnerability in the face of multiple, interpersonal stressors

Taken together, the findings regarding the development of depressive symptoms in the girls suggest that the estimated twofold increase in rates of depression in adolescent females may be a function of gender and developmental changes in stressors, cognitive-personality style, and coping in early adolescence. That is, the data suggest that early adolescent girls experience a high rate of chronic, uncontrollable stressors. These stressors, which are predominantly interpersonal in nature, occur in the context of a normative, gender-related developmental process in which an investment in interpersonal relationships becomes heightened. In addition, developmental changes in coping that result in less active and less adaptive stressor management strategies also occur at this time. These changes, which appear to be confounded by limited knowledge of effective coping techniques, lead to multiple failed attempts to manage stress. Not being able to resolve problems in areas that are deemed highly important leads to feelings of sadness, anger, and helplessness as well as to changes in self-schema and information processing. The girls begin to see themselves and their world in negative ways and, therefore, develop symptoms of depression. Furthermore, the girls' cognitive changes may become consolidated over time and create vulnerability for future episodes of depression. Thus, the data support a cognitive-behavioral-interpersonal, diatheses-stress model of female pre-adolescent depression in which limited knowledge of effective coping combines with normal gender-related and developmental processes (i.e., increased investment in interpersonal relationships, increased interpersonal stress, decreased active coping) to create significant current and, perhaps, future vulnerability for depression.

The findings regarding the development of depression in the study sample suggest that providing early adolescent girls with knowledge of more effective coping strategies and encouraging them to reverse the developmental trend of employing more passive techniques may halt the development of depression in the face of increased stress.

Furthermore, reducing high levels of investment in interpersonal relationships or, perhaps more realistically, providing environments in which safe and supportive interpersonal relationships can be fostered may also serve to reduce or prevent depressive symptoms in early adolescent girls.

The fact that the findings regarding pre-treatment stressors and stressor management strategies are consistent with numerous studies in the child and adolescent stress and coping literature, which were cited in this section, significantly increases the validity of the results and increases support for this model. In addition, the similarities between the cognitive errors outlined in the cognitive theory of depression and the pre-treatment cognitions of the participants as well as the developmental differences in stressors and negative cognitions, which are supported by the studies cited in this section, also lend credibility to the findings and provide further support for this model.

### *Overview of Post-Treatment Functioning*

Over the course of treatment, most of the participants evidenced improvements in several areas of functioning. Positive changes that were directly related to treatment included changes in stressors, stressor management strategies, emotions, and outlook. The ways in which the participants' functioning changed after treatment will be reviewed in the following section.

#### *Post-Treatment Stressors*

First, the participants experienced a decrease in the overall amount and duration of stressful life events. The girls reported that they had fewer stressors and that their stressors were less chronic in nature. It is important to note that many girls reported that they continued to experience some stress despite a reduction in the overall amount of stressors. Thus, being in treatment did not resolve all of their problems and did not prevent new problems from developing.

Participants attributed changes in the amount of stressors to learning how to solve problems in the ACTION program. Thus, decreases in the amount of stressors over the course of treatment seemed be the consequence of acquiring and using more effective stressor management strategies, which will be discussed more in the following section. It is important to note that it is also possible that the girls' improved mood and outlook, which will be discussed in subsequent sections, influenced their perception of post-treatment stress. That is, since the girls felt better and had a more positive self-perception, they felt more equipped to deal with stress and, therefore, stressors seemed less problematic. Or, since they were less focused on the negative aspects of their lives, the participants simply did not notice as many problems as they had before treatment.

***Post-Treatment Stressor Management Strategies***

Although the majority of the participants continued to use mostly emotion-focused stressor management techniques to cope with difficulties and the overall amount of strategies used did not significantly change, the girls did employ much more active and effective strategies (e.g., distraction, relaxation, positive thinking, physical release, seeking social support) after treatment. Given the fact that the majority of strategies that the girls used after treatment were specifically taught in the ACTION program, it seems that the intervention successfully halted the gender and developmental trend discussed previously (i.e., Hampel & Petermann, 2005) by replacing passive stressor management strategies with more active techniques.

The most popular post-treatment emotion-focused coping strategy was seeking social support. Given the gender and age of the participants, this finding parallels recent results in research on gender and age effects on coping in children and adolescents, which suggests that early adolescent girls are much more likely to seek social support in the face

of stress than their same-aged male peers (Broderick & Korteland, 2002; Hampel & Petermann, 2005).

After treatment, none of the girls reported using emotional release despite the fact that it was the most commonly employed pre-treatment stressor management strategy. In addition, none of the participants engaged in rumination. This is an interesting finding given the fact that rumination has repeatedly been associated with depression in females and recent evidence suggests that it is a common coping strategy in early adolescent girls (Broderick & Korteland, 2002; Hampel & Petermann, 2005).

***Post-Treatment Emotions***

After treatment, the participants reported an increase in pleasant emotions and a decrease in unpleasant feelings. The participants attributed this elevation in mood to learning more effective ways of coping with stress. This finding is supported in the extant literature, which suggests that changes in coping can significantly influence the development of and the reduction in depressive symptoms over time (Herman-Stahl et al., 1995). Prospective research has demonstrated that replacing passive coping strategies with active stressor management techniques significantly decreases symptoms of depression in youth over the course of a year (Herman-Stahl et al., 1995). Thus, the data suggest that the girls' reduction in unpleasant emotions may be a function of the adoption of more active coping strategies.

***Post-Treatment Outlook***

In addition to emotional changes, the participants also experienced changes in their post-treatment outlook. By the end of treatment, the participants developed more positive ways of thinking. The girls reported more positive self-directed thoughts about their worth and their ability and they reported more positive thought patterns (i.e.,

increasing focus on positive events in their lives and decreasing focus on negative events).

These positive changes seem to be related to learning and using two treatment skills: cognitive restructuring and self-monitoring. By learning to challenge negative thoughts about the self, others, and the world, the participants were able to create more positive and more realistic ways of viewing themselves and their lives. In addition, by learning to self-monitor for pleasant events, the participants were able to change a cognitive distortion of only noticing negative situations. These findings lend support to the cognitive and reinforcement models of depression reviewed in Chapter Two: Review of the Literature.

### *Summary and Conclusions*

Prior to treatment, the combination of multiple stressors and ineffective stressor management strategies resulted in ineffectual coping which led to feelings of sadness and anger and negative ways of thinking. This chain of events led to marked distress in the participants that, eventually, developed into depressive disorders. By the end of treatment, the participants reported fewer stressors, improved stressor management strategies, elevated mood, and more positive outlooks. These positive changes resulted in a reduction in depressive symptoms for most participants. Thus, the data suggest that the treatment was highly successful in alleviating depressive symptoms, increasing skills, elevating mood, and improving cognitions.

In sum, the results from this study suggest that the ACTION program is a highly efficacious group CBT treatment for depressed girls. Furthermore, the data suggest that not only does the treatment reduce depressive symptoms in the majority of participants, but that it is also perceived as helpful regardless of whether or not it produces full symptom remission. This is an interesting and unique finding that underscores the

importance of conducting treatment outcome research that includes both quantitative and qualitative measures. Given the fact that the ACTION program appears to improve participant functioning, the following section will explore the study findings with regard to how the treatment produces positive change.

**Question 2: How Does the Treatment Work?**

Multiple factors have been suggested to influence and contribute to treatment outcome, including specific factors (e.g., treatment techniques) and non-specific factors such as therapist qualities, client characteristics, therapeutic relationship, change processes, and treatment structure (Bickman, 2005). Compared with adult studies, the mechanisms of change in child and adolescent treatments has received far less empirical attention and has generally focused on the influence of common factors (i.e., therapeutic relationship) on treatment outcome (Karver, Handelsman, Fields, and Bickman, 2005; Shirk & Karver, 2003).

In the adult psychotherapy outcome literature, it is estimated that, when combined, non-specific factors such as common factors (i.e., client-therapist relationship), extra-therapeutic change (i.e., factors outside of therapy), and expectancy (i.e., placebo effect) account for 85% of the variance in treatment outcome, whereas specific therapeutic techniques account for only 15% of client improvement (Lambert & Barley, 2001). Thus, different treatment modalities (e.g., CBT, psychodynamic therapy) and forms of treatment delivery (e.g., individual, group) are assumed to be relatively equivalent since specific factors contribute so little to client improvement. This assertion, however, seems questionable since some forms of psychosocial intervention appear to be more efficacious than others in treating certain disorders.

With regard to CBT interventions, researchers have explored the relative contribution of specific and non-specific factors to treatment outcome in depressed adults

with mixed findings. Researchers have demonstrated that non-specific factors related to the therapeutic relationship (i.e., therapeutic alliance, therapist empathy, therapist training), the structure of treatment (i.e., group cohesiveness), and individual characteristics (i.e., expectations of treatment outcome, social adjustment, pre-treatment social support, perceived mastery, learned resourcefulness, willingness to engage in treatment) contribute significantly to CBT treatment outcome (Burns & Nolen-Hoeksema, 1992; Castonguay et al., 1996; Hoberman, Lewinsohn, & Tilson, 1988). Some studies have suggested that non-specific mechanisms of change are positively correlated with improvement in depressive symptoms and global functioning, whereas factors that are specific to CBT interventions are actually negatively correlated with treatment outcome (e.g., Castonguay et al., 1996). Other studies have found evidence that both specific and non-specific factors are responsible for positive change in CBT interventions for depression (e.g., Burns & Nolen-Hoeksema, 1992). Finally, it has been argued that CBT has therapeutic effects on depression which exceed the influence of non-specific factors such as expectancy (Thase et al., 2000) and that specific factors in group CBT interventions for depression are more influential in treatment outcome than non-specific factors (Oei & Shuttlewood, 1996). Thus, in the adult literature, the mechanisms of change in CBT interventions for depression as well as their relative contribution to treatment outcome remains unclear.

Few studies have examined the contribution of specific factors relative to non-specific factors to treatment outcome in CBT interventions designed to treat youth depression. As discussed previously in Chapter Two: Review of the Literature, in the only known study to date, Kaufman and colleagues (2005) examined the mediational effects of six specific factors to CBT (e.g., problem-solving, self-monitoring) and two non-specific factors (e.g., therapeutic alliance, group cohesion) in a group intervention

for depressed and conduct disordered adolescents. Results showed that, of the eight variables examined, only one specific factor (i.e., changes in negative thinking) mediated treatment effects on depressive symptoms. Thus, preliminary evidence suggests that specific factors may be more related to treatment outcome in CBT interventions for depressed youth than non-specific factors.

### ***Specific Mechanisms of Change***

While many studies have shown that CBT interventions are efficacious in reducing depressive symptoms in youth, these investigations have failed to explore how or why these treatments produce positive outcomes (Kazdin, 2002; Kazdin & Nock, 2003). Since the ACTION program appears to be a highly efficacious group CBT intervention, it is important to understand how and why the treatment produces positive change. As discussed in Chapter Nine: Helpfulness of the ACTION Program, the data suggest that both specific and non-specific factors contributed to participant improvement and perceived helpfulness of the treatment. However, contrary to theories that suggest that non-specific factors are responsible for the majority of the variance in treatment outcome (e.g., Lambert & Barley, 2001), findings from this study suggest that factors that were specific to the intervention (i.e., treatment components) influenced positive change to a greater degree than non-specific factors. This finding is consistent with more recent treatment outcome research (e.g., Kaufman et al., 2005)

The overall helpfulness of the ACTION program as evaluated by the participants was most frequently attributed to the acquisition and application of therapeutic skills that were specific to the CBT model of intervention. In fact, 11 out of 17 participants reported that the treatment components were the most helpful aspect of treatment. Learning and applying these skills helped the participants to make several positive changes such as elevated mood, decreased stressors, improved stressor management

strategies, and more positive ways of thinking. The following section will explore which treatment components contributed the most to positive change.

***Essential Treatment Components***

Researchers have suggested that the debate over the importance of specific versus non-specific factors may not be as important as understanding the unique contribution of each treatment component in an intervention to treatment outcome (Kazdin & Marciano, 1998). As discussed in Chapter Two: Review of the Literature, the majority of CBT interventions for depressed youth combine several treatment components into one treatment package in an effort to address different deficits (e.g., maladaptive coping, distorted cognitions) that may contribute to the development and maintenance of the disorder. Although many of these treatment components are theoretically based, most have not been adequately tested to see if they actually produce the changes that their models suggest (Kazdin & Nock, 2003).

Furthermore, no known studies have attempted to dismantle an entire CBT intervention in order to compare the relative contribution of each component to treatment outcome (Kaslow & Thompson, 1998). As discussed in Chapter Two: Review of the Literature, there are only two known studies that have attempted to compare the efficacy of different CBT treatment components with each other (e.g., Butler et al., 1980; Feehan & Vostanis, 1996). Preliminary results from these studies suggest that problem-solving may be more successful in reducing depressive symptoms in youth than cognitive restructuring; however, since exposure to problem-solving and cognitive restructuring was not equivalent in one of these investigations (i.e., Feehan & Vostanis, 1996) and the cognitive restructuring techniques were not well-developed in the other study (i.e., Butler et al., 1980), these findings are considered extremely tentative. Thus, for the most part, it

is still unclear which treatment components included in CBT interventions for depressed youth are necessary and/or sufficient for change.

In the present investigation, different treatment components in the ACTION program were explored with participants in terms of saliency (i.e., level of recall), comprehension, frequency and appropriateness of use, level of difficulty, and level of helpfulness. Given the fact that the treatment components were reported to be more closely related to treatment outcome than non-specific factors, it was important to understand which treatment components were perceived to be the most helpful by the participants and how they produced positive change. The data suggest that core treatment components (i.e., coping strategies, problem-solving, cognitive restructuring) were more frequently recalled, better understood, more frequently used, and rated as more helpful than less central components (i.e., goal-setting).

