Helping Depressed Adolescents: A Menu of Cognitive-Behavioral Procedures for Primary Care

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Depression among adolescents has received recognition as a significant psychiatric problem that requires prompt intervention. This article will help primary care providers to understand the significance of adolescent depression, recognize its prevalence in primary care, cite the evidence supporting cognitive-behavioral therapy (CBT) as a treatment for depressed adolescents, recognize the challenges of using CBT in primary care, and use 7 different CBT approaches with their patients. Psychiatric diagnoses may be present in 38% of adolescents who see a primary care physician, and among that number, depression is the most common diagnosis. Cognitive-behavioral therapy provides a scientifically proven tool for those physicians who want to provide their young depressed patients an effective counseling approach. Cognitive-behavioral therapy enhances self-control, perceptions of personal efficacy, rational problem-solving skills, social skills, and participation in activities and physical exercise that bring the adolescent a sense of pleasure or mastery. CBT has been proven to be effective when delivered by physicians who have received significant instructions. Unfortunately, CBT techniques can at first seem overly abstract, overwhelming in number, and difficult to teach in the 15-minute visit. However, CBT techniques can be made clear and accessible for a busy physician. The case of a depressed 14-year-old male high school student who comes to his physician for a pre-participation sports physical is presented to illustrate the application of CBT in primary care.

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CASE REPORT

Jay Somerset is a 14-year-old ninth-grader. Jay and his family have just moved to the community, and he is visiting Dr. Regan, a family physician, for the first time. Jay is trying out for his high school's freshman soccer team, and the school district requires a pre-participation physical. His stepmother accompanies him.*

Jay has been quiet so far. Mrs. Somerset energetically takes the lead. She works at home taking care of her family, a career she has taken on with remarkable determination and patience. She married Jay's father 2 years ago. In addition to Jay, the Somersets have a 5-month-old son and 2 sons older than Jay from Mr. Somerset's first marriage. Jay's natural mother has been out of touch with him since the divorce 4 years ago.

Mrs. Somerset tells Dr. Regan about Jay's medical history including the successful heart surgery he had 1 year ago. She reports that Jay has recovered beautifully. Mrs. Somerset adds that Jay seems unenthused about soccer and says that, "He's been looking sad lately." She has had difficulty getting Jay out of bed on time for school. Jay tells her that he feels "bored." Dr. Regan thanks Mrs. Somerset for bringing in the medical records. He then suggests that she step outside while he examines Jay.

BACKGROUND

Over the past several decades, depression among adolescents like Jay has received recognition as a significant psychiatric problem that requires prompt intervention.[1] Although many physicians rely on psychopharmacology to treat depression, cognitive-behavioral therapy (CBT) is a scientifically proven addition or alternative for those physicians who want to provide an effective counseling approach. Cognitive-behavioral therapy encourages practitioners to diagnose possible dysfunction by assessing how a person appraises the world, solves interpersonal problems, and navigates the social environment. It is a "talking therapy." Practical, active, and problem-oriented, CBT aims to teach patients skills to more effectively

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cope. Cognitive-behavioral therapy practitioners help patients change the maladaptive beliefs, attitudes, and behaviors that create the emotional distress.[2] Cognitive-behavioral therapy can include such active interventions as teaching patients about the causes of depression; how to monitor mood; how to articulate reasonable and reachable goals; how to negotiate, compromise, and be assertive with others; and how to increase pleasant and pleasurable activities.

Cognitive-behavioral therapy may include "homework" assignments for the patient to complete. The "cognitively" oriented interventions include a hallmark CBT approach of teaching persons to avoid perceiving or judging situations as "terrible" or "awful" or "catastrophic" or "impossible" to handle. Cognitive-behavioral therapy maintains that such extreme interpretations and judgments can occur rather quickly and can be psychologically toxic, leading a person to feel depressed. The CBT approach helps patients recognize that forming these harsh perceptions is harmful and teaches them to use more realistic and factual appraisals of events. Other cognitive CBT approaches include teaching patients a step-by-step social problem-solving strategy such as defining a problem, identifying a clear goal, and brainstorming solutions. The more "behaviorally" oriented CBT interventions include procedures that enhance self-control, such as diaphragmatic breathing, developing social skills such as how to comport one's body posture and eye contact in different social situations, learning how to assertively handle peer pressure, and being encouraged to participate in activities that bring the adolescent a sense of pleasure or mastery.

Some primary care physicians have incorporated behavioral health professionals such as licensed psychologists, nurses, and social workers into their practice to provide CBT for their patients. However, expectations for physician competency in CBT may be growing because there may be few CBT practitioners to whom referrals can be made or because adolescents may prefer seeing their own primary care physician for their counseling.

This article will help health care providers understand the significance of adolescent depression, recognize its prevalence in primary care, cite the evidence supporting CBT as a treatment for depressed adolescents, recognize the challenges of using CBT in primary care, and select from a menu of 7 different CBT approaches with these patients. It is very important to note that physicians are not expected to learn and use all of the techniques presented here. Primary care physicians are just too busy in their daily practice for that. This article aims to encourage physicians by demystifying CBT concepts and techniques and offering a "menu." Realistically, most physicians will select 1 or more of the simplest and most practical CBT procedures from this menu that best fit their personal style and patient population.

