

CHILD AND ADOLESCENT DEPRESSION: USING A CBT TREATMENT APPROACH

by

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Abstract

This thesis is a non-empirical, manuscript style document in which I examine Cognitive Behavioural Therapy (CBT) and its effectiveness in treating depression at an early age, focusing on the developmental periods- childhood, pre-adolescence, and adolescence. This research provides recent findings on CBT for professionals in this field. The purpose of this research is to bring awareness to the many different causes of child depression and create a better understanding of the effectiveness of CBT interventions for youth experiencing depression. In Chapter 2, I will discuss three factors that contribute to child depression. These factors include: (1) biological changes as a result of depression; (2) developmental issues such as child attachment style and maternal depression; and, (3) unhealthy environments. In this thesis I will focus on research with young children, pre-adolescents, and adolescents (ages 0-18). In Chapter 3, I will focus on Trauma Focused Cognitive Behavioural Therapy as traumatic childhood events can leave painful memories and further lead to depression. In Chapter 4, I will discuss the limitations and criticisms of CBT when used as a treatment modality for children and adolescents. In Chapter 5, I will summarize the previous chapters and reflect upon implications for future research.

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CHAPTER 1: INTRODUCTION

Depression is a mental health issue that impacts many individuals at some point in their lives. Many children and adolescents experience depression, a fact that, if left untended, may lead to more severe mental health illnesses in adulthood. Cognitive Behavioural Therapy (CBT) is an evidence based therapeutic approach which has demonstrated effectiveness in treating depression at early ages (Bru et al., 2013). This thesis is a non-empirical, manuscript style document in which I examine the positives, as well as some of the criticisms, of Cognitive Behavioural Therapy and its effectiveness in treating depression at an early age, focusing on the developmental periods childhood, pre-adolescence, and adolescence.

Currently, I am doing a practicum placement as a mental health therapist with the Burnaby Mental Health team at the Burnaby General Hospital in Burnaby, BC. This program provides specific interventions for adults with acute mental health issues, focusing on the modality of Cognitive Behavioural Therapy. Also, the hospital's provision of group therapy involves CBT sessions for adults suffering from depression and/or anxiety. My experience in working with these adults allowed me to realize how many adults were not treated at a young age. I became more curious about child and adolescent depression and how they would respond to CBT if given the opportunity. Such exposure would, I hypothesized, provide support and alleviation for children and youth who suffer as well as prevent mental health problems in their adult life.

Factors that contribute to childhood and adolescent depression include: (1) biological changes as a result of depression; (2) developmental influences, such as child attachment style and maternal depression; and, (3) unhealthy environments (Cicchetti et al., 2010; Fox & Borelli, 2015; Cantón-Cortés et al., 2015; Agerup et al., 2014; Lewis et al., 2011). Further, CBT is a

well-known and widely used evidence based therapeutic approach that can be applied to many mental health issues, including depression (Bru, Solhom & Idsoe, 2013). However, researchers have found mixed results for the effectiveness of CBT with youth populations experiencing depressive symptoms. Due to these inconsistencies, it is essential that more research be conducted so as to better explicate these inconsistencies. Ultimately, it is important for counsellors to understand which components of CBT benefit youth and which components do not (Bru et al., 2013).

Problem Statement

This aim of this thesis is to better understand when treating depression whether or not CBT is an effective therapy for children and adolescents with depression.

Nature of the Study

In order to understand the importance of childhood and adolescent depression, one must effectively understand the causes, risks, and the effects of depression. Also, in order to evaluate CBT and use it as an effective treatment therapy, one must be aware of the components of CBT and when to use it effectively. What ways is CBT effective and why is depression important to treat at an early age must be examined in depth. Nonetheless, the benefits of CBT for the constituent population will be contrasted with criticisms of CBT more broadly.

Purpose of the Study

The purpose of this thesis research is to bring awareness to the many different causes of child depression and create a better understanding of the effectiveness of CBT interventions for adolescents and children experiencing depression. In preparing for this thesis and choosing research material to review, I reflected on my belief that more attention needs to be paid to

mental health at a young age prior to adulthood. I hypothesized that there would be a lower rate of adult depression if more attention were paid to depression at a younger age. My goal is to engage with relevant research that will contribute to effective therapy for young people and bring greater awareness to depressive symptoms that children and youth may have, while understanding how important it is to treat depression at an early age. As well, my goal is to provide better insight into CBT as an approach for child and youth depression. The ultimate aim is to provide clarity of the relevant research, which could prove useful to experienced and young health professionals alike such as therapists, GPs, psychiatrists, as well as parents/caretakers.