*Coping strategies.* The coping strategies were one of the most commonly recalled core treatment components. They were also rated as the most helpful treatment component by the majority of participants. The participants demonstrated good recall and understanding of the coping strategies and when to use them (i.e., with uncontrollable stressors). Most of the participants endorsed using this treatment component at a high rate during treatment, found it easy to use, and found it to be helpful. Factors that affected the helpfulness of the coping strategies were type of stressor with which they were used and level of emotional reaction to stressor. In the face of severe, loss-oriented uncontrollable stressors (e.g., death of a loved one) or severe, unpleasant emotions, coping strategies were seen as less helpful by the participants. Interestingly, some participants used coping strategies in the face of controllable stressors as a means of regulating unpleasant emotion before engaging in problem-solving. This finding parallels suggestions in the coping literature that coping strategies used to regulate

emotion in the face of controllable stressors may help children engage in more effective problem-focused techniques (Pincus & Friedman, 2004).

Two specific coping strategies were recalled more often and used more frequently by the participants: distraction (i.e., “do something fun and distracting”) and relaxation (i.e., “do something soothing and relaxing”). The fact that the participants recalled and used distraction most frequently is interesting for several reasons. First, this finding is discrepant with recent developmental research on age and gender effects on coping which suggests that early adolescent girls use distraction as a coping strategy less often than younger or older girls (Hampel & Petermann, 2005). Thus, the participants in the present study showed a reverse gender and developmental trend by engaging in this particular skill more frequently after treatment.

Since one of the core symptoms of depression (i.e., anhedonia) is defined as the lack of interest or pleasure in most activities, the girls may have been drawn to this specific technique because “doing something fun” directly combated this depressive symptom. It is also interesting that the second most commonly recalled and employed coping strategy was relaxation. Given the fact that a high percentage (approximately 53%) of participants had pre-treatment comorbid anxiety disorders (e.g., GAD, social phobia), perhaps learning how to relax was particularly important to these girls. Thus, specific coping strategy use and preference may depend on how well a technique addresses specific symptoms of psychological distress.

The coping strategies were evaluated as the most helpful treatment component by the majority of participants. This core treatment component was seen as highly helpful because it provided participants with more effective ways to manage unpleasant emotions compared with pre-treatment stressors management strategies, multiple options for regulating emotions, and a way to decrease rumination.

*Problem-solving.* Another core treatment component that was frequently recalled by participants was problem-solving. Problem-solving appeared to be well understood, used in the manner in which it was intended (i.e., with controllable stressors), viewed as easy to use, and used at a moderate rate by most participants. This treatment component was generally viewed as helpful by the participants that used it; however, when used incorrectly (i.e., with uncontrollable stressors), it received a less favorable evaluation. This finding lends support to the theory that problem-focused coping strategies are more effective when used with controllable rather than uncontrollable stressors (Weisz et al., 1994) and underscores the importance of clearly teaching participants to use this skill exclusively with controllable stressors.

After coping strategies, problem-solving was rated as the most helpful treatment component by many participants. Problem-solving was viewed as the most helpful skill by some participants because it provided an organized process for resolving specific problems and it encouraged choice through the generation of multiple solutions. The fact that many girls indicated that problem-solving was the most helpful treatment component is consistent with previous qualitative research (e.g., Feehan & Vostanis, 1996).

*Cognitive restructuring.* The final core treatment component that was most frequently recalled by the participants was cognitive restructuring. The data suggest that most participants demonstrated good recall and understanding of this treatment component. In addition, it was generally viewed as easy to use, it was used at a high rate, and it was evaluated as very helpful. This finding is particularly important given the fact that some researchers have speculated that pre-adolescent children may not understand, be able to use, and, therefore, benefit from cognitive restructuring techniques in CBT interventions since cognitive capabilities are still developing at this age (Garber, 2000).

Despite their age and level of cognitive development, it is clear that the girls in the study understood, used, and benefited from cognitive restructuring.

Cognitive restructuring was the third treatment component to be rated as most helpful by the participants. Participants that rated cognitive restructuring as the most helpful skill indicated that it helped them develop more positive self-schema and outlooks, and it was easy to use. The fact that slightly more participants preferred problem-solving compared with cognitive restructuring is somewhat consistent with previous quantitative and qualitative studies that compared these treatment components in child and adolescent CBT interventions for depression (Butler et al., 1980; Feehan & Vostanis, 1996).

*Affective education.* Although most of the core treatment components were recalled at high rates by the participants, affective education represented an exception to this general rule. Despite being a core treatment component, affective education was recalled by few participants. Although there is limited data to explain this finding, it may be possible that affective education evidenced a low rate of recall due to the fact that the participants were already capable of identifying and labeling their emotions prior to treatment. When asked about their pre-treatment emotions, none of the participants had difficulty describing how they felt before the ACTION program. Furthermore, many participants indicated that identifying feelings was not a problem for them; however, knowing how to cope with those feelings proved more difficult. Thus, it is possible that affective education was recalled by few participants because it was not a novel concept.

While most of the participants seemed capable of identifying and labeling their emotions prior to treatment, affective education was probably still quite helpful since it also taught the girls that unpleasant emotions are a cue to take action to elevate mood. This was the case for the participant that rated affective education as the most helpful

treatment component. For this girl, affective education helped her to identify and label her unpleasant emotions; however, it also prompted her to engage in coping when she experienced a decline in mood.

***Treatment Component Acquisition, Application, and Preference***

The data suggest that treatment component acquisition, application, and preference was facilitated by several different factors, including skill characteristics (e.g., level of helpfulness), aspects of treatment (e.g., activities, rewards) and participant characteristics (e.g., coping style). These factors will be discussed in more detail in this section. In addition, the data suggest that a non-specific factor (i.e., group support) also influenced treatment component acquisition and application. This finding will be discussed later in the *Non-Specific Mechanisms of Change* section of this chapter.

*Level of helpfulness.* Since the treatment components that were most frequently recalled and used were also the skills that were rated as the most helpful, it seems that skill acquisition, application, and preference are, at least partially, influenced by level of helpfulness. Thus, it can be assumed that treatment components that were not discussed by participants may have been less helpful and, therefore, may be less essential to treatment outcome. Two treatment components, building a positive sense of self and goal-setting, were not discussed by any of the participants.

*Enjoyable activities and rewards.* An interesting finding in the present investigation is that almost all of the participants described the ACTION program as "fun." The participants tended to view the activities and the rewards as enjoyable aspects of treatment. Since these aspects of treatment facilitate the acquisition and application of the treatment components, the data suggest that degree of enjoyment and reinforcement may moderate the relationship between how the treatment components are presented and how well they are acquired, used, and later recalled.

*Coping style.* Treatment component acquisition, application, and preference also seemed to depend on factors that were external to the treatment such as the pre-treatment coping style of the participants. The majority of participants in the present investigation had emotion-focused coping styles prior to treatment. After learning all of the different skills in the ACTION program, most of the participants recalled and continued to use emotion-focused strategies (e.g., the coping strategies) at a higher rate than problem-focused strategies (e.g., problem-solving). In addition, the majority of participants rated the coping strategies as the most helpful treatment component. Thus, coping style did not change over the course of treatment and appeared to influence skill acquisition, usage, and preference. It is important to note that although coping style remained fairly consistent across treatment, participants with emotion-focused coping styles engaged in more active and effective stressor management strategies after being in the ACTION program. Thus, while the participants preferred to cope with stressors by managing their emotions rather than trying to solve the problem, they used more active and successful ways of doing this after treatment. In addition, given the length of treatment (approximately 12 weeks), it is likely that coping style would not undergo a complete change in such a short amount of time.

Two important factors may have influenced coping style: gender and controllability of stressors. First, some studies have shown that girls tend to utilize emotion-focusing coping strategies such as support seeking and minimization at higher rates than boys (Hampel & Petermann, 2005) and are more likely than their male peers to use emotion-focused coping strategies in relation to academic events (Compas et al., 1988). Thus, the fact that the participants in the present study demonstrated a preference for emotion-focused coping could be a function of their female gender.

The fact that the participants used emotion-focused strategies at higher rates both before and after treatment may also be related to level of controllability of the stressors that they experienced. The participants in the study were specifically taught to employ emotion-focused strategies in the face of uncontrollable stressors and problem-focused strategies in the face of controllable stressors based on literature which suggests that this pattern of coping leads to more favorable emotional and behavioral adjustment (Weisz et al., 1994). Since the data suggest that the participants did experience more uncontrollable than controllable stressors both before and after treatment, this may explain why they showed a preference for emotion-focused coping strategies.

Although it is not entirely clear what prompted participants to prefer emotion-focused coping strategies, the fact that most participants maintained an emotion-focused coping style is interesting since it has been suggested in the coping literature that emotion-focused coping is positively correlated with depressive symptoms and problem-focused coping is negatively related to depressive symptoms in children and adolescents (Compas et al., 1988). This study suggests that this may not be entirely true. The approach (e.g., active, passive) and the level of helpfulness of the stressor management strategy seemed to be more associated with the development of depressive symptoms than its domain (e.g., emotion-focused, problem-focused).

***Summary and Conclusions***

The results of this study suggest that treatment outcome in the ACTION program is more strongly influenced by specific than non-specific factors. The treatment components which were viewed as the most helpful in terms of producing positive change were the coping strategies, problem-solving, and cognitive restructuring. To date, very few studies have attempted to dismantle CBT interventions for depressed youth and compare the efficacy of the specific treatment components (Kaslow & Thompson, 1998).

The findings from the present study suggest that this is an important empirical endeavor that may contribute to a better understanding of how and why treatment works. The following section will discuss findings related to the non-specific mechanisms of change.

## *Non-Specific Mechanisms of Change*

It has been suggested that several non-specific mechanisms of change may influence treatment outcome as much as specific mechanisms of change (Bickman, 2005). As discussed previously in Chapter Two: Review of the Literature, non-specific factors are variables such as therapist qualities, client characteristics, change processes, treatment structure, and the therapeutic alliance or relationship (Bickman, 2005). In previous investigations of mechanisms of change in CBT interventions with depressed adults, non-specific factors related to therapist qualities, the therapeutic alliance, and client characteristics were found to contribute to improvement in depressive symptoms and global functioning (Burns & Nolen-Hoeksema, 1992; Castonguay et al., 1996) in addition to specific mechanisms of change (Burns & Nolen-Hoeksema, 1992).

The data from the present study suggest that two domains of non-specific mechanisms of change appear to be related to treatment outcome and evaluation in a CBT intervention for depressed early adolescent girls: treatment structure and participant characteristics. The following section will summarize the results from the present study with regard to these two factors and discuss how these findings relate to current research.

### *Treatment Structure*

Some of the participants reported that the structure of treatment facilitated positive change alone or in combination with the treatment components. For these girls, the characteristics of treatment (e.g., group, diagnoses, gender-specific, same-aged peers) contributed to the development of a sense of relatedness among group members, which helped them to not feel alone. That is, being in a group with other depressed girls in

similar grades and with similar problems resulted in a feeling of connectedness among the participants. The data suggest that sense of relatedness had a reciprocal relationship with problem-sharing. Thus, sense of relatedness functioned as both a catalyst and a consequence of problem-sharing. It is interesting to note that the data suggest that the participants that reported higher levels of problem-sharing made more positive changes over the course of treatment and evaluated treatment as more helpful than participants that reported lower levels of problem-sharing. This finding will be discussed in more detail in the *Participant Characteristics* section.

The data suggest that sense of relatedness and problem-sharing also increased group support, which resulted in increased skill practice, more solutions to problems, and increased social support. Since many of the participants experienced high levels of interpersonal conflict and low levels of social support prior to treatment, the high level of support that resulted from aspects associated with the structure of treatment influenced level of perceived helpfulness of the ACTION program. Thus, participants that lacked support or experienced high levels of interpersonal conflict at the beginning of treatment and experienced an increase in support related to being in a group intervention for depressed, pre-adolescent girls perceived the ACTION program as highly helpful. Thus, group support appears to be an important non-specific therapeutic factor related to treatment outcome. This is an interesting finding in light of the fact that recent research has demonstrated that social support and depression in adolescents has a reciprocal relationship in which lack of social support predicts depressive symptoms and depressive symptoms predict decreases in social support over time (Galambos et al., 2004). Thus, increasing social support appears to be an important intervention for depressed youth.

In addition to increasing support, problem-sharing also acts as a setting event for the acquisition and application of the treatment components. That is, when participants

shared their problems with the group, these difficulties were incorporated into the specific skill lessons by the treatment therapists and the therapists as well as the other group members encouraged the participants that engaged in problem-sharing to apply the treatment skills to their specific stressors. Thus, by disclosing personal problems with the group, the girls were able to immediately learn and apply skills to solve their problems. That is, problem-sharing acted as a prerequisite for the acquisition and application of the treatment components. This is an important finding because it suggests that a non-specific factor (i.e., participant's level of problem-sharing) in the context of another non-specific factor (i.e., group support) facilitated specific factors (i.e., treatment components). Thus, specific and non-specific factors worked together to produce change.

To date, very little research exists regarding the therapeutic factors associated with group interventions for children and adolescents. In the adult literature, several therapeutic factors have been identified that are hypothesized to relate to treatment outcome in group interventions. For example, Yalom (1995) described eleven non-specific therapeutic factors that are suggested to facilitate positive change in group therapy. These factors include instillation of hope, universality, imparting information, altruism, corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors (Yalom, 1995). Two concepts in the present study, sense of relatedness and group support, seem to be consistent with two of these factors: universality and group cohesiveness.