THE SIGNIFICANCE OF ADOLESCENT DEPRESSION AND DYSPHORIA

Epidemiologic studies indicate that whether it is first incidence, total incidence, or lifetime prevalence, the number of high school students with depression is high. One prevalence study[3] examined data from an initial sample of 1710 high school students. The authors ask the reader to imagine a high school of 1000 students. Based upon their data, the authors predict that during 1 school year approximately 42 students will become depressed and that among those depressed students, 32 will become depressed again. So, the physician going to a weekend football game at that 1000-student high school can expect that 74 students will qualify for a diagnosis of depression that year. These large numbers suggest a serious charge for all primary health care providers to examine how they clinically and programmatically identify and treat these adolescents.[3] The consequences of untreated depression in adolescents can be gravely serious. Depression among young people is associated with a wide range of negative outcomes including but not limited to severe social impairment, long-lasting effects on cognitive development, suicidal behavior, and a high risk of recurrence.[4] In 1 important follow-up study,[5] adolescents who had been diagnosed with major depressive disorder were compared with adolescents without psychiatric disorders 10 to 15 years later. The depressed group was at increased risk for a number of problems including increased medical and psychiatric hospitalizations, suicide attempts, and life challenges at home, at work, and in social groups.[5]

PREVALENCE OF ADOLESCENT DEPRESSION IN PRIMARY CARE

Unfortunately, studies of the rates of psychiatric disorders among adolescents in primary care are rare. One important study[6] was completed in a primary care practice in central London, a community described as heterogeneous in ethnicity, culture, and socioeconomic status.[6] The 212 teens that came into the office over a 10-month period were asked to participate without any special consideration for age, gender, reason for their coming into the office, or any assessment of psychological or psychiatric disorders. Of those 212 adolescents who were initially approached, 57 males and 79 females consented to participate. Seventy percent of the presenting complaints were respiratory illness or ill-defined signs or symptoms (aches and pains, poor appetite, injury, poisoning, and musculoskeletal problems such as stiff neck). Only 4 cases presented primarily with a psychiatric problem. The adolescents were interviewed using the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS-III-R),[7] a semistructured interview protocol. Additional data were obtained through interviews with the

parents using the Child Behavior Checklist,[8] another instrument of well-established reliability and validity. The researchers report that *Diagnostic and Statistical Manual of Mental Disorders,* Third Edition (DSM-III-R), diagnoses were present in 38% of the teens. Of the psychiatric diagnoses, major depression was the most common, followed by depressive disorder not specified and dysthymia.[6]

EVIDENCE SUPPORTING THE EFFECTIVENESS OF COGNITIVE-BEHAVIORAL THERAPY WITH ADOLESCENTS

An important analysis of the effectiveness of CBT in treating depression and depressive symptoms among adolescents provides encouragement for this treatment.[9] The a priori criteria for the studies included in this meta-analysis were the following: the CBT interventions taught patients to change their thought processes in an overt, active, and problem-oriented manner; the studies were written in English, were conducted between 1970 and 1997, and focused on teens aged 19 or younger who were clinically depressed or dysphoric; and every study compared a CBT group with a randomly assigned control group (e.g., a relaxation or wait-list control) from the same population. In addition, the authors of these studies do not report any external funding sources that would suggest a publication bias. As a way of ensuring the quality of the studies that were reviewed, the authors report using 3 methods to locate studies. These include computerized investigations of medical and psychological databases, a manual search of pertinent journals, and a review of references from both identified studies and narrative descriptions of CBT therapy. The authors also report that with this literature approach, there may have been a bias against studies that had negative findings. Six studies with a total of 241 participants met the pre-established criteria. The studies in this meta-analysis measured depression with such valid and reliable measures as the Reynolds Adolescent Depression Scale[10] or the Children's Depression Inventory.[11] The authors concluded that CBT may be useful for reducing dysphoria among adolescents and that treatment gains are maintained over time. Although their conclusions are based on a limited number of studies, the authors maintain that their findings are robust and consistent with outcome research with depressed adults.[9]

A second systematic review provides further encouragement.[4] In this review, the criteria for eligibility included those studies in which the subjects were diagnosed with depressive disorder using DSM-III-R criteria, were between 6 and 18 years old, and were randomly assigned to CBT or a comparison intervention. As in the prior review,[9] the authors do not report any external funding sources that would suggest a publication bias. The authors report a literature search that began with MEDLINE and PsychLit. Conference proceedings were also reviewed, as were reviews and book chapters. The computer searches were repeated, and journals that had published a randomized controlled trial in the CBT field were also searched manually. In addition, authors who had published papers on CBT were contacted to learn more detail about their work. Investigators working in the field of CBT were also contacted, and a search for randomized controlled trials of CBT was made of the Cochrane Library. Six studies emerged that fit the above criteria, all dealing with outpatients. Two of the studies in this systematic review were studies that were also included in the prior review.[9] The comparison groups used in these 6 studies were varied and included a waiting list control, art exercises, relaxation training, supportive therapy, and family therapy. The authors report that all studies showed positive effects in favor of CBT. They conclude that CBT may be of benefit for mild or moderate depression among youngsters.