The primary focus on children and youth that are considered in this thesis are ages 5-19 whom are participating in group and individual studies. The review of the material, while focused on the North American/ Western context could include research from other global locales since CBT does have international attention in mental health research.

Scholarly Context

In order to achieve a greater understanding of child and youth based depression, health professionals such as therapists, GPs, and psychiatrists as well as parents/caretakers need to be aware of the indicators of depression. Also, risk factors for depression need to be understood in order to treat and prevent depression. Some studies show that therapists focus on certain components of CBT more than others while working with adolescents, and there are variations in the therapy's effectiveness as a whole (Bru, Solhom & Idsoe, 2013; Stikkelbroek et al., 2013). Also, research shows that Trauma Focused CBT is important to consider as many traumatic events at a young age lead to depression, i.e., sexual abuse, violence, and family issues such as divorce (Arellano et al., 2014). While health many professionals along with parents recognize the consequences of trauma as depressive symptoms, up-to-date research is necessary on trauma

leading to depression (Arellano et al., 2014). Further, it is important to treat or manage depression that has resulted from traumatic experiences, which occurred during childhood (Huh et al., 2014).

I came across three specific scholarly studies that emphasize the importance of treating depression in children and adolescents, articles that have substantially contributed to my choice of thesis topic. The first article was by Garvik, Idsoe, & Bru (2014) states that group based cognitive behavioural therapy interventions for depressed adolescents are effective as this is demonstrated in studies where adolescents are diagnosed with major depression. Also, “according to the world health organization, depression is the leading cause of disability in high income countries for the age group 15-44 years and is currently the fourth disorder worldwide for disease burden” (p. 195). In addition the authors discussed that the risk of depression increases in adolescence in Norway and that girls are twice as likely to experience depression at an early age. Depression is a highly prevalent and serious mental health problem in adolescence overall and is associated with a range of problems such as problematic peer and family relationships, school difficulties and dropout, health problems, increased substance abuse and suicide (Garvik et al., 2014, p. 196).

The second article was written by Perrino et al. (2015), who stated, “certain subgroups of youth are at a high risk for depression and elevated depressive symptoms, and experience limited access to quality mental health care” (p. 642). In addition, ethnic minority groups are more likely to experience poor mental health when compared to white youth since they are more likely to experience socioeconomic issues, minority stress, and social stress. Perrino et al. (2015) point out that depression can also be the outcome of other concerns such as obesity, diabetes, and substance use (Perrino et al., 2015).

The third article, was by Stikkelbroke, Delovic, and van Bar (2013), who stated that it is important to study depression in adolescents as there is a high risk of recurrence and a heightened risk of development of other serious problems like suicide attempts. Also, “before entering adulthood 14-25% of adolescents have experienced at least one episode of a depressive disorder” (p. 3). Moreover, it is important to treat depression as there is an increased risk for development of social problems, learning problems, substance abuse, negative life events, physical problems, teen pregnancies, and suicide (Stikkelbroek et al., 2013, p. 4).

Overall, these scholarly texts provide information on the importance of studying depression at an early age, the causes of depression, and risk associated with depression at a young age.

Background and Definitions

A few key terms that are related to my thesis require clear understanding before I proceed. Also, as many people hold different definitions and may/may not be in disagreement in the field, there needs to be consistent understanding of these terms.

Depression

Depression can be a difficult concept to define. The American Psychiatric Association (2013), states that depression constitutes feelings of sadness, emptiness, and irritability as well as cognitive changes that affect one’s ability to adequately function (American Psychiatric Association, 2013). As cited in the American Psychological Association and American Academy of Child and Adolescent Psychiatry, depression is “one of the most prevalent psychological problems in youth” (Mychailyszyn, Brodman, Read, & Kendall, 2012, p. 129) and is associated with increased risk of suicide, hospitalization, as well as lower education

achievement (Bru, Solhom & Idsoe, 2013). Additionally, there are many negative outcomes for youth who suffer from depression regardless of clinical or subclinical levels of depression (Mychailyszyn et al., 2012). Further, depressive symptoms result in risks of dysthymia and major depression (Mychailyszyn et al., 2012). DSM-V identifies the symptoms of subclinical and clinical depression. These symptoms include, but are not limited to, negative thoughts and feelings, including shame and guilt, negative self-concept, and dysfunctional beliefs (American Psychiatric Association, 2013). In addition, whether it's mild, moderate or severe, having negative automatic thoughts, negative self- concept, and dysfunctional beliefs are all signs of depression (Chu & Harrison, 2007).