*Sense of relatedness and universality.* According to Yalom (1995) the concept of universality describes the phenomenon that individuals tend to enter group therapy believing that they are alone in their plight, yet quickly realize that the other members have similar problems. This realization provides therapeutic effects because it reassures

group members that they are not alone. The data from this study supports the idea that universality is a non-specific therapeutic factor related to group treatment outcome. Furthermore, the data suggest that this construct works in the way that the theory suggests and is applicable to children. Finally, the present investigation suggests that universality does more than simply provide comfort to group participants; it influences problem-sharing in a reciprocal manner and results in a high degree of group support.

To date, there are no known studies that have examined the concept of sense of relatedness or universality in group interventions for depressed youth. Thus, the finding that this construct plays an important role in group process and treatment outcome is a novel contribution to the field of child and adolescent therapy and suggests a need for more research in this area.

*Group support and group cohesiveness.* Yalom (1995) suggested that group cohesiveness is an essential therapeutic factor in group interventions that influences the impact of all other therapeutic factors. Group cohesiveness refers to the level of attraction and commitment that group members feel for one another and it increases self-disclosure, interpersonal testing, and exploration (Yalom, 1995). The data from the present investigation suggest that group cohesiveness or support is a valid construct that indeed strongly influences the process and outcome of group therapy for depressed girls. Additionally, findings regarding group support suggest that it influences specific mechanisms of change by providing a safe and encouraging environment in which to disclose problems and receive help with practicing new skills. Thus, treatment component acquisition and application depend, in part, on being able to learn, practice, and apply new skills to specific problems in the context of a supportive group.

Although group cohesiveness has been studied in some group CBT interventions for depressed adults (Hoberman, Lewinsohn, & Tilson, 1988; Oei & Browne, 2006),

investigations of this therapeutic factor in relation to group CBT interventions for depressed children and adolescents are rare. A recent investigation of specific and non-specific factors suggested that group cohesion did not mediate reduction in depressive symptoms in a group CBT intervention for adolescents (Kaufman et al., 2005). Given the results from this study, this seems to be an important non-specific factor that deserves further investigation.

In sum, non-specific factors related to the structure of treatment appear to influence treatment outcome in a group CBT intervention for depressed girls. The data suggest that these factors are similar to constructs in the adult group therapy literature. Although these factors were less directly related to treatment outcome in comparison to the treatment components, they played an essential role in facilitating the success of the specific factors and, therefore, deserve further attention in treatment outcome research. The following section will discuss other non-specific factors that affected treatment outcome for some participants.

***Participant Characteristics***

One of the non-specific mechanisms of change that has been associated with treatment outcome in both youth and adults is pre-treatment client characteristics (Karver, et al., 2005). Pre-treatment client characteristics in youth can include variables such as age, gender, race, socioeconomic status, developmental stage, primary and comorbid diagnoses, interpersonal functioning, parental intelligence and mental health, child and parent expectancies, and family environment (Bickman, 2005; Karver et al., 2005). Pre-treatment characteristics have been suggested to account for 40% of the variance in treatment outcome (Lambert & Barley, 2001).

In the present study several participant characteristics seemed to influence treatment outcome and evaluation. These characteristics included expectations, readiness

for change, and level of problem-sharing. Each of these characteristics will be discussed and compared with relevant literature in the following section.

*Expectations and outcome expectancies.* A participant characteristic that appeared to influence treatment outcome in the present investigation was participant expectations. This finding is consistent with current literature on common factors in treatment outcome. One common factor that has been shown to influence treatment outcome is pre-treatment client expectancies. According to Arnkoff, Glass, and Shapiro (2002) there are two main types of expectancies that clients have about therapy: role expectancies and outcome expectancies. Role expectancies encompass the behaviors that the client views as appropriate or expected of both herself and the therapist, whereas outcome expectancies are related to client's belief or expectation that the treatment will produce change (Arnkoff et al., 2002).

Current research suggests that positive outcome expectancies are typically associated with client improvement (see Dew & Bickman, 2005 for a review). That is, if a client believes that treatment will be helpful, then she usually benefits from it. This idea is somewhat in conflict with the findings from the present investigation in that positive client expectation was inversely related to positive treatment outcome. It is possible that these findings are incongruent because the accuracy of pre-treatment client expectation or expectancy may mediate the relationship between this common factor and treatment outcome. In the present investigation, participants that held expectations that hindered positive change tended to have beliefs that were not realistic (e.g., all of their problems would be solved by the end of treatment). Thus, these girls had inaccurate expectations that may have led to fewer positive changes and, therefore, a perception that treatment was not very helpful.

*Readiness for change.* Another client characteristic that seemed to influence treatment outcome was readiness for change. Although much has been written in the literature about the importance of the client's readiness to change in treatment, very few studies have examined this idea with adults or children (Bohart, 2000). Furthermore, this construct has frequently been subsumed under another common factor: therapeutic alliance (Karver et al., 2005). In the present investigation readiness for change seemed to include both the participant's openness and effort to change. These factors appeared to influence treatment outcome in that participants that were less open or put forth less effort made fewer positive changes over the course of treatment.

In the present investigation, the degree of a participant's openness to change appeared to influence treatment outcome. Participants that were less open to change made fewer positive changes over the course of treatment. In the current treatment outcome literature, the construct that appears to be most similar to openness to change is willingness to participate in treatment (Karver et al., 2005). Willingness to participate in treatment has been suggested to include concepts such as the client's desire to engage in treatment, the client's perceived importance of therapy, and the client's commitment to the therapeutic process (Adelman, Kaser-Boyd, & Taylor, 1984).

In the present investigation openness to change encompasses these ideas, yet also seems to include the concept of cognitive flexibility since participants that were "hard-headed" and did not allow their beliefs to be challenged appeared less open to change. To date, the construct of willingness to participate in treatment has only been examined with youth in one treatment outcome study (e.g., Adelman et al., 1984). The researchers found that this variable had a moderate relationship with treatment outcome ($r = 0.27$). The data from the present study somewhat support these findings and suggest that

openness to change or willingness to participate in treatment deserves more attention in the youth treatment outcome literature.

Effort to change was another component of readiness for change that appears to affect treatment outcome. Participants that invested less effort in treatment were less likely to make positive changes. This non-specific mechanism of change has been explored in the treatment outcome literature in terms of client participation in treatment. This construct has been suggested to include concepts such as client effort, collaboration, engagement, and cooperation in treatment (Karver et al., 2005).

In a recent meta-analysis, Karver, Handelsman, Fields, and Bickman (2006) examined youth participation in treatment in relation to treatment outcome in 13 studies and found a wide range of effect sizes (0.11 to 1.05). The weighted mean effect size revealed a moderate relationship between participation in treatment and treatment outcome ($r = 0.27$); however, the researchers suggested that this result be interpreted with caution given the wide range of effect sizes across studies included in the meta-analysis. Findings from the present investigation support the relationship between client effort and treatment outcome found in the studies included in the meta-analysis completed by Karver and colleagues (2006). Since the magnitude of this relationship remains unclear, further investigations of client effort and treatment outcome in youth populations are warranted.

*Problem-sharing and self-disclosure.* Another client characteristic that appeared to influence treatment outcome was problem-sharing or self-disclosure. Participants that engaged in lower levels of problem-sharing over the course of treatment appeared to make fewer positive changes and tended to view treatment as less helpful. This finding is particularly important given the fact that the both of the participants that continued to

meet criteria for depression at post-treatment assessment reported that they engaged in limited problem-sharing over the course of treatment.

Disclosure in therapy and its relation to treatment outcome has been discussed and debated extensively in the adult literature on non-specific mechanisms of change in psychotherapy (see Kelly, 2000 for a review); however, this topic has been rarely addressed with regard to treatment outcome in youth. In a recent investigation by Panichelli-Mindel, Flannery-Schroeder, Kendall, and Angelosante (2005), level of distress disclosure in children and adolescents with anxiety disorders was examined in relation to treatment outcome. The researchers found that youth with higher levels of pre-treatment distress disclosure evidenced more improvement on child, parent, and teacher report measures compared with their low distress disclosing peers. Unfortunately, this study did not track degree of client disclosure during treatment and, therefore, the researchers' preliminary conclusion that youth that are "…more open, less defensive, and more willing to discuss their distress in therapy" (Panichelli-Mindel et al., 2005, p. 418) may benefit more from treatment is not fully supported. However, the present investigation lends support to this theory in that higher levels of problem-sharing during treatment was associated with remission of depressive symptoms, whereas lower levels of problem-sharing was related to fewer positive changes and continued depression. Given the fact that client problem-sharing or self-disclosure is believed to be a requisite for effective intervention, this area of treatment outcome deserves more empirical attention.

***Summary and Conclusions***

Several non-specific factors affected treatment outcome, including variables related to the structure of treatment as well as client characteristics. While the participants indicated that specific mechanisms of change were more helpful than these

non-specific factors, these variables played an important role in treatment outcome independently and in combination with other factors.

### *Mechanisms of Change in the ACTION Program*

The mechanisms of change in the ACTION program included both specific (i.e., treatment components) and non-specific factors (i.e., treatment structure, participant characteristics). These variables did not work to produce change in isolation. Rather, several non-specific factors influenced specific factors, some specific factors influenced non-specific factors, and some non-specific factors demonstrated a reciprocally influential relationship. The most important specific mechanisms of change were the core treatment components; however, other aspects of treatment (i.e., confidentiality) played a vital role in treatment outcome. Non-specific mechanisms of change that significantly contributed to treatment outcome included variables related to the structure of treatment (i.e., trust, sense of relatedness, group support) and participant characteristics (i.e., problem-sharing, expectations, readiness for change). The following section will provide a summary of how the different specific and non-specific variables in the ACTION program worked together to influence change. Figure 1 also illustrates the relationship between these variables.

#### *Treatment Components and Group Support*

According to the participants, specific factors were the primary mechanism of change in the ACTION program. Thus, giving the girls specific skills (i.e., coping strategies, problem-solving, cognitive restructuring) for addressing specific difficulties (i.e., unpleasant emotions, stressors, negative cognitions) resulted in specific improvements (i.e., improved mood, decreased stressors, more positive outlook). Thus, the treatment components were the most important and the most helpful aspect of the intervention from the perspective of the participants.

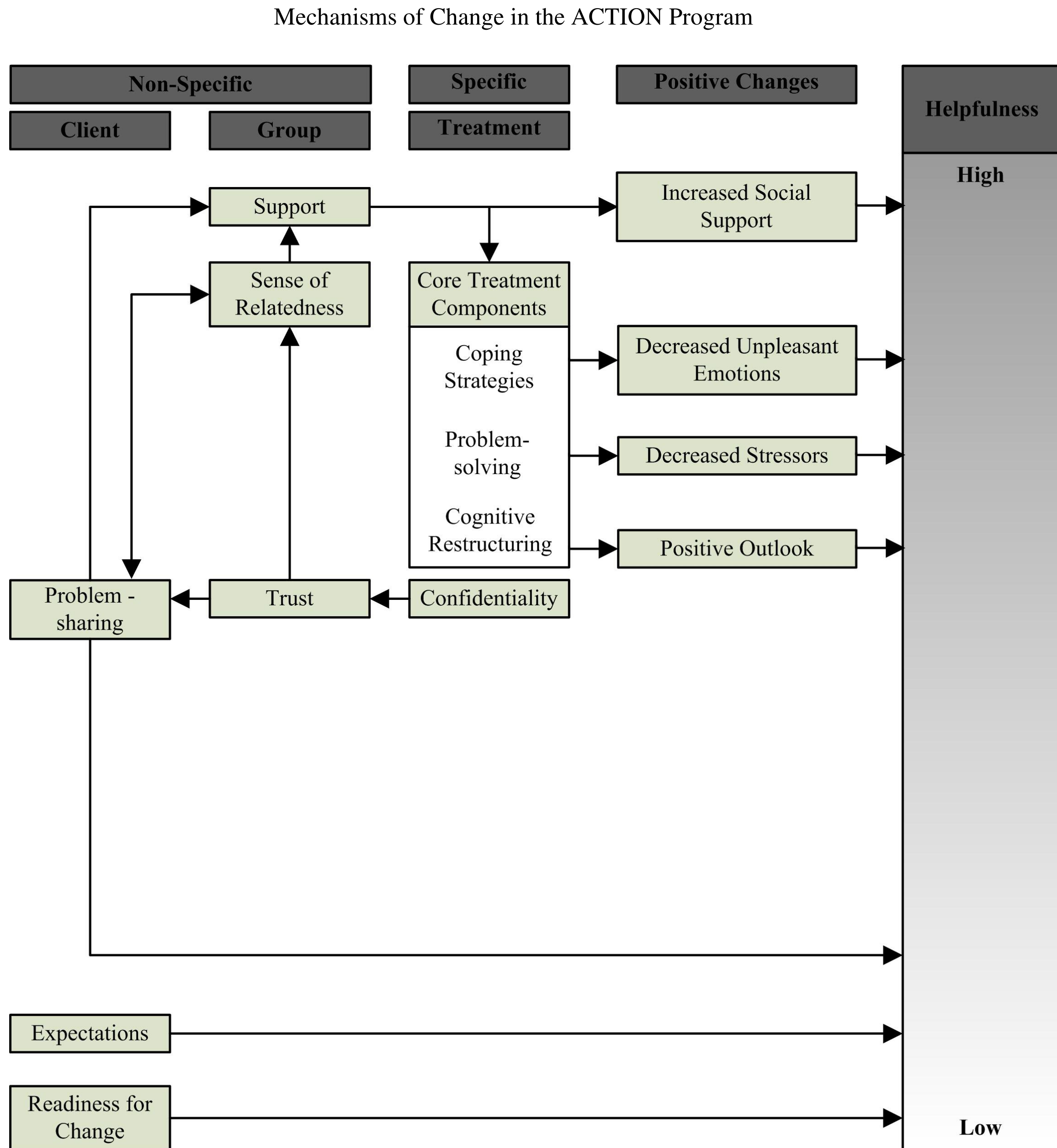
The acquisition and application of the treatment components, however, depended on an important non-specific factor: group support. As discussed previously in Chapter Seven: Treatment Structure, group support facilitated that acquisition and application of the treatment components by creating a safe place in which the girls were able to share problems and practice new skills. For example, when a participant had a specific problem that she was willing to share, she disclosed it to her other group members. In response, the group members assumed the role of "mini-therapists" and immediately helped the girl to recall, apply, and practice specific treatment components in an effort to support her in solving the problem. Thus, group support among the girls in the ACTION program resulted in better acquisition and application of different treatment components by providing participants with opportunities to practice new skills. This finding suggests that a non-specific factor (i.e., group support) indirectly influenced treatment outcome by increasing the helpfulness of specific factors (i.e., treatment components).