The evidence that supports the effectiveness of CBT with depressed adolescents often presents a specific bundle of CBT approaches as the treatment package. In one study,[12] a group CBT approach was examined. Some depressed adolescents were randomly assigned to the CBT group therapy experience that taught such depression-lifting skills as mood monitoring and how to improve social skills, decrease anxiety, and improve communication. Other depressed adolescents were randomly assigned to a control group that taught such life skills as filling out job applications and reviewing current events. The CBT group curriculum approach was proven to be an effective approach. In fact, the authors report that the odds of recovering from major depressive disorder after treatment for the CBT group were more than 2-fold those for the comparison group. As a follow-up to this study, researchers[13] report that reducing negative thinking may be the most important mediator as compared with such mediators as improved social skills, increased engagement in pleasant activities, the use of relaxation techniques, and improved problem-solving conflict-resolution skills. The science of separating out what specific CBT elements are the most critical is just beginning to be developed. Until this separation process is more definitively shaped, clinicians are encouraged to become acquainted with the variety of techniques presented here and use a broad approach by packaging 2 or 3 that are appealing.[9]

USING COGNITIVE-BEHAVIORAL THERAPY IN PRIMARY CARE

Many primary care physicians struggle to provide their patients with adequate behavioral health care, and CBT has presented its own unique obstacles. Primary care physicians must overcome a paucity of efficient screening tools and systems, a lack of knowledge of behavioral health issues and treatment providers, and an absence of adequate reimbursement for attending to these issues.[14]

Cognitive-behavioral therapy has been proven to be effective when delivered by physicians who have received significant instructions, but, unfortunately, a great many physicians do not have the time or interest to pursue such training.[15] Some physicians may get discouraged because CBT techniques can appear overly abstract, overwhelming in number, and difficult to teach in the 15-minute visit or even in a succession of such visits.

But CBT techniques can be unpacked and made clear and accessible for busy physicians, and that is the main objective of this article. Each of the summaries of the CBT techniques presented here includes a reference for those who are interested in additional detail. For our present purpose, think of this menu of 7 CBT approaches like the menu of dinner specials in 1 of your favorite restaurants. Of all the possible specials, the chef determines which ones might most appeal to the customer. The customer narrows matters down even more by selecting an item or 2 that looks appealing. The following menu is not meant to be comprehensive. Rather, it is a subset of possible CBT approaches that might appeal to primary care physicians. To make it easier for busy physicians to add these techniques to their repertoire, the procedures are presented in a stepwise fashion beginning with the most simple, practical, and time-efficient ones. However, all of the strategies presented have been selected because of their relative ease of use. The case of Jay is included to illustrate how the techniques can be applied. It is not meant to imply that the order in which the techniques are presented here with Jay is the order in which practitioners should use them. While it is recommended to begin with the BATHE technique to assess the psychosocial world of the patient, Jay's physician could have easily used any of the other techniques in any order. Oftentimes the decision to use a particular technique is based upon the personal style and comfort level of the physician.

When physicians successfully use CBT with adolescents, they provide another effective treatment: interpersonal support for the family. An important consideration is how parents and caregivers might be included in the process. The physician and adolescent can discuss how to enlist the support of parents and other caregivers. Physicians working with teens need to explain to the adolescent that in the case of potential physical risk to himself/herself or others, parents and caregivers need to be advised. Preparing for a discussion with parents or caregivers is a challenging task for the teen and doctor. But of the available short-term therapies, CBT can make this kind of sharing a more comfortable experience. This is because CBT techniques are explicit and quite visible. It is often therapeutic for a depressed adolescent to be given the opportunity to explain the skills to the parents in the presence of the physician. This also provides more practice opportunities for the adolescent to "over-learn" the skills. Confidentiality between adolescent and doctor still applies, but the doctor can work with the teen to discuss how to bring the parents on board with an understanding of the kind of at-home support that is needed. One of the great benefits of the CBT procedures presented here is the emphasis on practical technique. It cannot be overemphasized, however, that the rapport, bonding, and therapeutic alliance between physician and patient are foundational to this therapeutic intervention. The following narrative introduces the 7-CBT-procedure menu, and Table 1 provides a summary reference.

(1) BATHE: Background, Affect, Trouble, Handle, and Empathy

The purpose of this procedure is to assess what is going on psychosocially with the patient. While it is not specific to CBT, the BATHE approach[16] is one of the most helpful and supportive ways to accomplish this. BATHE is useful not only as a way to identify psychosocial problems, but also as a way to help the physician focus on what most concerns the patient in that area. It also helps determine what, if any, additional intervention might be needed. As he examines Jay, Dr. Regan respectfully and efficiently assess Jay's psychosocial world.

Background.

Dr. Regan: What else is going on in your life, Jay?

Jay: I don't know . . . some of the kids at this new school are kind of rough. This one kid Todd is a real pain.

Affect.

Dr. Regan: How did you feel about that?

Jay: Kind of bad. I don't know what to do.

Trouble.

Dr. Regan: What troubles you the most about all of this, Jay?

Jay: That he used to be my best friend when we first moved in.