Cognitive Behavioural Therapy

CBT is a form of psychotherapy that works to solve current problems and changing unhelpful thinking and behaviors, further, explaining how emotions, thoughts and behaviors influence one another (Bru et al., 2013). CBT was first created by Ellis and Beck in the 1960s, where Ellis and Beck used the ABC model, a model that focused on how the emotional consequences (C) of an activating event (A) are influenced by a belief (B) (Bru et al., 2013). Through this model, self- monitoring, cognitive structuring, relaxation exercises and seeking pleasurable activities became the basis of this model (Bru et al., 2013). Further, this model shows the relationship between our thoughts, emotions, and behaviours (Breiner et al., 2012; Miyahira et al., 2010).

Assumptions, Limits, and Scope

It is important to note that the argument in favour of CBT in this thesis may have a potential bias as I have had great experience with CBT at my practicum site and seen how

effective it has been with adults suffering from depression. Hence, while conducting my research, I may have focused on the pros of CBT versus the cons. Moreover, my bias may cause my thesis to have limited information on the cons of CBT since there are many more research studies out there than the ones I discussed in my thesis.

Significance

My thesis contributes to professional development as it gives health professionals current findings on the symptoms, causes and treatment methods of child and youth depression. The results provide information that health professionals could pass along to parents/caretakers of children and adolescents that suffer from depression. As such it could provide additional psycho-educational material for dissemination. As CBT is a well-known therapy, this thesis provides crucial information on the effectiveness of CBT on children and youth with depression and the importance of treating depression at an early age in order to prevent serious mental health problems in later adult life.

Thesis Structure

I am writing a manuscript thesis in which I analyze research on depression on children and adolescents using CBT as a treatment method for these young individuals. In this first introductory chapter, I have discussed the purpose, nature, and significance of the thesis while discussing scholarly texts that ground the research being conducted. In Chapter 2, I will explore the various forms of distress and developmental issues that may lead to depression. In Chapter 3, I will examine Trauma Focused CBT (TF-CBT) on Youth with Depression as trauma at an early age often leads to depression (Hayashi et al., 2015). In Chapter 4, I will discuss the overall effectiveness and ineffectiveness of CBT on children and youth with depression, regardless of

having or not having traumatic experiences. In Chapter 5, I will discuss the implications for counselling and provide a conclusion.

CHAPTER 2- UNDERSTANDING DEVELOPMENTAL DEPRESSION AND ITS CAUSES

INTRODUCTION

In order to understand why treating depression is important at an early age, one must become familiar with the physiological changes a child goes through when suffering from depression. One must also have an understanding of developmental issues that propose risks for depression and recognize the environmental causes for depression. In addition, in order to treat adolescent depression, one must understand factors that contribute to depression in early life leading to adolescence.

In this chapter, I will discuss three factors that contribute to child depression. These factors include: (1) biological changes; (2) developmental issues such as child attachment style and maternal depression; and, (3) unhealthy environments. In this chapter, I will focus on research with young children, pre-adolescents, and adolescents (ages 0-18). My intention is to provide an ample understanding of childhood depression and to bring awareness to the importance of treating depression at an early age.

Biological Changes in Children with Depression

It is important for professionals such as psychiatrists, GPs, and therapists to understand the biological changes that occur in a child as these could be used to prevent child depression and be used in early treatment (Harpur, Polek, & van Harmelen, 2015). Further, in early adolescence, maltreatment or emotional stress can cause damage to the brain and neuro-hormonal system (Harpur et al., 2015). In addition, Lévesque, Bearegard, Ottenhof, Fortier,

Tremblay, Brendgen, & Boonij (2011) discussed that a risk for depression may exert a negative impact on the brain and neural circuitry underlying emotional regulation and emotional processing.