***Group Support, Trust, Problem-Sharing, and Sense of Relatedness***

As discussed previously, group support was also seen as one of the most helpful components of treatment due to the fact that it increased social support in girls that had high levels of conflict-oriented interpersonal stressors and low levels of peer support prior to treatment. Thus, in addition to indirectly influencing treatment outcome via the acquisition and application of specific factors (i.e., treatment components), this non-specific factor also demonstrated a direct treatment effect by increasing social support.

Several non-specific factors contributed to the development of group support, including trust, problem-sharing, and sense of relatedness. These variables, therefore, also contributed to the overall helpfulness of the ACTION program by indirectly influencing non-specific and specific factors.

*Figure 1.* Illustration of model.



*Confidentiality, trust, and problem-sharing.* As discussed in Chapter Seven: Treatment Structure, initial levels of trust among group members were low due to low levels of familiarity at the beginning of group. Level of trust increased significantly after the introduction of confidentiality. This specific factor facilitated trust because it helped the girls to feel safe since they believed that their secrets were not going to be shared with individuals outside of the group. As the girls built more trust, they became more open and began to share their feelings, thoughts, and problems with each other. Thus, trust exerted a direct effect on problem-sharing among group members. That is, when levels of trust were low, girls engaged in no or limited problem-sharing; however, as trust increased, levels of problem-sharing increased. Thus, a non-specific factor (i.e., trust) directly influenced another non-specific factor (i.e., problem-sharing). In addition, a specific factor (i.e., confidentiality) directly and indirectly influenced two non-specific factors (i.e., trust and problem-sharing). These three variables worked together to indirectly influence group support.

*Problem-sharing, sense of relatedness, and group support.* The data suggest that problem-sharing is one of the most crucial non-specific factors related to treatment outcome. There are multiple pathways through which problem-sharing influenced the overall helpfulness of the ACTION program. First, problem-sharing seems to have a reciprocal relationship with sense of relatedness in which the more the girls talked with each other about their problems, the more they realized that they had a lot in common, and the more the girls realized that they could relate to each other, the more they felt safe to talk about their problems. Thus, these two non-specific factors demonstrated a bidirectional relationship.

Next, problem-sharing seemed to affect group support both directly and indirectly. Problem-sharing directly increased group support because it allowed the girls

to help each other build skills. In addition, problem-sharing indirectly increased group support by increasing sense of relatedness among group members. That is, the more the girls engaged in problem-sharing, the more they felt connected to one another and the more they felt connected to each other, the closer and more supportive they became.

Finally, since group support also influenced the helpfulness of the treatment directly and indirectly (i.e., via the treatment components) and problem-sharing influenced group support, problem-sharing influenced treatment outcome. In fact, problem-sharing was an essential non-specific factor because it was a prerequisite for change. If participants did not engage in problem-sharing, then they did not have an opportunity to receive support from other group members or to practice the treatment components. The essential role of problem-sharing is supported by the fact that participants that engaged in low levels of problem-sharing made fewer positive changes over the course of treatment and, therefore, found the ACTION program to be less helpful.

*Sense of relatedness, group support, and treatment components.* Sense of relatedness also influenced the overall helpfulness of the ACTION program by directly increasing problem-sharing and group support as well as by indirectly affecting the acquisition and application of the treatment components via group support. In addition, sense of relatedness appears to have been helpful in and of itself since it led to the participants not feeling alone. Since many of the girls felt lonely and isolated as well as different and defective, being in a group with other girls that were experiencing similar difficulties provided them with reassurance and relief.

Another way in which sense of relatedness may have influenced treatment outcome is by facilitating two core treatment components: cognitive restructuring and problem-solving. First, sense of relatedness may have helped alter some of the

participants' core beliefs by providing evidence that they were not alone, different, or defective. Thus, it may have facilitated a more positive outlook for some of the girls by helping them to cognitively restructure some of their core beliefs. Next, sense of relatedness may have also affected problem-solving and, therefore, decreased stressors among participants. Since the girls had a lot in common and they practice problem-solving together, they may have been able to help each other generate solutions to problems that were particularly useful and appropriate.

*Participant expectations and readiness for change.* As discussed previously, two non-specific, participant characteristics, participant expectations and readiness for change, also influenced the helpfulness of the ACTION program and, therefore, treatment outcome. Participants that had unrealistic expectations, were not willing to put forth effort to change, and were not open to change made fewer positive changes over the course of treatment. For these girls, the ACTION program was less helpful.

***Summary and Conclusions***

Although the primary mechanism of change in the ACTION program were specific factors (i.e., the treatment components), several non-specific variables also contributed to treatment evaluation and outcome. These common factors produced direct and indirect effects such as increasing social support or facilitating the acquisition and application of the treatment components. Thus, change in the ACTION program was the product of multiple variables that interacted with one another.

It is interesting to note that the ACTION program was designed in such a way as to capitalize on many of the non-specific factors discussed in this section. First, the ACTION program was specifically designed to be a group treatment for depressed, pre-adolescent girls. Given the significant increase in depression in adolescent females, the diagnoses, age, and gender specificity of the treatment was a deliberate attempt to target a

particularly vulnerable youth population at a particularly crucial developmental stage. In addition, in pilot studies using mixed boys and girls groups, the primary researcher quickly discovered that the boys tended to take over the meetings, which made the girls reluctant to participate. Given this experience, another reason for making the treatment gender specific was to allow girls to have a safe place in which to cope with their distress and learn new skills. In addition, certain aspects of the intervention were designed with the specific goal of increasing safety, trust, and support among group members such as confidentiality contracts, group rules, and activities to build group rapport and cohesion. Thus, non-specific factors that related to the structure of treatment such as trust, sense of relatedness, and support were the result of carefully planned efforts on the part of the ACTION program designers.

Next, by linking the different therapeutic skills with different types of stressors, the researchers attempted to clearly convey that different problems require different forms of coping. For example, the girls were taught to use coping strategies to manage unpleasant emotions associated with uncontrollable stressors, to use problem-solving to address controllable stressors, and to use cognitive restructuring to counter negative thoughts. Thus, it was not suggested that by being in treatment, all problems would be solved. Instead, it was suggested that different stressors could be managed in different ways. By clearly outlining the utility of each therapeutic component in this way, the researchers attempted to directly avoid participant confusion about when to use which skill and, indirectly, unrealistic expectations that treatment would "fix" every problem.

Next, although willingness to change is difficult to alter, the researchers that designed the ACTION program did try to encourage client participation and engagement in treatment via the use of rewards and rules. As discussed previously, the girls were given prizes for coming to group, for completing therapeutic homework assignments, and

for participating in certain treatment activities. In addition, group rules were created collaboratively by the therapists and girls in each group, and one of the rules that therapists were instructed to add to every group list was "Everybody participates." Thus, the researchers built into the treatment several ways to encourage participant effort.

According to the primary research, all of these variables were considered necessary but not sufficient for change (K.D. Stark, personal communication, June 22, 2007). The following section will discuss how findings from the current study can be applied to other psychosocial interventions. In addition, directions for future research will be suggested.

**Implications for Intervention and Directions for Future Research**

The present investigation provides preliminary evidence that the ACTION program is an extremely efficacious treatment for depressed, pre-adolescent girls. These results obviously need to be validated with quantitative measures and larger sample sizes; however, the fact that even the participants that continued to be depressed at the end of treatment evaluated the program as helpful suggests that this intervention is an important contribution to the field. Since the ACTION program is a manualized, school-based treatment, it can be easily adapted and applied in a variety of settings. Upon completion of the on-going study, results from this study can be compared with quantitative findings. Should the ACTION program prove to be a highly efficacious study, it would be interesting to conduct a treatment outcome studying comparing it to another, well-established CBT intervention for depressed youth. In addition, the program should be adapted and tested with boys and with adolescents.

Since the primary mechanisms of change in the present study were specific factors (i.e., treatment components), it is suggested that the theory underlying many aspects of CBT interventions for depression is valid, that the variance accounted for in

treatment outcome by specific factors has been underestimated in the youth treatment literature, and that more research exploring and testing mediators of treatment outcome is necessary, especially in the area of child and adolescent psychotherapy.

The finding that both specific and non-specific mechanisms of change contributed to treatment outcome and, at times, influenced one another is also noteworthy. This study supports the idea that non-specific factors play a vital role in treatment outcome and should continue to be studied in conjunction with specific factors. As with many other concepts in psychology, the relationship between these variables may, in fact, be reciprocal. Rather than arguing for or against the importance of one factor, research should focus on identifying and validating all factors in an effort to truly understand how therapy works and how to make it better. Once again, it is strongly recommended that these factors be explored in child and adolescent treatment outcome studies and that effort be made to incorporate and capitalize on these variables in current treatment interventions as was done in the ACTION program.

One of the goals of the present investigation was to determine which treatment components are necessary and sufficient for change from the perspective of the participants. The data clearly suggest that three core treatment components, the coping strategies, problem-solving, and cognitive restructuring, play a crucial role in producing positive change and, therefore, are essential ingredients in CBT interventions for depressed youth. Given the link between level of helpfulness and level of recall, it can be concluded that treatment components that were not discussed by participants were less helpful and, therefore, are less necessary for producing positive change. Thus, in order to create a more streamlined and potent treatment, the ACTION program as well as other similar CBT interventions for depressed youth, may benefit from eliminating or spending less time on treatment components that were less frequently recalled in this investigation

such as goal setting and building a positive sense of self. It is further recommended that the ACTION program (and other, similar CBT interventions) be dismantled and its core treatment components be tested against each other as well as against the entire treatment to compare the efficacy of the parts with each other and to the whole.

Another important finding from this study is that skills were best learned and better recalled when they were presented in an enjoyable manner. Skills were also easier to practice, in group and outside of group via therapeutic homework, when they were positively reinforced with tangible rewards. These findings are not surprising given the fact that the researchers that designed the ACTION program treatment materials (i.e., Stark et al., 2004a) made a concerted effort to create lessons and activities that were fun, engaging, and memorable. Extensive revisions of the treatment manual were made in its early stages in order to maximize the enjoyment of each session. This was done to increase the likelihood that the girls would recall the lessons as well as to improve participants' engagement in treatment and to provide uplifting experiences. Furthermore, the use of rewards for attending group meetings, completing therapeutic homework assignments, and engaging in specific treatment activities (i.e., identifying negative thoughts) was explicitly built into the treatment manual in an effort to reinforce these crucial aspects of treatment. Thus, an implication for future interventions with depressed youth would be to explicitly build engaging and fun activities into treatment manuals and to create in-session rewards systems in order to increase the acquisition and application of treatment skills.

This study also found that certain, non-specific factors can hinder treatment outcome. Of these factors, the one that presents the most promise for intervention is participant expectations. The finding that the accuracy of pre-treatment client expectations may moderate the relationship between expectancies and treatment outcome

has important implications for research and intervention. Measures can be devised and used to assess the accuracy of clients' pre-treatment expectations. Studies can then be conducted to test the hypothesis that inaccurate expectations moderate the relationship between expectancies and treatment outcome. This would be an important empirical endeavor since it is generally believed that many pre-treatment client characteristics that influence treatment outcome are not malleable (Nock & Kazdin, 2001). Should this relationship prove to be robust, these measures can then be used in clinical practice to assess and, if necessary, to change clients' pre-treatment expectations before conducting treatment. Clinicians can use information gathered in this manner to determine if it is necessary to provide clients with additional information about the process and typical outcomes of treatment. This may be particularly important with child and adolescent clients since participant expectations may be influenced by developmental differences.

## Study Limitations

The method of data collection in the present investigation was semi-structured interviews with pre-adolescents. Most of the interviews yielded comprehensive descriptions of the experience and evaluation of treatment and proved useful for examining relatively unexplored concepts. At times, however, this method of data collection was somewhat challenging for younger participants or for participants with less developed verbal skills. Some participants had difficulty with open-ended questions or with providing detailed responses. In future investigations, it may prove useful to combine semi-structured interviews with other assessment measures such as diaries or questionnaires.

The timing of the data collection was another limitation of the study. Since the semi-structured interviews were completed several weeks after treatment, the information that was gathered relied on retrospective accounts that may have been limited by the

participants' ability to recall different aspects of treatment. In future research, conducting interviews with participants before, during, and after treatment may provide richer and more accurate descriptions of the process and evaluation of treatment. In addition, participants could be asked to keep weekly diaries in which they record their experience and evaluation of the intervention over the course of treatment.

Since the model presented in this study is derived from data that was collected from depressed, pre-adolescent girls that had participated in a group CBT intervention, another limitation of this study is the ability of the findings to generalize to other populations (e.g., males, adults), different treatment modalities (e.g., IPT-A), or other forms of treatment delivery (e.g., individual therapy). As suggested earlier, the ACTION program should be adapted for use with males. It would be very interesting to replicate and compare the results of this study with depressed, pre-adolescent boys to see if gender differences exist in the experience and evaluation of treatment since the findings from this investigation suggest that the gender specificity of the group was an important element in building group cohesion and, ultimately, contributing to treatment outcome. To further explore how gender affects treatment outcome, it would be interesting to replicate and compare the present study with findings from a mixed-gendered ACTION program group. Finally, it would be interesting to replicate this study with adolescents and adults, with different treatment modalities, and with individual and family interventions. In order to truly be of service to our clients, we need to find a way to represent their voices in our research.