Handle.

Dr. Regan: How are you handling it?

Jay: Not too good. I tried to ignore him but it doesn't work. He waits for me every day after school and gives me a hard time . . . he shoves me, takes my stuff. He does it in front of everyone.

Empathy.

Dr. Regan: That sounds really hard, especially coming from someone who used to be your best friend. I'm sorry about all of that. How about if we set up an appointment for you and I to figure this out? I have some ideas that might help.

Jay: Okay.

Because Dr. Regan "BATHED" Jay, he learned that Jay is not preoccupied by questions about his natural mother, or his heart health, or the attention that his baby brother

Table 1. A Menu of Cognitive-Behavioral Therapy (CBT) Procedures

Skill	Purpose	Situation	Example
BATHE[16] **B**ackground, **A**ffect, **T**rouble, **H**andle, and **E**mpathy	To feel connected and competent by prioritizing feelings, concerns, and solutions.	Used at the first interview to assess. Also used in ongoing sessions as a guide for conducting most primary care counseling.	The physician asks, "What is going on in your life?" "How do you feel about it?" "What troubles you the most about this?" "How are you handling it?" and then expresses empathy.
CARL[16] **C**hange it, **A**ccept it, **R**eframe it, or **L**eave it	To recognize and feel empowered by the available options. It reduces feelings of helplessness.	Can be taught in 1 session with the patient. The physician begins by actively listening and empathizing and then explains the usefulness of this technique as a way to anchor and organize oneself before taking some action.	The message that the physician wants to convey here is that depressed patients no longer have to feel "stuck," ineffective, and discouraged. The physician confidently and encouragingly shares this good news with the patient. It is a patient self-reminder that keeps patients aware of their options. No matter what the situation, one of these options is always available.
BEST[17] **B**ody posture, **E**ye contact, **S**peech, and **T**one of voice	To change behavior. The physician uses BEST to assess a patient's interpersonal presentation skills. Then BEST is used to coach a patient to adjust these modalities to reflect an appropriate assertive demeanor rather than a passive or aggressive one.	Can be taught in 1 session with the patient. Useful when a patient has decided to take interpersonal action by speaking directly to another person.	Patients can minimize their discouragement and low mood by mentally or literally rehearsing with BEST before taking on such socially challenging situations as standing up to a bully, interviewing for a job, negotiating an evaluation with a supervisor, or asking someone out.
EDGAR **E**motions, **D**escription, **G**oal, **A**nticipation, and **R**ehearsal	To promote clear thinking that leads to an action plan. This is a 5-step social problem-solving/social decision-making process.	The physician needs at least 2 sessions to teach this. EDGAR is especially helpful when a patient is feeling overwhelmed with the enormity of a problem. The physician helps the patient to pause and succinctly describe the problem, determine a realistic goal, brainstorm solutions/consequences, and then develop the who, what, when, and where of a plan and a backup strategy.	The patient learns a step-wise way of decision-making/problem-solving. In working to get in charge of a bullying situation, the patient would ask: **E**motions: How do I feel? **D**escription: How can I briefly describe this problem? **G**oal: What is the most important thing that I want to have happen? **A**nticipation: What are all the solutions that can help me reach my goal and what are the possible consequences? **R**ehearsal: What plan could best help me use my best solution?
Talking sense to myself[21–23]	To promote healthy and rational perceptions regarding life events. Depressed patients often diminish themselves by a habit of self-talk that is self-defeating, critical, and sets up unrealistically high standards or expectations of themselves.This CBT tool works to vigorously attack that habit.	This helps when it is unrealistic for the patient to literally change the environmental stimulus that is the trigger for the depression. The physician needs at least 2 meetings: one to explain the technique and a second to practice.	An adolescent may be unable to get a bully to stop the verbal harassment, convince a friend not to end a romantic relationship, or change a parent, teacher, or boss's opinion. This strategy shows patients how to reduce the toxicity of such events by reframing what is hard to change.
CBT journaling[17]	To reinforce healthy change. This is a diary-like experience in which a patient reinforces the problem-solving skills taught in EDGAR and the interpersonal skills taught in BEST.	This is for the patient who has learned the BEST approach to presentation of self and the problem-solving steps of EDGAR. The physician can teach this in 1 session.	To minimize relapse and promote positive expectancy, the physician expresses confidence in the patient's ability to use what has been learned in the sessions. This helps the patient use the assertiveness of BEST and the problem-solving of EDGAR in an ongoing way. The patient could even bring in completed copies to show the physician at follow-up.
BE FAST **B**est, **E**xercise, **F**un, **A**ctive, **S**olve, and **T**alk sense to yourself	To reinforce healthy change. This is a 1-page patient handout that summarizes and reminds the patient of all the CBT techniques taught here.	The physician can teach this in 1 session after all of the above strategies have been taught.	This also aims to minimize relapse. BE FAST is introduced to the patient as a daily check on how to maintain a lifestyle that contributes to a positive mood.

may have been getting. Like many adolescents, what bothers Jay the most is the "here and now" peer relations problem of being teased and bullied by Todd. Even if Jay were not willing to make a follow-up appointment, Dr. Regan's psychological "BATHE-ing" of Jay is already therapeutic. Why? Because Jay was able to share his concerns and feelings with a significant person—his doctor. He was also able to narrow down his concerns to a possibly more manageable situation because Dr. Regan asked him to describe "what bothered him the most." Jay may also feel empowered because Dr. Regan did not preach to him about how he should handle the situation but asked Jay how he was handling it.