The Cognitive Model

Beck's (1976) cognition theory of depression is based on the assumption that conscious meaning of things is derived from basic beliefs that are embedded in cognitive structures, known as schemas (Haigh & Baber, 2012, p. 517). Negative childhood experiences can lead to negative memory schema and when this schema is activated later in life, whether its preadolescence, adolescence, or adulthood this would lead to depressive symptoms (Haigh & Barber). Similarly, Beck et al. (2012) proposed that difficult experiences in later life that are similar to the ones one had in childhood may cause symptoms of depression (Beck et al., 2012). Further environmental stressors, i.e., significant loss at an early age, sexual abuse, physical abuse, and parental divorce, may lead to the development of depressive symptoms (Beck et al., 2012). Moreover, once depressive thoughts are formed, a "loop" forms that maintains depressive episodes (Beck et al., 2012).

However, it is important to note that the cognitive model alone cannot explain why some children who experienced childhood trauma developed depression while others do not. In addition, the model did not account for symptoms such as fatigue, loss of appetite, sleep disturbances, and loss of libido (Beck et al., 2012). How the cognitive model correlates at a biological level, in particular the brain, helps explain this (Beck et al., 2012). Moreover, research by Beck et al. (2012) stated that the brain regions associated with "bottom-up" processing include amygdala, thalamus, nucleus accumbens (NA), hippocampus, caudate, putamen, and the anterior cingulate cortex (ACC), whereas the "top-down" processing, which is equivalent to

secondary processing based on the cognitive model, refer to high-level cognitive processes that bring up stored knowledge (Beck et al., 2012). These top- up brain regions include: the prefrontal cortex (PFC), medial PFC (MPFC), ventral lateral (VLPFC), dorsal lateral PFC (DLPFC), rostral ACC, and the superior parietal cortex (Beck et al., 2012). “[B]ottom-up processes proceed to connected cortical areas higher up and are generally spread by cognitive control” (Beck et al., 2012, p. 520). Research has suggested that the cognitive model of depression can be understood biologically as the failure of top-down cortical processes to reduce the over-active bottom up processes (Beck, 2008). In short, self-referring schemas discussed above, are related to the activities that detect emotion in the amygdala of the brain and the top- down region is involved in self-understanding thought (Beck, 2008).

The Biological Level—The Brain

When depressed individuals self-understand in negative ways, i.e., judging whether a negative trait represents them, there is an increased activation in the amygdala, ACC-anterior cingulate cortex and MPFC-medial prefrontal cortex (Harpur et al., 2015). The amygdala functions in emotional processing, MPFC functions as a region that allows one to have an internal representation of the self; and the ACC determines the incoming stimuli with an emotional carrier and to what degree it acts as a self-referring stimuli (Beck et al., 2012). In addition, “research showed that hyperactivity of the amygdala is associated with increased sensitivity to negative stimuli” (Beck et al., 2012, p. 512). Similarly, when Harpur et al. (2015) examined the amygdala based on its structure and function, where groups of children with depressed parents and a group of children of parents without a history of depression, the children with depressed parents showed hyper-activation of amygdala to negative stimuli. In addition to

the activation of amygdala, during adverse circumstances the hypothalamic-pituitary-adrenal (HPA) axis secretes “stress hormones” such as cortisol (Beck et al., 2015).

The Physiological Levels- Hormones

On a physiological level, Cicchetti et al. (2010) provide research that discussed cortisol hormone levels and stated that long term elevated cortisol levels increased the production of fear-mediating neurochemicals in the nucleus of the amygdala. In addition, early effects on the brain during developmental periods where the child depends on the mother for care is a reflection of the child’s developmental experience on a hormonal level. Dickerson and Kemeny (2004) discussed that threats to social rejections for a child produced elevated cortisol responses, leading to depressive symptoms. Likewise, as a child depends on the mother for survival and care, maternal depression can also cause child depression (Cicchetti et al., 2010). Additionally, as young children focus more on family relationships than peer relationships, the effects and changes a child experiences before adolescence are important to consider as depressive symptoms often arise overtime (Cicchetti et al., 2010). Hence, as a child’s upbringing is determined by a mother’s behaviour and influence on a child, how the child is, the way the child sees life is partially influenced by mother if not all (Fox & Borelli, 2015).