## Conclusion

Despite its limitations, this study is an important initial effort to better understand how and why therapy works from the perspective of the most important component in treatment: the client. It is my hope that the present investigation has demonstrated the

importance of understanding the process of therapy from the perspective of the client. I also hope that the present study has shown that children and adolescents are quite capable of understanding, communicating, and contributing their thoughts, feelings, and opinions about the therapeutic process and that these contributions are invaluable in terms of developing treatments that are truly helpful. Finally, it is my hope that the present investigation will inspire research and, ultimately, clinical practices with youth that endeavor to maximize recovery from depression by understanding and optimizing all of the factors, both specific and non-specific, that contribute to positive change.

# Appendix A

## DSM-IV-TR Criteria for MD, DD, and DDNOS

**Major Depressive Disorder, Single Episode**

A. Presence of a one or more Major Depressive Episodes
B. The Major Depressive Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode.

**Major Depressive Episode**

A. Five (or more) of the following symptoms must be present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood, or (2) loss of interest or pleasure.
    1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). ***Note:*** *In children and adolescents, can be irritable mood.*
    2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
    3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. ***Note:*** *In children, consider failure to make expected weight gains.*
    4. Insomnia or hypersomnia nearly every day.
    5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
    6. Fatigue or loss of energy nearly every day.
    7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
    8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
    9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms doe not meet criteria for a Mixed Episode.
C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

**Dysthymic Disorder**

A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account of observation by others, for at least 2 years. ***Note:*** *In children and adolescents, mood can be irritable and duration must be at least 1 year.*

B. Presence, while depressed, of two (or more) of the following:
    1. Poor appetite or overeating
    2. Insomnia or hypersomnia
    3. Low energy or fatigue
    4. Low self-esteem
    5. Poor concentration or difficulty making decisions
    6. Feelings of hopelessness
C. During the 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.
D. No Major Depressive Episode has been present during the first 2 years of the disturbance (1 year for children or adolescents); i.e., the disturbance is not better accounted for by chronic Major Depressive Disorder, or Major Depressive Disorder, in Partial Remission.

***Note:*** *There may have been a previous Major Depressive Episode provided there was a full remission (no significant signs or symptoms for 2 months) before development of the Dysthymic Disorder. In addition, after the initial 2 years (1 year in children or adolescents) of Dysthymic Disorder, there may be superimposed episodes of Major Depressive Disorder, in which case both diagnoses may be given when the criteria are met for Major Depressive Episode.*

E. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode, and criteria have never been met for Cyclothymic Disorder.
F. The disturbance does not occur exclusively during the course of a chronic Psychotic Disorder, such as Schizophrenia or Delusional Disorder.
G. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

**Depressive Disorder Not Otherwise Specified**

The Depressive Disorder Not Otherwise Specified category includes disorders with depressive features that do not meet the criteria for Major Depressive Disorder, Dysthymic Disorder, Adjustment Disorder with Depressed Mood, or Adjustment Disorder with Mixed Anxiety and Depressed Mood. Sometimes depressive symptoms can present as part of an Anxiety Disorder Not Otherwise Specified.

Minor depressive disorder is included in this category and represents episodes of at least 2 weeks of depressive symptoms but with fewer than the five items required for Major Depressive Disorder.

**Research criteria for minor depressive disorder:**

A. A mood disturbance, defined as follows:
    1. At least two (but less than five) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least on of the symptoms is either (a) or (b):
        a. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). ***Note:*** *in children and adolescents, can be irritable mood.*
        b. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
        *c.* Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite

nearly every day. ***Note:*** *in children, consider failure to make expected weight gains.*

   d. Insomnia or hypersomnia nearly every day.
   e. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
   f. Fatigue or loss of energy nearly every day.
   g. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
   h. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
   i. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

2. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
3. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
4. The symptoms are not better accounted for by Bereavement

B. There has never been a Major Depressive Episode, and criteria are not met for Dysthymic Disorder.

C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode, and criteria are not met for Cyclothymic Disorder.

D. The mood disturbance does not occur exclusively during Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

# Appendix B

## Sample Affective Education Worksheet

(Participant Workbook for ACTION; Stark et al., 2004b)

Tell about a time when your feelings changed:

What was your first feeling? Very sad.

What happened to change that feeling? Went outside and played with my friends.

What was the new feeling? Happy.

What were the clues?

Body: Butterflies inside.

Brain: Confusing thoughts.

Behavior: Crying.

What did you do to feel better? Played a game of tag with my friends.

## Appendix C

## Sample Coping Strategies Worksheet

(Participant Workbook for ACTION; Stark et al., 2004b)

Notice when you are feeling a negative emotion and try a coping strategy to help yourself feel better.

Describe what you felt and what you did using the form below.

I was feeling sad and nervous

So I tried to take ACTION by listening to music

And then I felt happy

## Appendix D

### Sample Problem-Solving Worksheet

(Participant Workbook for ACTION; Stark et al., 2004b)

Notice a time when you have a problem. Write about your problem and how you solved it by going through the 5 Ps.

What's the **problem**? The problem is my best friend thinks I'm taking another girl's side.

What's the **purpose**? What I want to have happen is for her to believe me than I'm not.

What are some **plans**? I could 1. Talk to her.

2. Write a letter.

3. Tell someone else to talk to her.

4. Call her on the phone.

5. Wait until she talks to me.

**Predict** and **pick** the best plan. It is #1.

How did it work? It worked fine. She believed me.

**Pat** yourself on the back!

## Appendix E

## Sample Cognitive Restructuring Worksheet

(Participant Workbook for ACTION; Stark et al., 2004b)

Step 1: What was happening? I thought a boy in my class was talking about me.

Step 2: Negative Thought: He was talking about me. He doesn't like me.

Step 3: What is your mood meter rating? (1-10) 5

Step 4: What's a different way to look at it? He was talking about something else.

What are the clues?

Clues for the thought: People told me.

Clues against the thought: None.

Step 5: New, Positive Thought: Just because he was talking about me doesn't mean that he doesn't like me.

Step 6: What is your new mood meter rating? (1-10) 9

## Appendix F

## Sample Self-Map

(Participant Workbook for ACTION; Stark et al., 2004b)

What's good about me…

As a friend I am funny, nice, crazy, playful, reliable, fun, active, loyal, helpful, worthy, positive, silly.

In my looks I have pretty eyes, clothes, jewelry, teeth, lips, smile, skin, cheeks, hair, and feet.

In school I am smart, good at sports, hard-working, curious, organized, respectful, patient, and helpful.

As a family member I am responsible, tolerant, supportive, helpful, loving, caring, sharing, and I do my chores.

In helping others I pick things up that people drop, I entertain my siblings, I baby-sit, I share things with other people, I try to cheer up my friends when they are sad, I stay in my seat in class, I do what I'm told, I give others compliments.

That I do for fun I'm good at dancing, shopping, playing basketball, writing, skateboarding, riding my motor scooter.

# Appendix G

## Sample Goals Sheet

(Participant Workbook for ACTION; Stark et al., 2004b)

Goal 1: **To get a better grade in Math.**

Problem-Solving: 1. Check over my work, 2. Do homework right after school, 3. Focus in class by ignoring other kids and listening to the teacher, 4. Do extra credit, 5. Get help from my sister or my dad.

Goal 2: **To worry less.**

Coping: 1. Play with my cat, 2. Play video games, 3. Do my sister's hair, 4. Play ball, 5, Fly a kite.

Problem-Solving: 1. Talk back to the worry thoughts, 2. Think of ways to solve the problems that cause the worry thoughts.

Change Thinking: 1. "I got passing grades on all of my report cards. So, if I'm passing now and I kept up with my schoolwork, then I will pass," 2. "I can get my work done. I will find a way to get it done. I almost always get it done."

Goal 3: **To spend more time with friends.**

Problem-Solving: 1. Ask my mom to drive me over to friends' houses, 2. Ask friends if they want to do homework together, 3. Invite friends over after school, 4. Invite friends to do something during the weekend.

## Appendix H

## Sample Take ACTION List (TAL)

(Participant Workbook for ACTION; Stark et al., 2004b)

Singing

Taking a bubble bath

Listening to music

Eating chocolate

Talking to my mom

Going to ACTION

# Appendix I

## Sample Catch the Positive Diary (CPD) Entry

(Participant Workbook for ACTION; Stark et al., 2004b)

I have gotten many compliments the past couple of days. I have gotten compliments on my eyes, my grades, my teeth, my clothes, the way I work with others, and the decisions I make.

## Appendix J

## Screening Permission Letter and Parental Consent Form

Dear Parent,

(Insert school name) is teaming up with Kevin Stark, Ph.D. from the University of Texas to evaluate a coping skills training program for girls called ACTION. The ACTION program is designed to teach girls how to manage their emotions and stress, solve problems, and think more positively about themselves. While we believe that all students could benefit from this program, currently, only girls who are experiencing high levels of distress will be able to participate. We are asking for permission from all parents of girls in grades (insert grades) for their daughters to participate in a screening that will help identify girls who are experiencing distress. Girls who participate in the screening will fill out a questionnaire that takes approximately 10 minutes to complete. Doctoral psychology students with appropriate training will supervise the completion of the questionnaires. At this time we do not anticipate any discomfort in completing the ACTION questionnaire.

Girls who report having more than a typical number symptoms of distress will be interviewed about specific symptoms of depression to determine if they are experiencing high levels of distress. The brief symptom interview will be conducted by trained graduate students or project staff under the supervision of Dr. Stark. If a girl in the study is reporting distress on the questionnaire or brief symptom interview, the parents will be contacted by phone to ensure the girl's well-being. ACTION staff or the school counselor may discuss your child's further participation in this research project at that time. For all girls who complete the questionnaire or interview and do not show significant symptoms of distress, parents will receive a letter stating those findings.

The purpose of the project is to determine whether the ACTION coping skills program is more effective than no counseling, and whether parent participation makes the program more effective. In addition, we are trying to learn whether adding follow-up meetings prevents future distress. The benefits to participants include possible participation in the ACTION program and helping advance our understanding of how to best help young girls manage emotions and stress, solve problems and feel better about themselves.

Participation in the project will not cost you anything and there will not be any financial compensation for participation. There are not any risks of harm from completing the questionnaire. There are no anticipated risks from completing the brief symptom interview. In fact, the procedure is designed to quickly identify and assist children who are in distress. All materials and forms will be stored in locked file cabinets in a secure office at UT to protect confidentiality.

If a child reports that she is at risk of hurting herself or others, her parents would be immediately informed and she would immediately talk with her school counselor. In addition, she would be evaluated by one of the consulting psychiatrists at no cost to the family.

If you choose to participate, you or your daughter may stop participation at any time. Participation in the study is entirely voluntary. You are free to say that you do not want to participate by returning this form indicating on the back of this page that you do not want to participate. You can refuse to participate without penalty or loss of benefits to which you and your daughter are otherwise entitled. It will not affect your relationship with your child's school or the University of Texas.

Researchers are required by Texas state law and professional ethics codes to report to Child Protective Services (or other appropriate regulatory agency) all instances of alleged child abuse and neglect. Please note that if your child completes the screening questionnaire or interview and is believed to be at risk for emotional, psychological or possible physical harm or neglect, then the investigator will report this information to the attending physician, Child Protective Services, and any other necessary regulatory agencies. Please note when a child reports neglect or being harmed, participants cannot stop the referral of their child's case to the authorities and any subsequent actions taken.

If you have any questions about the study, you can call Kevin Stark, Ph.D. at (512) 471-0267, your school counselor, or principal.

If you have questions about your rights as a participant, please contact Lisa Leiden, Ph.D., Chair, the University of Texas at Austin Institutional Review Board for the Protection of Human Subjects, (512) 471-8871.

Sincerely,

____________________________________________

Researcher's Signature

_____________________________________

Principal's Signature

_______________

Date

PLEASE KEEP THIS LETTER FOR YOUR RECORDS

PARENT/GUARDIAN SCREENING PROCEDURE CONSENT

Please check the appropriate box indicating that **YES** you have read this letter and are giving permission for your daughter to participate in the ACTION project at your child's school by completing the screening questionnaire and brief symptom interview, or **NO**, you have read this letter and you do not want your daughter to complete the questionnaire or interview. Regardless of your decision, please sign this form and return it to your child's teacher.

PLEASE RETURN THIS FORM TO YOUR CHILD'S SCHOOL WITH YOUR PREFERENCE NOTED BELOW:

______**YES, I give my permission** for my daughter to participate by completing the screening questionnaire and brief symptom interview.

_______**NO, I do not give my permission** for my daughter to participate by completing the screening questionnaire or brief symptom interview

________________________________________ ____________________
Parent's Signature Date

________________________________________
Child's Name (please print)

We will provide feedback for all participants. Please provide information below if your child will be participating.

Parent/adult guardian name(s): ________________________

Mailing address:____________________________ City/ZIP: ___________________

Parent phone number(s) in case we need to reach you with a concern about your child:

Home_________________Cell______________________Work________________

## Appendix K

## Child/Adolescent Assent Form for Screening

Child/Adolescent Assent Form

I agree to complete a questionnaire about my thoughts, feelings, and behaviors. This questionnaire has been explained to my parent or guardian and he or she has given permission for me to participate. I may decide at any time that I do not wish to participate and that it will be stopped if I say so. My specific responses will not be shared with anyone. However, general information about how I am doing and feeling may be shared with my parent.

When I sign my name to this page I am indicating that I read this page and that I am agreeing to participate.