Let us take a look now at some other CBT procedures that Dr. Regan could use with Jay. Note that these CBT procedures could be used either alone or in various combinations, depending on the physician's personal preferences and time availability.

(2) CARL: Change It, Accept It, Reframe It, or Leave It

The purpose of CARL is to help patients (1) take credit for some decisions they have already made and (2) decide what pathway to choose next. When a depressed patient feels that he or she is not taking action on a problem, the person's feelings of helplessness and victimization deepen further. CARL helps minimize this. Jay's doctor helps him notice the actions he has already taken, thus allowing him to feel that he is doing something to take charge of his life.

Dr. Regan explains to Jay that in any problem situation he always has at least 4 different ways he can handle things. He can leave it, change it, accept it, or "reframe" it into something positive.[16] Some adolescent patients have found it helpful to think about this in terms of going to their friend "CARL": **C**hange it, **A**ccept it, **R**eframe it, or **L**eave it. It is a technique that they can use to acknowledge the efforts they have already taken and as a guide for handling future hassles. Here is how Jay may have responded after Dr. Regan explained CARL.

Change it? "Yes. Todd's tough. Everybody knows that. But I want to change it."

Accept it? "But I can't accept it. I just can't take it anymore."

Reframe it? "Not sure what you mean by that." (Dr. Regan explains that it means describing what is going on in a less self-critical way.)

Leave it? "I've tried to leave him, but he always finds me no matter what I try."

Jay regains power just by recognizing that he always has the 4 choices of CARL to make no matter what difficult circumstances confront him. Jay may not be aware how well he has already thought through a number of CARL options, so Dr. Regan legitimately compliments him for having taken some action. Dr. Regan relates his understanding that Jay is considering changing things somehow, has decided not to accept Todd's behavior, is intrigued with the "reframing it" idea, and has already tried the option of leaving it.

(3) BEST: Body Posture, Eye Contact, Speech, and Tone of Voice

The purpose of BEST is to assess how well patients present themselves interpersonally. For many patients, how they present themselves to others can compound or exacerbate the already difficult situation. Some patients are too aggressive, and, on the other hand, some patients are meek or passive. Persons who do not modify their behaviors to fit what is needed in social situations accumulate a series of interpersonal failures that further isolate and discourage them. BEST, as it is explained below, helps the physician assess where a patient is along this continuum and facilitates the coaching that the doctor does during the role play practice. Patients can then use BEST on their own to self-monitor and make adjustments.

Jay can "change it" by sticking up for himself with Todd. Jay may be boiling with hurt and anger. If so, Dr. Regan is concerned that Jay may become overly aggressive with Todd and exacerbate the problem. Jay needs to learn how to confront Todd assertively but not aggressively.

1. Dr. Regan asks Jay about the consequences if he were to talk to Todd in either an aggressive or a passive way. Dr. Regan points out the intermediate interpersonal strategy, which is assertiveness.
2. The physician then asks Jay how he knows someone is coming across to him in an aggressive, passive, or assertive way. Often, adolescents will comment on a person's posture, eye contact, use of language, or sound of voice.
3. Dr. Regan explains that much of what Jay has talked about could be summarized by the strategy BEST: **B**ody posture, **E**ye contact, **S**peech, and **T**one of voice.[17] Jay writes this down.
4. Dr. Regan quickly and casually demonstrates how to approach Todd and then asks Jay to give him some feedback regarding the component parts of BEST. Jay tries next. Dr. Regan is a positive coach and makes role-play comfortable with a relaxed, disarming, and even humorous style.

BEST can be learned very quickly. Depressed patients who learn it feel that they are starting to take charge. Asking patients to do their "best" focuses on a manageable personal goal rather than an unreasonable or perfectionist standard. This is a particularly important goal for depressed patients.

(4) EDGAR: Emotions, Description, Goal, Anticipation, and Rehearsal

The purpose of EDGAR is to teach social problem-solving. Patients learn a sequence of clear-thinking tech-

niques: how to accurately size up a social conflict, choose a manageable goal, anticipate multiple solutions and consequences, plan the "nuts and bolts" of a solution, and anticipate life's curves by preparing for obstacles to that solution.[18] Researchers have proposed that when poor social problem-solvers are highly stressed, their inability to generate and use effective solutions causes them to feel helpless, hopeless, depressed, and at risk for becoming suicidal. One intervention study assessed older adolescents who had made prior suicide attempts. They were treated with either group social problem-solving or group supportive counseling, e.g., empathetic listening. The results indicated that while both interventions were equally effective in reducing suicidal ideation, the social problem-solving intervention was superior to the supportive counseling in reducing depression, hopelessness, and loneliness at 3-month follow-up.[19] Dr. Regan teaches 5 steps of social problem solving by introducing Jay to a new friend, EDGAR: **E**motions, **D**escription, **G**oal, **A**nticipation, and **R**ehearsal. Dr. Regan asks him to think about the following:

Emotions. "That's easy. I feel sad and angry at the same time." This is in response to Dr. Regan's asking Jay how he feels about what is happening. Just supporting Jay's efforts at finding a word that describes his inner life is therapeutic. Why? This is because naming this feeling brings clarity to Jay, as he may be struggling with multiple confusing emotions. If Jay gets better at naming his feelings, he has a much better chance of clearly explaining himself to others, who then might be better able to engage and help him.