Developmental Concepts

Similarly, as a child’s developmental experience is a reflection of a mother’s care, the style of connection is also an influential factor in the level of risks for child depression. Furthermore, since not all depressed mothers have depressed children, it is important to examine attachment styles of children and the direct relationship between a parent and child in order to determine how these factors play a role in child depression. In addition, as a child is most attached to the mother at earliest ages, pre-adolescence is an important age to examine (Canton,

Cortes et al., 2015). Also, maternal depression would be another area to explore as a mother's direct behaviour may influence the attachment of a child.

Attachment Theory

As proposed by Bowlby (1969) "attachment theory is derived from the idea that interpersonal relationships and social support are an innate necessity for people; hence, children develop internal working models of significant others based on the quality of early interpersonal relationships" (Canton- Cortes et al., 2015, p. 421).

In times of distress, a child may feel that her distress would be resolved by parental support whereas a child that is insecurely attached, may not receive adequate support to overcome the distress; hence he/she can become depressed (Fox & Borelli, 2015). Nonetheless, to visualize how the relationship between attachment style and depression are measured, researchers used instruments that include Attachment Style Measure and the Beck Depression Inventory (Cicchetti et al., 2010). The attachment theory developed by Bowlby and Ainsworth (1991) provided insight on parent-child relationships and whether a child feels secure by their parents.

According to Bowlby (1969) and Ainsworth and Wittig (1969), there are three attachment styles: secure, avoidant, and ambivalent (Cantón-Cortés et al., 2015). Secure attachment is when the primary caregiver responds to the child's distress on a consistent basis thus promoting a trusting relationship. Parents of secure children consistently respond to their children's needs and concerns than parents of insecure children (Borelli & Fox, 2015). Secure attachment allows children to rely on their caregiver for support, and these children have the ability to maintain healthy relationships and have better emotional regulation (Borelli & Fox, 2015). On the other hand, avoidant attachment style is when the child's distress is consistently

ignored or he or she is rejected on a continuous basis. And anxious-ambivalent style develops when a child's distress is responded to on an inconsistent basis leading to a high level of anxiety and difficulty in expressing emotions (Cortes et al., 2015). Further, attachment theory suggests that secure attachment allows for healthy regulation of negative affect and insecure attachment style causes one to focus on negative emotions leading to inappropriate emotional regulation (Cortes et al., 2015). Nonetheless, "individuals with poorer psychological adjustment may be more likely maintaining an avoidant and ambivalent attachment style" (Cortes et al., 2015, p.423). Similarly, Agerup, Lydersen, Wallander, and Sund (2014) have found that adolescents who were securely attached to their parents were less depressed whereas less secure attachment to mothers and fathers was associated with becoming depressed (Agerup et al., 2014). These findings question whether these adolescents were depressed in earlier age as well and continued to be depressed in adolescents and young adulthood. On the other hand, research by Borelli and Fox (2015) found that attachment security was not associated with child depressive symptoms; however, participants from diverse socioeconomic status families were not included as past research indicates a clear association of attachment security, maternal behaviour, and child psychopathology with a samples of lower socioeconomic status (Borelli & Fox, 2015). As maternal behaviour influences a child's mental health, a mother's mental health also influences the child's behaviour and mental health (Agerup et al., 2014).

Maternal Depression

Likewise, "depressed mothers may rely on strategies requiring less cognitive effort more often than no depressed mothers, i.e. flexibility enforcing obedience and withdrawing when difficulties arise" (Borelli & Fox, 2015, p. 30). Furthermore, these cognitive strategies can lead to child depression. Also, depression appears to be stronger in girls than in boys, suggesting that

depression in mothers produces larger risks for their daughters as daughters are more sensitive to stressful life events, especially those that are related to interpersonal relationships (Lewis et al., 2011). Nonetheless, Lewis et al. (2011) conclude that the association of maternal and offspring depression is stronger in daughters, whereas some studies did not reveal gender differences. Similarly, Miller et al. (1999) discussed that when examining self-esteem and depression of a child of a depressed mother, daughters with mothers who had depression had low self-esteem and suffered from depression a few years later. Likewise, mothers and daughter's had a stronger correlation in Lewis et al. (2011)'s study, as environmental links such as socioeconomic status was higher in girls.

Environmental Factors

The environment, including socioeconomic status, plays an important role in child depression (Lewis et al., 2011). Shared adversity such as family income and socioeconomic status are important factors to consider (Agerup et al., 2014). In addition, as the environment in which a child grows up in significantly plays a role in childhood depression, other environmental factors related to depression need to be explored. Likewise, "a consistent finding from twin research has been that genetic influences on depression symptoms are greater in adolescents whereas shared environment is more influential in children" (Lewis et al., 2011, p. 457).