________________________________________ ________________
Your Signature Date

________________________________________

Please Print your Name

Date of Birth ____________________
Month Day Year

## Appendix L

## Permission Letter and Parental Consent Form for K-SADS Interview

Dear Parent,

Per our contact with you regarding your daughter's responses to the screening questionnaire and brief symptom interview, we are requesting permission for you and your daughter to complete a more comprehensive interview that will help us determine more accurately whether she is experiencing serious emotional concerns or whether she was not feeling well on the days that she completed the questionnaire and brief interview. The interviews will be conducted by trained doctoral psychology students under the supervision of Kevin Stark, Ph.D., licensed psychologist. The interview of your daughter will be completed in a room at school that will protect her privacy. It takes 45 to 90 minutes to complete and asks specific questions about how your daughter is feeling, thinking and behaving and a range of experiences she may have encountered. The interview with you will cover the same topics and can be conducted in person or over the phone if that is preferable, at a time that is convenient for you. Participation in the interview will not cost you anything and there will not be any financial compensation for participation. Completed interviews will be stored in locked file cabinets in a secure office at UT to protect confidentiality. If she is, she may be eligible for participating in the ACTION program. If this wouldn't be the best program for her, we will provide you with possible resources from within the school and the community.

If a child reports that she is at risk of hurting herself or others, her parents would be immediately informed and she would immediately talk to her school counselor. In addition, she would be interviewed by Kevin Stark, Ph.D., a licensed psychologist, or one of the consulting psychiatrists at no cost to the family. If a child reports that she is being hurt, the school's standard procedures for reporting such instances to the relevant state agency would be followed.

The purpose of the project is to determine whether the ACTION coping skills program is helpful, and whether parent participation makes the program more effective. In addition, we are trying to learn whether adding follow-up meetings prevents future distress. If you have any questions about the study, you can call Kevin Stark, Ph.D. at (512) 471-0267 your school counselor, or principal.

If you choose to participate, you or your daughter may stop participation at any time. Participation in the study is entirely voluntary. You are free to say that you do not want to participate by returning this form indicating that you do not want to participate. You can refuse to participate and this decision will not affect your relationship with your child's school or the University of Texas.

Researchers are required by Texas state law and professional ethics codes to report to Child Protective Services (or other appropriate regulatory agency) all instances of alleged child abuse and neglect. Please note that if your child completes the screening questionnaire or interview and is believed to be at risk for emotional, psychological or possible physical harm or neglect, then the investigator will report this information to the attending physician, Child Protective Services, and any other necessary regulatory agencies. Please note when a child reports neglect or being harmed, participants cannot stop the referral of their child's case to the authorities and any subsequent actions taken.

If you have questions about your rights as a participant, please contact Lisa Leiden, Ph.D., Chair, the University of Texas at Austin Institutional Review Board for the Protection of Human Subjects, (512) 471-

8871. Let her know that you are enquiring about the study entitled "Helpfulness of the ACTION Coping Skills Program with and Without Parent Participation."

Please check the appropriate box indicating that **YES** you have read this letter and are giving permission for you and your daughter to participate by completing the interview, or **NO** you do not want to complete the interview nor do you want your daughter to complete the interview. Regardless of your decision, please sign this form and return it to your child's teacher. You will be given a copy of this permission letter to keep for your records.

☐ **YES,** I give my permission for my daughter and myself to participate by completing the interview.

☐ **NO,** I do not give my permission for my daughter and myself to participate by completing the interview.

| ______________________________ | ______________ |
|---|---|
| Parent's Signature | Date |
| ______________________________ | ______________ |
| Researcher's Signature | Date |
| ______________________________ | ______________ |
| Principal's Signature | Date |

## Appendix M

## Child/Adolescent Assent Form for K-SADS Interview

Child/Adolescent Assent Form

I agree to participate in an interview about my thoughts, feelings, and behaviors. It has been explained to me that this interview will help to determine whether the ACTIION counseling program may be helpful for me. This interview has been explained to my parent or guardian and he or she has given permission for me to participate. The interview will be stopped if I say so. Specific things that I say during the interview will not be shared with anyone. However, general information about how I am doing and feeling may be shared with my parent for the sake of talking about what to do to help me.

I will be asked to complete an interview about my current feelings, behaviors, and thoughts. By signing this form I am giving permission for the interview to be audio-taped for the purpose of being sure that the interview was conducted correctly. These tapes will be erased as soon as the ACTION program is completed.

It is okay if I decide to stop my participation in this interview at any time. When I sign my name to this page I am indicating that this page was read to me and that I am agreeing to participate.

______________________________ ______________

Child/Adolescent Signature Date

______________________________ ______________

Staff/Researcher Signature Date

# Appendix N

## Treatment Permission Letter and Parental Consent Form

Dear Parent,

Based on results of the screening and interview that you and your daughter have participated in so far, we are requesting permission for you and your daughter to continue and participate in the evaluation of the ACTION coping skills program. If you give your permission for your daughter to participate, she will be randomly assigned to one of three groups: (1) ACTION coping skills program, (2) ACTION coping skills program plus parent participation, or (3) wait to receive the program in about 12 weeks.

If your daughter is randomly assigned to the ACTION coping skills program, she will meet 20 times over the next twelve to sixteen weeks with a group of girls to participate in a counseling program that is designed to teach her problem solving, coping skills for managing her emotions and stress, and strategies for thinking more positively about herself and things in general.

If your daughter is randomly assigned to the counseling plus parent participation, she will meet 20 times over the next twelve to sixteen weeks with a group of girls to participate in a counseling program that is designed to teach her problem solving, coping skills for managing her emotions and stress, and strategies for thinking more positively about herself and things in general. In addition, you would be asked to attend a total of 10 meetings over this period that will last about an hour and a half. The parent meetings will be held at school after hours and daycare and refreshments will be provided at no expense. During these meetings parents will have a chance to learn the skills that their daughter is learning, and parents will learn strategies for helping their daughter to use the skills.

The girls will meet in a small group during an elective class. Each meeting will last one class period. Steps have already been taken to ensure that she will receive any class materials that she misses. The group meetings will be led by a trained doctoral psychology student or Ph.D. level therapist and a counselor from your daughter's school. The group leaders will be supervised by Kevin Stark, Ph.D. It is not expected that your daughter will experience any discomfort or risks from participating in the ACTION coping skills program. In fact, past experience with the program indicates that the girls enjoy participating and benefit from it.

If your daughter is randomly assigned to wait to receive counseling in about 12 weeks, we will take the following steps to ensure that she is okay. A doctoral psychology student will meet with her each week to monitor how she is doing, she will be discreetly observed in school at lunch or recess for about fifteen minutes per week, and the staff member will check-in with her teacher each week. In addition, every other week, the staff member will check with you to see if you have any concerns. At the end of the waiting period, she will have the opportunity to participate in the coping skills program. If at any point during this waiting period she reports feeling worse or you would like to seek counseling elsewhere, we will provide you with information about community and school resources. You have the option at anytime to seek additional services including consultation with one of the project's consulting psychiatrists at no cost to you.

We will be monitoring each girl's progress and report this information to two psychiatrists who are being paid by us to oversee each child's welfare. If a participant is not improving as a result of the program, then parents will be informed and we will meet with you to discuss other options for providing your daughter with help. If you would like information about medications that might be of assistance, the psychiatrists are available to meet with you and discuss these options at no cost to you.

To determine whether the ACTION coping skills program is helpful, we are asking you and your daughter to complete some questionnaires that help guide, and evaluate the effectiveness of the ACTION program. The questionnaires will take your daughter about one hour to complete. It will take you about 30 minutes to complete your questionnaires. We are asking you to complete the questionnaires so that we can determine whether participation in the ACTION program also benefits you and your family. The questionnaires have been completed by other children and adults without any discomfort. In order to assess the potential benefits of ACTION on school performance, our staff collects the following general education information: grades from reporting periods, attendance, and discipline information for participants.

For one year after completion of the ACTION program, your daughter will have the opportunity to meet with her group and apply the skills to the new problems and stresses that she faces as she grows up and navigates her way through the many difficulties of being a teenager. The groups will meet three times a semester over the rest of the course of the study. In addition, to determine if your daughter needs additional help, once a year, we will ask you and your daughter to complete the interview and the questionnaires to determine whether we have achieved the goal of preventing the difficulties from recurring. Each time in the future that you and your daughter are asked to complete the measures, you will be paid $25.00 and your daughter will be paid $20.00.

If a participant reports at any time that she is feeling like she would like to hurt herself or someone else, then, she would be immediately interviewed by a trained staff member and the school counselor. In addition, if there is concern about a child's safety, the staff member would immediately contact the parents and Kevin Stark, Ph.D. or one of the consulting psychiatrists. If at all possible, the psychiatrist on call would be available to meet with the girl and her parents to further evaluate the situation and to provide you with information about resources from within the community that could be of help. If it is not possible to immediately meet with one of the mental health professionals, then it would be recommended that the child and parents pursue the conventional procedure of driving to the emergency room of a local hospital. If a participant reports that she is being hurt, then the staff member and school counselor would follow the school's standard procedures for reporting such instances to the relevant state agency.

All of the services that we provide are available to you at no cost to your family.

The benefits to you and your daughter are that she may learn skills and strategies that will help her to be happy and healthy throughout adolescence. Similarly, you may learn strategies for helping her to successfully make it through adolescence. The benefit to society is that it will help us to determine whether teaching girls who are experiencing depression these skills helps to reduce the depression and whether it is even more helpful to involve parents. Furthermore, since girls are at very high risk for becoming depressed between the ages of 13 to 15, the results of this study will help us learn whether there is a procedure for preventing this from occurring.

The ACTION program meetings are audiotaped for quality assurance purposes. To ensure confidentiality, the following steps will be taken: (a) the cassettes will be coded so that no personal identifying information is visible on them; (b) they will be kept in a locked file cabinet in a secure office at UT; (c) they will be reviewed only for research purposes by the relevant research staff; and (d) they will be erased after they are checked and the study has been completed. Identifying information will be removed from all of the assessment materials completed during the study and the materials will be stored in a locked file cabinet in a locked research office at UT.

Participation in the ACTION coping skills program is entirely voluntary. You are free to refuse to be in the study, you are free to discontinue participation for any reason at any time, and your refusal or discontinuation will not influence current or future relationships with The University of Texas at Austin or your child's school district

Researchers are required by Texas state law and professional ethics codes to report to Child Protective Services (or other appropriate regulatory agency) all instances of alleged child abuse and neglect. Please note that if your child is believed to be at risk for emotional, psychological or possible physical harm or neglect, then the investigator will report this information to the attending physician, Child Protective Services, and any other necessary regulatory agencies. Please note when a child reports neglect or being harmed, participants cannot stop the referral of their child's case to the authorities and any subsequent actions taken.

If you have any questions about the study, you can call Kevin Stark, Ph.D. at (512) 471-4407, your school counselor, or principal. You may also contact the project coordinator, Jennifer L. Hargrave, Ph.D., with questions, concerns, or to withdraw from the study at any time at (512) 471-0218.

If you have questions about your rights as a participant, please contact Lisa Leiden, Ph.D., Chair, The University of Texas at Austin Institutional Review Board for the Protection of Human Subjects, (512) 471-8871. Let her know that you are enquiring about the study entitled "Helpfulness of the ACTION Coping Skills Program with and Without Parent Participation."

Please check the appropriate box indicating that **YES** you have read this letter and are giving permission for you and your daughter to participate in the ACTION coping skills program and to complete the questionnaires, or **NO** you do not want to participate in the ACTION coping skills program and you do not want to complete the questionnaires. Regardless of your decision, please sign this form and return it to your child's counselor. With this permission letter, you should have received a copy to keep for your records.

NOTE: TWO COPIES OF THIS LETTER ARE PROVIDED; ONE IS TO KEEP FOR YOUR RECORDS

PLEASE RETURN ONE COPY OF THIS PORTION TO THE SCHOOL COUNSELOR

☐ **YES,** I give my permission for my daughter, _________________________, and me to participate in the ACTION coping skills program and to complete the questionnaires. This includes permission for ACTION staff to access report card information, discipline referrals, and attendance records during participation.

☐ **NO,** I do not give my permission for my daughter, _____________________, to continue any further with the ACTION project.

Parent's Signature | Date
--- | ---

Kevin D. Stark, Ph.D. | Date

NOTE: TWO COPIES OF THIS LETTER ARE PROVIDED; ONE IS TO KEEP FOR YOUR RECORDS

# Appendix O

## Treatment Manual Excerpt

(Counselor Manual for ACTION; Stark et al., 2004a)

### INTRODUCE THE CATCH THE POSITIVE DIARIES

It may be beneficial to refer back to the Sunglasses activity from the first meeting, as well as the activity completed above with the candy and the beads. Catching positive events and feelings is an important way to start lifting the dark brown lenses. In order to help the participants catch the positive, discuss that they will each be keeping **Catch the Positive Diaries** for the rest of the group meetings. Give each participant a small notebook that will fit inside of her ACTION binder. Each notebook has a series of prompts the girls can utilize to help them direct their attention to positive things (for example: something nice someone did for me, a compliment someone gave me, a time I had fun with my friends, something nice I did for someone else, etc.). The girls can choose to write down any of these things but are free to write about any positive event they would like. Encourage individualization of this process. The girls can use the diaries to write the specific feelings they had about themselves and others as well as the thoughts they were having in addition to just the events. Inform the girls that every other meeting, they will have an opportunity to share the things they have written in the **Catch the Positive Diaries**.

### THE 3 B'S: RECOGNIZING EMOTIONS

The goal in this section is to provide a memory tool to help the participants to recognize the clues that define different emotions.

You have covered this to some extent during the Hula Hoop activity. You can go into more detail here. Put up the Emotion Detective **poster**. Note that the Emotion Detective also appears on page 6 of their Workbooks. On the Detective's notepad are the three places (3 B's: Body, Brain, Behavior) where people can tell what they are feeling. Introduce the Emotion Detective as someone that is being used to help them remember to try to find clues that tell them what they are feeling. Note that we want them to learn to recognize changes in their emotions so that they can use this as a sign to use one of the skills that we are going to teach them to help themselves to feel better.