Description of the problem. " . . . because Todd turned on me. He picks on me every day." While the first step spoke about emotional clarity, this step refers to the power of cognitive clarity. How often have you listened to a friend talk and talk about a bothersome issue and you are still not clear about the specifics of the problem? Here, Dr. Regan is asking Jay for some specifics that will help narrow down an ambiguous and complex situation into a manageable parcel. As a bonus, manageable tasks are easier for patients to describe to others who want to help.

Goal. " . . . to make it less fun for Todd to tease me." Setting a reasonable and reachable goal can be a challenge. An important technique is to guide Jay toward a goal that is in his power to reach. For example, Jay might have initially said that his goal was "for Todd to be friends with me again" or "to get Todd to stop." But this is where persons who are prone to depression can set themselves up for failure. Jay is headed for difficulty if he assigns himself a goal of changing another person's attitude or behavior. Getting the patient to reframe the goal from a dysfunctional one into one that is achievable is important. What is most helpful here is the quality of the bond or therapeutic alliance that the physician has established. People tend to consider the questions and ideas that come from people they trust. Simply and gently validating and empathizing with the patient's desire to "get Todd to stop" is the first step. For example, the physician can state, "It really is understandable that you would want a goal like getting Todd to stop . . . I think I'd feel the same way." Once the patient receives the validation and empathy, the physician can then ask, "I'm concerned that taking on a goal to change another person's behavior may not be possible to reach. Can you think of a goal that is more within your reach? . . . a goal that you have a good chance of delivering on?" If the patient struggles with this, the physician can suggest an alternative goal to consider. Dr. Regan guides Jay toward a goal that is within his reach: "to make it less fun for Todd to tease me."

Anticipation of solutions, consequences, and obstacles. "I'll tell him to stop." "I could tell his mother . . . but that would make it worse." "I could just walk up to him and hit him . . . it's not right; besides, my parents wouldn't approve." "If he hits me and I'm cornered, I'll defend myself physically."

When it comes to solutions, Dr. Regan and Jay would include his parents or guardians to weigh in on those choices that have physical implications. Moreover, Jay and his parents benefit from understanding that social problem-solving is a technique that can be used beyond this current problem. Dr. Regan's long-term goal is to help Jay believe that he no longer has to feel "stuck" in any negative situation. Jay can learn to think clearly about such dilemmas and be confident that there is always another way to handle a problem. What is the legacy from such brief conversations with Dr. Regan? Jay may say to himself one day, "I remember my doctor once told me that I never have to feel stuck." This could save an impulsive or depressed adolescent's life. Real life success in social problem-solving often relates to planning the who, what, when, where, and how of a good solution. The most skilled social problem-solvers also anticipate obstacles that real life could throw at their well-planned solutions, and they prepare appropriate backup plans.

Rehearsal. When an adolescent is preparing to take on a challenging conversation, such as standing up to a bully, interviewing for a job, or asking someone out, the procedure of actually rehearsing and practicing it out loud by oneself or, even better, with a person like his or her doctor can be essential. Dr. Regan encourages this and can move into role-playing Todd's taking Jay's books. Jay can practice using an assertive body posture, eye contact, what he would say to Todd, and a firm tone of voice.

(5) Cognitive-Behavioral Therapy Journaling

Cognitive-behavioral therapy (CBT) journaling, writing down thoughts and feelings, reinforces the social problem-solving skills taught in EDGAR and the interpersonal presentation skills taught in BEST. However, it has

also successfully been used with adolescents who have not yet learned these skills. Many patients prefer the chance to reflect on what has happened. They gain mastery by quietly thinking, writing, and planning what action to take. In a recent study, patients who were randomly assigned to write 1 journal entry per day for 3 days describing an "upsetting event" were compared with patients who were randomly assigned to a control intervention of "casual" content writing for 3 days. The individuals in the intervention group that wrote about the distressing event reported lower physical illness symptom levels at 3-month follow-up and made fewer visits to their doctors during the 3-month and 15-month follow-up periods.[20] The procedure described next combines journaling with the CBT technique of specific skill practice. Here, the physician creates a worksheet[17] that incorporates several CBT elements: the clear thinking of social problem solving, the self-monitoring of BEST, and the stress-reducing benefits of diaphragmatic or belly breathing. The adolescent takes copies of this worksheet and writes down ideas and feelings as needed in this CBT approach to journaling.

As Figure 1 illustrates, the first question provides a chance for the patient to identify the problem in specific terms so that the situation can be easily understood by the patient and others. The next 3 questions identify the patient's feelings, what solutions were used, and their consequences. The adolescent recalls the physical signs of stress, how well he may have used a calming technique such as diaphragmatic or "belly" breathing, and reviews how he comported himself in terms of the BEST technique. The patient finishes with some reflection on how well it all worked out as well as offering some alternative solutions.