Stressful Events

Significant environmental links to depression were found when children were four to 10 and 7 to 13 years old (Lewis et al., 2011). Studies that account for environmental factors such as negative life events, family income, and family socioeconomic status indicate that direct environmental factors as opposed to inherited traits, play an important role in child depression

(Lewis et al., 2011). As mentioned, stressful life events lead to depression; hence, from a developmental perspective, “examining stress generation can better understand the course of depression over the life span by examining the reciprocal processes at work between children and their environment” (Chan, Doan & Tompson, 2013, p. 32). Thus, the stress generation theory helps understand how negative life events contribute to increase in depression particularly in adolescents. Nonetheless, as stated by Chan et al. (2014), “many stress generation studies have focused primarily on adolescence, the preadolescent transitional period for children is a particularly critical timeframe for understanding early stress generation” (p. 33).

Child Abuse

Factors such as parenting, life stress, maltreatment and poverty, stressful life events, and childhood abuse are the most critical environmental factors for the development of depression (Hayashi et al., 2015). For example, many children grow up in environments where their parents fight and even get divorced, the rates of childhood sexual abuse are high, and experiencing trauma and stress at an early age can result in childhood depression (Hayashi et al., 2015).

Additionally, a highly stressful environment for a child would be one where physical and sexual abuse occur. It is important to examine sexual abuse as “studies have consistently shown that survivors of child sexual abuse (CSA) experience social and psychological difficulties including interpersonal, sexual and emotional disorders” (Cantón-Cortés et al., 2015, p. 421). Children who experience physical and sexual abuse often internalize depressive symptoms, which may lead to major depressive disorder in adulthood (Cicchetti et al., 2010).

Cicchetti et al. (2010) stated that biological and psychological functioning is highly impacted by early life stress, which may lead to neuroendocrine dysregulation and depression; hence both physical and sexual abuse can result in depression. In addition, the affects of sexual

abuse, where abuse consisted of oral sex or penetration, a non-family member as perpetrator and in isolated, compared with continued abuse were stronger based on attachment style (Cantón-Cortés et al., 2015). Also, some studies revealed that the healing process after sexual abuse varies in the type of abuse experienced, the frequency of these acts and the type of victim-perpetrator relationship (Cantón-Cortés et al., 2015).

On the other hand, some studies have indicated that socio-cognitive factors outweigh abuse characteristics in determining psychological adjustment (Cantón-Cortés et al., 2015). Okada et al. (2015) used Structural Equation Modelling (SEM) to determine the relationship of variables such as abuse in childhood, life events in adulthood and personality and focus on these variables and state that childhood abuse affects behaviours, character tendencies and sensitivity to stressors in adulthood. Also, in Okada et al.'s (2015) study, a self-rating questionnaire of 38 items called the Child Abuse and Trauma Scale (CATS) was given to adult participants. This questionnaire asked about questions about their childhood abuse experiences, if any. According to Okada et al. (2015) results indicated that “childhood abuse directly predicted the severity of depression and indirectly predicted the severity of depression based on one’s personality” (p. 6). This indicated that based on personality, high neuroticism, low extroversion, and low conscientiousness in the five factor model of personality are linked to depression (Hayashi et al., 2015).

Conclusion

Overall, having an understanding of the biological effects of depression such as the cognitive model, the brain, and hormones, health professionals can help treat child depression at an early age. Also, developmental factors such as attachment styles and maternal depression are risk factors for depression. It has been found that securely attached children are less likely to

develop depressive symptoms whereas insecure or ambivalent attachment styles have a higher risk for child depression. In terms of maternal depression, a daughter is more likely to have lower self-esteem and depressive symptoms than a son as daughters are more sensitive to stressful life events, especially those that are related to interpersonal relationships. It is important to treat depression at an early age. Various environmental factors such as maternal depression, low family income, low socioeconomic status, as well as negative life events lead to childhood depression. Of the many negative life events, childhood trauma results from physical and sexual abuse that further results in depression as well.