Refer back to the cut outs they completed during the previous meeting and give examples of how they used the 3 Bs to tell how they were feeling.

1. Somewhere in your body.
2. In your brain—through thoughts.
3. In your behavior.

Choose 3-6 of the emotion cards that best characterize the dominant emotions of the members of your group. Ask the girls to take turns drawing a card from the pile and ask them to think back to the last time they felt that emotion. Encourage the participants to describe how they knew they were feeling that emotion (refer to the 3 B's).

In their

- Body
- Brain
- Behavior

As each participant describes her experiences, the therapist uses a cut-out to illustrate for the whole group where the participant was feeling the emotion, what she was thinking, and what she was doing. The main thing we want to do is to help the participants to recognize the internal and behavioral clues that they are experiencing various emotions. Eventually, we want those clues to become cues to engage in coping strategies.

Discuss how they just learned the **I** in ACTION—Identify the emotion. In other words, identify your feelings. If they can do this, then they can learn to take ACTION to feel better. When they notice they feel bad, they can use the things they are going to learn in the group to help themselves to feel better.

**INTRODUCTION TO COPING STRATEGIES**

Refer the participants to page 8 in their Workbooks. Discuss the idea that we are working hard at paying attention to the 3 B's because we want them to recognize when they first start to feel bad or worse. When they notice this, we want them to take ACTION to feel better. Solicit the participants' ideas about things that they can do to help themselves to feel better when they are in a bad mood. Remind them that they can do something fun like the hula hoops. Introduce and discuss the POSTER that has the 5 categories of coping strategies on it. Ask the girls to generate examples of what they do for each of the five categories of coping strategies. Write them down in your notes and on the poster board. AFTER THE ACTIVITY HELP THE PARTICIPANTS TO ADD A COUPLE EXAMPLES OF EACH OF THESE TO THEIR TAL.

1) Do something fun and distracting.
2) Do something soothing and relaxing.
3) Do something that uses energy.
4) Talk to someone
5) Think positive. (You may wish to note that what the participants did earlier by focusing their attention on the candy instead of the unpleasant sensation of the bead in their shoe was an example of this fifth coping strategy.

## Appendix P

## Parent Letter

Dear Parent(s)/Guardian(s),

You and your daughter are invited to participate in a project conducted by a graduate student researcher and ACTION counselor from the Department of Education at the University of Texas at Austin. You have been selected for participation in this program because of your daughter's participation in the ACTION program. The purpose of this research project is to learn more about the experience of counseling from your daughter's perspective as well as the effectiveness of the different counseling components or skills. This research project will be conducted under the supervision of Kevin Stark, Ph.D., a professor at the University of Texas at Austin and the primary investigator of the ACTION program.

If you decide to participate, a graduate student/ACTION staff member will interview your daughter at school, at your home, or at another convenient location on one or two occasions. The interviews will last approximately 30 to 45 minutes. The interview questions will focus on (1) what counseling was like for your daughter, (2) which counseling skills were helpful, and (3) ways that we can improve counseling for future participants.

Interviews will be audio-taped; however, all information that identifies you or your daughter will remain confidential. In addition, the audiotapes will be kept in a secure location and they will be erased once they are transcribed or coded.

Your decision whether or not to participate will not affect your present or future relations with the University of Texas at Austin, the (Name) School District, or the ACTION program. Should you allow your daughter to participate, she will have a chance to decide whether or not to complete the interviews. In addition, you and your daughter are free to discontinue participation at any time.

If you would like to participate, please sign and date the attached interview and audiotape consent forms and return them to your daughter's ACTION counselor or to the school counselor **no later than (Date).** Please keep a copy of the consent forms for your records.

Thank you for your time. If you would like to learn more about the project or have any questions, please contact Johanna M. Warchola at (512) 471-4407 or jmolnar@mail.utexas.edu.

## Appendix Q

## Parental Consent Form for Interview

***Informed Consent to Participate in Research***

**The University of Texas at Austin**

You are being asked to participate in a research study. This form provides you with information about the study. The Principal Investigator (the person in charge of this research) or his/her representative will provide you with a copy of this form to keep for your reference, and will also describe this study to you and answer all of your questions. Please read the information below and ask questions about anything that you don't understand before deciding whether or not to take part. Your participation is entirely voluntary and you can refuse to participate without penalty or loss of benefits to which you are otherwise entitled.

**Title of Research Study:**

Cognitive-Behavioral Therapy for Depressed Girls: A Qualitative Analysis of the ACTION Program

**Principal Investigator, Faculty Sponsor, UT Affiliation, and Telephone Numbers:**

Principal Investigator: Johanna M. Warchola M.A., Doctoral Candidate, School Psychology,
University of Texas at Austin
Telephone Number: (512) 471-4407

Faculty Sponsor: Kevin D. Stark, Ph.D., Professor of Educational Psychology, University of
Texas at Austin
Telephone Number: (512) 471-4407

**Funding Source:**

Not applicable. Only personal funds are used.

**What is the purpose of this study?**

The purpose of this study is to learn about the experience of counseling from your daughter's perspective. In addition, we would like to find out which ACTION program skills or components were helpful to your daughter. We are looking for ways to improve counseling by providing better and more effective treatment for children with symptoms of depression. In addition, the information gathered in these interviews will be used to complete the principal investigator's dissertation.

**What will be done if you take part in this research study?**

If you decide to participant and allow your daughter to participate, the primary investigator or another ACTION staff member will interview your daughter at school, at home, or at another convenient location on one or two occasions. Each interview will last approximately 30 to 45 minutes. The interview questions will focus on (1) what counseling was like for your daughter, (2) which counseling skills were helpful, and (3) ways that we can improve counseling for future participants. These interviews will be audio taped; however, all information that identifies you or your daughter will remain confidential and the audiotapes will be kept in a secure location and will be erased after they are transcribed or coded.

**The Project Duration is:**

The anticipated duration of this project is one school semester; however, the project will continue until the principal investigator's dissertation is complete.

**What are the possible discomforts and risks?**

There are few known risks involved in this study. Your daughter may disclose information during the interviews that affects her emotionally or she may feel uncomfortable talking about her experience in the ACTION program. Since the interview questions are not intended to cause discomfort, your daughter will not be required to answer any questions that she does not wish to answer. Your daughter will be provided with the option of taking breaks during the interview in order to avoid fatigue. Parents may contact the primary investigator in the days following the interviews with any questions or concerns, and we will coordinate with your daughter's ACTION program counselor and/or school counselor should it become clear that she requires further emotional support.

**What are the possible benefits to you or to others?**

Your daughter may enjoy talking about her experiences in the ACTION program and her participation in this study may help to improve future interventions with depressed children.

**If you choose to take part in this study, will it cost you anything?**

There is no cost for participating in this study.

**Will you receive compensation for your participation in this study?**

There is no financial compensation for participating in this study.

**What if you are injured because of the study?**

There are no known physical risks associated with this study.

**If you do not want to take part in this study, what other options are available to you?**

Your participation in this study is entirely voluntary. You are free to refuse to participate in this study or to allow your daughter to participate in this study, and your refusal will not influence current or future relationships with the University of Texas at Austin, the Pflugerville or Georgetown Independent School Districts, or the ACTION program.

**How can you withdraw from this study and who should you call if you have questions?**

If you wish to stop participation in this research study for any reason, you should contact Johanna M. Warchola at (512) 471-4407. You should also call the principal investigator for any questions, concerns, or complaints about the research. You are free to withdraw your consent and stop participation in this research study at any time without penalty or loss of benefit for which you may be entitled. Throughout the study, the researchers will notify you of new information that may become available and that might affect your decision to remain in the study.

In addition, if you have questions about your rights as a research participant, or if you have complaints, concerns, or questions about the research, please contact Lisa Leiden, Ph.D., Chair, the University of Texas at Austin Institutional Review Board for the Protection of Human Subjects, or the Office of Research Compliance and Support at (512) 471-8871.

**How will your privacy and the confidentiality of your research records be protected?**

Authorized persons from the University of Texas at Austin and the Institutional Review Board have the legal right to review your research records. If in the unlikely event it becomes necessary for the Institutional Review Board to review your research records, then the University of Texas at Austin will protect the confidentiality of those records to the extent permitted by law. Your research records will not be released without your consent unless required by law or a court order. The data resulting from your participation may be made available to other researchers in the future for research purposes not detailed within this consent form. In these cases, the data will contain no identifying information that could associate you with it, or with your participation in any study.

Interviews will be audio-taped and cassettes will be coded so that no personally identifying information is visible on them. Cassettes will be kept in a secure place (e.g., a locked file cabinet in the principal investigator's office) and will be heard only for research purposes by the primary investigator and her associates. Cassettes will be erased after they are transcribed or coded.

If the results of this research are published or presented at scientific meetings, your and your daughter's identity will not be disclosed.

**Will the researchers benefit from your participation in this study?**

This research is being completed as part of the degree requirements for a doctorate in Educational Psychology. Potential benefits of your and your daughter's participation include providing data for the primary investigator's doctoral dissertation.

**Signatures:**

As a representative of this study, I have explained the purpose, the procedures, the benefits, and the risks that are involved in this research study:

____________________________________________________________

**Signature and printed name of person obtaining consent** **Date**

You have been informed about this study's purpose, procedures, possible benefits and risks, and you have received a copy of this from. You have been given the opportunity to ask questions before you sign, and you have been told that you can ask other questions at any time. You voluntarily agree to participate in this study. By signing this form, you are not waiving any of your legal rights.

____________________________________________________________

**Printed Name of Subject** **Date**

____________________________________________________________

**Signature of Subject** **Date**

____________________________________________________________

**Signature of Principal Investigator** **Date**

## Appendix R

## Child/Adolescent Assent Form for Interview

Assent Form
ACTION Program Experience
(Reactions to being in the ACTION program)

I agree to be in a study about my experience in the ACTION program. This study was explained to me by my parent(s) or guardian(s) and she/he/they said that I could be in it. The only people that will know about what I say and do in the study will be the people in charge of the study and my parent(s) or guardian(s). My name will not be shared with anyone outside of this study.

In this study, I will be interviewed by an ACTION program staff member. I will be asked questions about my experience in the ACTION program. I will be asked about what I liked, what I didn't like, and ways that the program did or did not help me to feel better. My answers will not be shared with my ACTION program counselor or school counselor. I understand that it is important for me to be honest. I also understand that I do not have to answer any questions that I do not want to answer and that I can stop the interview(s) at any time. Finally, I understand that doing this interview(s) does not change my participation in the ACTION program. If I decide not to do the interview(s), then I will still be in the ACTION program.

Writing my name on this page means that I have read this page or that it was read to me and that I agree to be in the study. I know what will happen to me. If I decide to quit the study, all I have to do is tell the person in charge.

________________________________________ ______________
Child's Signature Date

________________________________________ ______________
Signature of Researcher Date

## Appendix S

### Sample Therapist Session Summary

(Counselor Manual for ACTION; Stark et al., 2004a)

*Please describe the following information for each participant: (1) attendance (present/not present), (2) mood (happy, sad, anxious, etc.) and behavior (talkative, withdrawn, hyper, etc.), (3) degree of participation in the meeting in terms of talking and listening, (4) degree to which she demonstrated understanding of the concepts discussed in the meeting, (5) specific examples of her using skills discussed in the meeting, (6) any important information that was revealed during the meeting (issues related to core beliefs, self-schema, interpersonal relationships, family dynamics, and (7) whether or not the skills taught in this meeting seem be to helping this girl.*

Date of meeting: 10/19/05, 8:15-9:15

Participant 1: 1) present, 2) happy and talkative, a little anxious, 3) talked the most of the four girls, introduced self immediately and asked the names of the other girls, engaged in a little side talking but responded to redirection, 4) seemed to grasp concepts readily, contributed meaningfully to sunglasses activity, may require reinforcement to show good listening behaviors, 5) followed rules, was actively engaged, seemed excited to be in group, 6) seemed somewhat anxious, demonstrated some excessive chatter, very friendly with other girls, smiled a lot, 7) seems like this girl will respond well to the group

Participant 2: 1) present, 2) happy, pleasant affect, smiled and laughed appropriately, 3) talkative, but not overly so, listened well to others 4) seemed to grasp concepts easily, 5) contributed meaningfully to sunglasses discussion, followed rules, 6) talked about her parent living in City, State, mentioned this was her first year at ABC school, talked about 2 best friends - one of which Participant 4 knows, 7) seems to respond very positively to being in group

Participant 3: 1) present, 2) flat affect but did smile a few times, 3) relatively quiet but did answer questions, contributed to group rules, volunteered ideas about confidentiality, did not suck thumb, 4) seemed to understand concepts well, 5) contributed meaningfully to sunglasses discussion, 6) soft-spoken, described herself as a "unique artist," mentioned that she wanted to be on a gymnastics team but her parent did not follow through - face became more sullen when she said this, said she was new to ABC school this year, 7) seems to respond well to being in group

Participant 4: 1) present, 2) neutral, pleasant affect, smiled some but less positive affect than both times we met for measures, 3) did not talk much but listened well, did contribute some but not as much as the other girls, 4) seemed to grasp concepts easily, 5) followed group rules, contributed meaningfully to sunglasses discussion, 6) quieter than I was expecting based on previous interactions - unsure why, 7) unsure how she feels about being in group - will continue to monitor

*Please note your overall impressions of the meeting. What did you think or feel about the meeting? What did you think or feel about the content, the participants, your ability, etc.?*

I thought this was a good first meeting. The girls seemed to be excited about being there (Participant 4, less so). They seemed to get along well. They all jumped right in and participated from the beginning - contributing to confidentiality discussion, setting rules, and discussing the sunglasses activity. They were able to focus their attention (Participant 1, less so). I really like these girls and am looking forward to working with them.