(6) Talking Sense to Myself

The purpose of "talking sense to myself" is teaching the "reframing" skill. What we say to ourselves about life's events and how we interpret them powerfully affects how we feel. If Jay cannot change the literal stressor, e.g., to directly stop Todd, he can still think about what has been happening in a less negative way. In other words, Jay can stop the self-bullying that can happen long after Todd is gone. This is the "reframing" that was discussed earlier. Many patients get depressed because they habitually use self-critical language or over-generalize the implications of a negative event. This habit greatly increases a distressing event's emotional toxicity. They maintain perceptions that, frankly, are just not true, e.g., "I can't stand this." Accordingly, they are not treating themselves fairly, and truth and fairness are 2 concepts that many adolescents hold dear to their hearts. Talking sense to yourself is a classic rational emotive therapy technique emerging from the seminal work of Albert Ellis[21–23] and Aaron Beck,[24] which has generated an immense and very rich array of scientific and practical application literature.

1. Dr. Regan points out that when we feel down or depressed, it is often because we innocently think in extreme and self-hurtful ways. We might say, "I can't stand it!" But the truth is that we can stand just about anything. Yes, Todd is a real pain, but when Jay tells himself he is weak or cannot handle the situation, he joins Todd in the bullying. We might be in the habit of repeating such phrases as "This always happens to me!" Well, is it true to say that it always happens to me? Probably not. But if I keep saying that to myself, I will be even more miserable. Sometimes we say, "This is a catastrophe!" Well, what really is a catastrophe? Perhaps a war is a catastrophe, or a major terrorist assault on our country would be a catastrophe. Frankly, 1 of the ways that many people actually do psychologically survive a real catastrophe is by adjusting how they think about it.
2. Dr. Regan explains to Jay that this kind of catastrophic thinking is like carrying around a critical friend or relative with him who is constantly putting him down. While Jay cannot change what happened, he can put a new frame around that scene so he can handle it better. On a 0 to 10 toxicity scale, perhaps we can bring the score down from a 9 to a 6.
3. Here is the 3-part strategy that Dr. Regan teaches to Jay:
   a. Lose the harmful, exaggerated, and untrue language when describing to myself what happened. Instead, say, "It would be better if . . . Todd did not give me a hard time."
   b. Just state the facts. "But the truth is . . . Todd does give me a hard time."
   c. Vigorously coach myself with a personally meaningful coping statement such as: " . . . and I can stand it!" or " . . . I refuse to make myself feel worse by putting myself down" or "This is lousy, but it is not a catastrophe" or "I refuse to let this get to me as much as it used to!" The physician's willingness to animatedly model this for the adolescent can be a big boost to the credibility of the counseling.

(7) BE FAST: Best, Exercise, Fun, Active, Solve, and Talk

The purpose of BE FAST, which has been developed for this article, is to provide a tight, organized, and comprehensive summary of the CBT techniques we have discussed. It is similar to the SPEAK approach developed by Cole et al.,[25] which is an excellent tool that summarizes 5 domains that patients can attend to in order to lift depressed feelings. In this approach, filling out a weekly schedule, getting involved with pleasurable activities, exercising, being assertive, and saying kind

Figure 1. Example of a Cognitive-Behavioral Therapy Journal Page Used by Adolescents[a]

JOURNAL

1. **E**MOTIONS:
   Think of a stressful situation you were involved in this week. How did you feel?
   Frustrated and alone. Sad.
   What physical signs of stress did you notice in yourself?
   Tenseness.
   Where?
   All over.
2. **D**ESCRIPTION:
   Briefly describe the situation. What happened?
   Todd started to give me a hard time. He's disrespecting me . . . giving me an attitude.
   Who were you with?
   Todd and his friends.
   When did it happen?
   Friday.
   Where were you?
   In the stairway at school.
3. **G**OAL:
   What did you want to have happen?
   To get Todd off my case.
4. **A**NTICIPATION:
   What solutions, consequences, or obstacles did you consider?
   Not many. I just decided to finally stand up to him . . . and take my chances.
   I made up my mind to say something the very next time he started up with me.
5. **R**EHEARSAL/REVIEW:
   How calm and under control were you before you said or did something? Circle one:

   Under control mostly calm so-so (tense and upset) out-of-control

   What did you say and do?
   Yelled. I became enraged. Told him to knock it off.
   How satisfied were you with the way you communicated?
   Satisfied with what I said, but I felt that I didn't get through to him entirely.

	Not at all	Only a little	So-so	Pretty satisfied	Very, very satisfied
Body posture		✓			
Eye contact			✓		
Speech				✓	
Tone of voice		✓			

   What happened in the end?
   He backed off a bit.
   What did you like about what you did?
   I stood up for myself and wouldn't have changed what I said if I could go back and do it all over again.
   What didn't you like about what you did?
   I felt like I could have tried harder to let him know I finally mean business.
   I wish I had done this a long time ago.
   What is something else you could have done to handle the situation?
   If I did this right away in September, when he first started to give me attitude, maybe I could have avoided it getting so out of hand for me.