## Appendix T

## Sample Case Conceptualization

(Counselor Manual for ACTION; Stark et al., 2004a)

Therapist(s):
Subject #:
Date:
Sessions referring to: Session 6

| **Core Belief(s)** | | |
|---|---|---|
| I'm unlikable<br>I'm a victim<br>**I'm helpless** | | |
| **Conditional Assumptions/Beliefs/Rules** | | |
| It's all my fault<br>The world is a very mean place<br>You cannot depend on other people (to be consistent)<br>Other people will get in my way | | |
| **Compensatory Strategy(ies)** | | |
| Does not form close attachments with others; plays by herself<br>When others are emotional, she makes jokes, smiles, and becomes distracted | | |
| **Situation 1**<br>Has a lot of homework | **Situation 2**<br>The teacher gives her homework | **Situation 3**<br>Her father acts inconsistently |
| **Automatic Thought**<br>"I won't be able to get it all done." | **Automatic Thought**<br>"The teacher is giving me so much homework!" | **Automatic Thought**<br>"He's evil. He's mean." |
| **Meaning of the A.T.**<br>I'm helpless | **Meaning of the A.T.**<br>I'm helpless/a victim | **Meaning of the A.T.**<br>I'm helpless |
| **Emotion**<br>Anxiety, sadness | **Emotion**<br>Mad | **Emotion**<br>Sad |
| **Behavior**<br>Panics, tells us that she can't come to group | **Behavior**<br>She thought about it in a more positive way "I guess I'll know what to do in 7th grade" | **Behavior**<br>Withdrawals?? |

## Appendix U

## Sample Skills Quiz

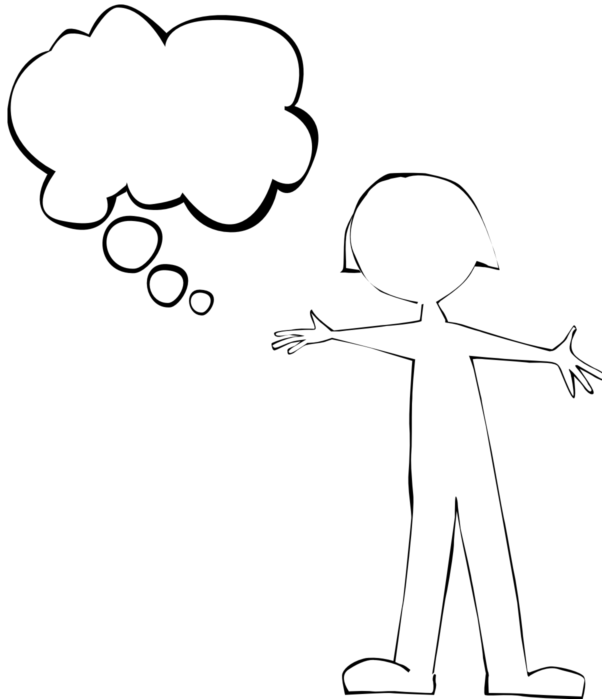
(Counselor Manual for ACTION; Stark et al., 2004a)

**Skills Check #1**

Name: ________________________________

Name the **negative or bad emotion** you have most often _________________________

Be an Emotion Detective. On the cutout, use the **3 Bs** to write or draw how you would know you're having that emotion.



Imagine that you could not change what was happening to make you feel bad. What could you do to help yourself feel better? Write down the **5 Coping Strategies** or "Make me feel betters" and give an example of each one.

| Coping Strategies | Example |
|---|---|
| 1. ____________________________ | ____________________________________ |
| 2. ____________________________ | ____________________________________ |
| 3. ____________________________ | ____________________________________ |
| 4. ____________________________ | ____________________________________ |
| 5. ____________________________ | ____________________________________ |

Imagine that you could change what was happening to make you feel bad. Write down **the 5 Problem Solving Steps or the 5 P's**.

**Problem Solving Steps**

1. ______________________________________________________________

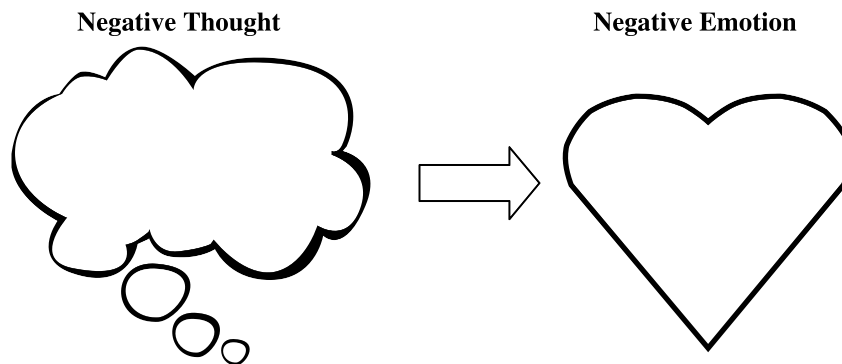
2. ______________________________________________________________

3. ______________________________________________________________

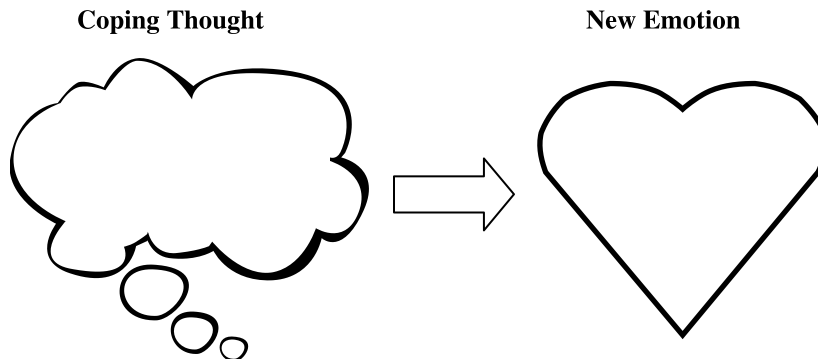
4. ______________________________________________________________

5. ______________________________________________________________

Sometimes our thoughts cause us to feel bad. Write a **negative thought** you have most often in the thought bubble and then put the **feeling or emotion** you would have if you had that thought in the heart.




Now, think of a **coping thought** or a **new, more positive thought** and write it in the thought bubble. Then, write down the **feeling or emotion** you would have if you thought the coping thought instead in the heart.



## Appendix V

## Satisfaction Questionnaire

(SQ; Stark, 2001)

### Satisfaction Questionnaire - Child

Name: ________________________________________________

For the following questions, please circle the answer that best describes how you feel:

1. How satisfactory or likeable was the counseling?

| Very unsatisfactory | Unsatisfactory | Somewhat unsatisfactory | I don't know | Somewhat satisfactory | Satisfactory | Very satisfactory |
|---|---|---|---|---|---|---|

2. If you felt very sad or angry again, how willing would you be to participate in this counseling again?

| Very unwilling | Unwilling | Somewhat unwilling | I don't know | Somewhat willing | Willing | Very willing |
|---|---|---|---|---|---|---|

3. How well would this counseling work for children with other kinds of emotional concerns?

| Not at all | Badly | Somewhat badly | I don't know | Somewhat | Good | Very well |
|---|---|---|---|---|---|---|

4. How much do you think the counseling helped you?

| Not at all | Very little | I don't know | A little | It helped | A lot | Very much |
|---|---|---|---|---|---|---|

5. How understandable were the materials covered in the meetings?

| Not at all | Very little | I don't know | A little | Understandable | A lot | Very |
|---|---|---|---|---|---|---|

6. How considerate was this counseling of your feelings?

| Very inconsiderate | Inconsiderate | Somewhat inconsiderate | I don't know | Somewhat considerate | Considerate | Very considerate |
|---|---|---|---|---|---|---|

7. Did bad or unpleasant things happen to you from participating in the meetings?

| No | A couple | A few | Some | Pretty many | A lot | Very many |
|---|---|---|---|---|---|---|

8. How likely is this counseling to help you feel better forever?

| Very unlikely | Unlikely | Somewhat unlikely | I don't know | Somewhat likely | Likely | Very likely |
|---|---|---|---|---|---|---|

9. Would you recommend this counseling program to a friend who was feeling sad or angry?

| No | Doubtful | Unlikely | Maybe | Yes | Definitely | Absolutely |
|---|---|---|---|---|---|---|

10. How many of the activities did you like?

| None | A couple | Some | Pretty many | Most | Almost all | All |
|---|---|---|---|---|---|---|

## Appendix W

## Example of Open Coding

Interviewer: And out of all of the things that they taught you, what helped you the most?

Participant: I think coping helped me the most (“**coping” strategies are most helpful treatment component).**

Interviewer: Why do you think that helped you the most?

Participant: ‘Cause, at the beginning (**pre-treatment**), like I think it’s like coping (“**coping” strategies**) and liking myself (**positive self-regard/self esteem**) or, you know, like spending more time with myself ‘cause coping (“**coping” strategies**) like, I guess, at the beginning (**pre-treatment**), I didn’t know what to do when I was upset (**lacked knowledge of how to manage unpleasant emotions**). I was just upset (**experienced unpleasant emotions**) and I didn’t know how to fix it (**lacked knowledge of how to manage stressor**), so I think coping (“**coping” strategies**), like, it gave me something, like, to do to (**provided a skill**), like, get my mind off of things (**distraction**). And then like, liking myself (**positive self-regard/self esteem**), it would be like, I guess just like focusing more on me (**increased self-attention**) ‘cause when they (**ACTION therapists**) taught us that, you know, you have to love yourself too (**worthiness/lovability**), don’t always put people first – I mean it’s okay to sometimes, but I guess that helped me a lot (**high level of helpfulness)** because I kinda put other people before me usually.

Interviewer: So, coping gave you a way to deal with the problems that you were having?

Participant: Uh huh.

Interviewer: So, before the ACTION program, how did you deal with problems?

Participant: I think I pretty much…I like dwelled on my problems (**rumination**). Like I’d never, I’d either fix it right away (**immediately engage in problem-solving**) or I’d just dwell on it (**rumination**) and never fix it (**never manage stressor**) and it would always just be like there (**chronic stressor**).

*Note*. Researcher codes are in bold and in-vivo codes are in parentheses.

## Appendix X

## Example of Memo

<u>Memo: Participant Expectations</u>

Some participants seemed to believe that the ACTION program will solve all of their problems. Where did the expectation come from? All three of the girls, Lucia, Mahina, and Gwendolyn, that held this expectation were in different groups, so it was probably not a message that they received from their therapist (unless all of the therapists sent this message). Having led Mahina's group, I know that this message was not conveyed directly; however, it may have been implied as different skills were taught. We do talk about using different skills to address different problems, which may imply that there's a skill for every problem.

Did all of the girls have this expectation? No one else talked about it. Did the treatment solve all of the girls' problems? No. Sophie had similar problems before and after group. Before group, she was the subject of gossip and rumors. After group, she said that people still put her down, but she said that it only gets to her when it happens "a lot." Paris also had similar stressors before and after group and, in fact, some of them were getting worse, like her brothers getting into trouble. These girls said that treatment helped them a lot. So, even though it did not resolve all of their problems, they still found that it had a high level of helpfulness. Since these girls still found treatment very helpful despite the fact that it did not resolve all of their problems, it seems likely that they did not have the expectation that treatment would fix everything. This is interesting because Sophie was in Lucia's group and Paris was in Gwendolyn's group. Although these girls were in the same group, they had very different group expectations. This lends support to the idea that this expectation was not imparted by the therapists.

So, where did it come from? Stage of development and culture do not seem to account for it since these three girls came from different ethnic backgrounds and grades. Where do expectations come from? We learn to expect things through repeated experiences. For example, my cat expects me to feed him in the morning because it is the first thing that I do when I get up. If I do not feed him before taking a shower, then he sits on the bathmat and voices his complaints. None of these girls were in therapy prior to the ACTION program, so they did not acquire this expectation as a result of prior treatment experiences.

Regardless of where the expectation came from, it seems to be an important factor in treatment evaluation and outcome since these three girls found the ACTION program to be less helpful. Expecting that the ACTION program would solve *all* of their problems seems to be somewhat unrealistic. Therefore, unrealistic expectations can hinder treatment outcome, whereas realistic expectations may facilitate it. In these examples, the participants' expectations seem to be personal beliefs rather than something that was specifically imparted in treatment. Thus, they are non-specific factors (i.e., client characteristics). Since expectations may be malleable, they seem to represent an opportunity to influence treatment outcome. We should probably address expectations more thoroughly at the beginning of treatment in order to prevent the development of unrealistic ideas.

## Appendix Y

## Examples of Axial Coding

Phenomenon: Stressor Management Strategies (during treatment)

<u>Interview: Olivia</u>
Causal condition: Has nothing to do
Contextual condition: At home, by herself
Intervening condition: Feels sad
Action: Listens to music
Consequence: Feels better
Properties:

- Amount: One strategy
- Type: Relaxation
- Domain: Emotion-focused
- Approach: Active
- Level of Helpfulness: High

<u>Interview: Gwendolyn</u>
Causal condition: Has a lot of homework to do
Contextual condition: At home
Intervening condition: Feels aggravated
Action: Plays with mother
Consequence: Feels better
Properties:

- Amount: One strategy
- Type: Distraction
- Domain: Emotion-focused
- Approach: Active
- Level of Helpfulness: High

<u>Interview: Paris</u>
Causal condition: Parents have a fight
Contextual condition: At home
Intervening condition: Feels helpless; thinks "I can't do nothing about it"
Action: Plays outside, listens to music, watches TV
Consequence: Feels better
Properties:

- Amount: Three strategies
- Type: Distraction and relaxation
- Domain: Emotion-focused
- Approach: Active
- Level of Helpfulness: High

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# VITA

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