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thoughts to oneself capture 5 important elements in cognitive, behavioral, and interpersonal psychotherapy.

BE FAST deals with similar categories as SPEAK[25] but uses more adolescent-friendly terms and descriptions and adds problem-solving as an important CBT technique. The image of BE FAST also encourages teens to "be fast" in combating the early signs of depression and maintaining their emotional health. The 6 elements of BE FAST are **B**EST, **E**xercise, **F**un, **A**ctive, **S**olve, and **T**alk Sense to Myself. It can be given to the patient as a 1-page handout and is included here as Table 2. Dr. Regan can explain BE FAST to Jay and suggest that he select 1 or more of these items to work on. A copy of BE FAST can be posted in the examination room to encourage patients and in the medical record to help organize Dr. Regan in the follow-up visits.

Table 2. BE FAST: A Select Summary of Cognitive-Behavioral Therapy Techniques[a]

BEST: Let others know how you feel and think about things. Talk to your parents, friends, or teachers about what's going on. This can divide your upsets and multiply the good feelings! You can get things off your chest in a direct and respectful way without being aggressive or passive. You can do this by paying attention to your **B**ody posture, **E**ye contact, **S**peech, and **T**one of voice.

EXERCISE: Taking care of your body by actively doing stuff like running, walking, dancing, swimming, lifting, and playing a sport just for the fun of it can raise your mood. Do a little or do a lot; it's all good. Just do it.

FUN: Remember that? Here's where you do those healthy things that you know bring a smile to your face, can get you to laugh out loud, or are just quietly pleasurable. Raise your spirit by listening to music, catching up with a positive friend, going to the store, reading, playing a fun video or computer game, sharing a healthy and delicious meal . . . whatever.

ACTIVE: Plan your next day. Put things in motion that will keep you active! Do these things even if your mood doesn't encourage you. The idea is to "Fake it until you make it!" Your mood will in time improve if you keep to a schedule where you are not idle. Think ahead about the things that will already be structured for you such as your classes at school, what you'll be eating at lunch, when you'll get a chance to do some exercise, and some things that will bring you some fun.

SOLVE: Remember you are a problem solver. You've successfully dealt with tough circumstances before. Write down how you feel, then describe the problem, decide on a manageable and healthy goal for yourself, and generate as many solutions to the problem as you can. Remember you never ever have to feel stuck because there are always a number of healthy solutions available for any problem. Believe it.

TALK SENSE TO YOURSELF: You always have 4 options to try: **C**hange it, **A**ccept it, **R**eframe it or **L**eave it! (CARL). Avoid carrying around a critical relative in your head who says, "This is a catastrophe!" or "This is awful!" or "How can you stand it?" Coach yourself to say "It would be better if . . . but the truth is . . . and I refuse to make myself miserable about it!" or "Nothing is that bad that I can't get through it!"

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CONCLUSION

Like Jay, many teens are confronted with unwanted changes in their relationships with friends, teachers, or family members. Or, they may see themselves as not measuring up to performance expectations in an after-school job or organized sport. It is when they chronically feel incompetent or helpless at dealing with such stress that their physician should begin to worry about depression. In this regard, doctors can be alert to a parallel process. Physicians are vulnerable to depressed feelings when they feel they are chronically not delivering all they think they could to their depressed patients. How do some doctors handle their own uncomfortable feelings? Some may deal with their feelings by an "automatic" recommendation of medication or an "automatic" referral to another practitioner, even when these are not the best choices. Others may ignore asking about depression because they do not know how to provide time-efficient and effective "talk" therapy.

Certainly there are times when it is appropriate to prescribe medication or refer the teen to a counselor. The challenge is how to manage adolescent depression when reliance on medication is not the best choice or going to see another counselor is not possible. Fortunately, there are times when adolescents let their physicians know about their depressed mood. They likely give that opportunity to those doctors who recognize depression as a legitimate health concern, give these teenagers a few private minutes to talk, and then genuinely listen to the concerns. As a part of clinical practice, the prepared physician knows the resources available from the schools, community agencies, support groups, and private mental health practitioners. The prepared physician is ready to recognize red flags such as suicidal ideation and will use community resources to include other professionals in the care team. Beyond that, a doctor can do much even in the 15-minute interview. All the CBT techniques presented here are designed to be introduced as part of a 15-minute interview with a patient who presents with depression. The doctor can follow up with reinforcement discussions during other 15-minute visits. By asking teenaged patients about their feelings such as depression, the physician is modeling that it is OK to actually discuss these matters with other persons. This patient-physician discussion might be the impetus for the adolescent to make the move to divide the sorrows by confiding in someone else such as a friend, family member, counselor, employer, or teacher.

There is compelling evidence that CBT works to relieve adolescent depression. The CBT techniques described here are drawn from that tradition. Based upon their own style, physicians can select 1 or more of these approaches from this menu. These 7 CBT procedures can be offered singly or in various combinations during 1 or several patient visits. Practitioners who stretch themselves to include 1 or more of these brief CBT procedures become strong catalysts for positive emotional health for their patients.

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