CHAPTER 3- TRAUMA FOCUSED- COGNITIVE BEHAVIOURAL THERAPY

Traumatic childhood events can leave painful memories. It is important for health professionals such as therapists and psychiatrists, along with parents to recognize the consequence of trauma as it can cause depressive symptoms later in life, whether it is adolescence or in adulthood (Arellano et al., 2014). Further, it is important to treat or manage depression that has resulted from traumatic experiences in childhood (Huh et al., 2014). One way of treating and managing this condition would be to use a well-known therapy called Trauma Focused- Cognitive Behavioural Therapy (TF-CBT). In this chapter, I will describe the components of TF-CBT, assess the level of evidence of existing studies on TF-CBT and depression, and provide an overall summary of studies on the effectiveness of this therapy. Further, I will provide a review of studies that investigated TF-CBT with the focus on children who have been exposed to traumatic events and have experienced trauma related mental health issues such as depression.

An Overview of TF-CBT

TF-CBT is a joint parent-child treatment developed by Cohen, Mannarino, and Deblinger as cited in Mannarino et al. (2012). This treatment method provides structure for the use of cognitive-behavioural interventions where it considers the role of the caregiver and the developing nature of a child's emotion regulation and coping capabilities. The model was originally designed to address PTSD symptoms associated with sexual abuse such as depressive symptoms, behaviour problems (including aggression and inappropriate sexual behaviours), and unhealthy thoughts and feelings regarding the abuse. Such unhealthy thoughts would include cognitive distortions, guilt, and shame. More recently, TF-CBT is also being used to treat symptoms of child maltreatment, abuse, and other traumas such as physical or emotional abuse.

or neglect and witnessing community or domestic violence, traumatic loss, war, or natural disasters. In addition, this therapeutic approach also addresses the reactions of non-offending parents and caregivers as their reactions help indicate the effects of trauma on a child (Arellano et al., 2014).

Along with the focus on the types of problems TF-CBT is used for, it is important for health professionals and parents to understand the model of TF-CBT itself. Key components of TF-CBT must be understood in order to effectively treat children and adolescents who are suffering from depression due to trauma. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides a general definition of TF-CBT as “a treatment that uses cognitive- behavioural principles, including exposure techniques, to address the various symptoms that children and adolescents may experience after a traumatic event” (Arellano et al., 2014, p. 592). There are five core components of the TF-CBT model: psychoeducation, gradual exposure, behaviour modeling, coping strategies, and body safety skills training, and each element is adjusted according to the treatment needs of the client (Cohen et al., 2007).

In terms of the psycho-educational component, certain techniques and skills must be taught in therapy. In order to help children and adolescents develop coping skills, treatment providers teach relaxation skills, affective modulation skills, and cognitive coping skills (Arellano et al., 2014).

As per the exposure component, it is important to use a gradual approach so we do not risk a child’s safety, i.e. re-traumatize them. Further, exposure in TF-CBT involves gradually introducing individuals to reminders to the trauma, such as places, people, or specific memories of traumatic events. In addition, a gradual exposure and cognitive processing exercise would be narrative based. For example, a narrative is told to reduce stress and to overcome trauma related

memories. Next, in the exposure component, cognitive restructuring is used in identifying inaccurate and unhelpful thoughts and beliefs. An example of an unhelpful thought would be self-blaming thoughts. TF-CBT helps with forming more helpful ways in understanding the traumatic experience (Arellano et al., 2014).

In TF-CBT the therapist spends part of the session with the child and part with the caregiver; hence, a non-offending caregiver is incorporated into the child's recovery process. It is important to have the caregiver participate in some sessions with the child so that the child can regain security and well being that was distorted as a result of a traumatic experience. It is important to note that the experience of trauma increases a child's risk of posttraumatic stress symptoms, depression and behavioural problems, and a primary goals of TF-CBT is to reduce PTSD symptoms among children and adolescents (Arellano et al., 2014).

Effectiveness of TF-CBT

I will now discuss TF-CBT and depression. In order to evaluate the effectiveness of TF-CBT, it is important for health professionals such as psychiatrists and therapists to evaluate childhood trauma and childhood depression as well as childhood trauma and later life depression.

I will start off by examining Arellano et al.'s (2014) work entitled "Trauma Focused Cognitive Behavioural Therapy for Children and Adolescents: Assessing the Evidence" that provided reviews on findings on various studies that assessed the effectiveness of Trauma Focused- CBT (TF-CBT). These studies found that TF-CBT demonstrated positive outcomes in reducing symptoms of PTSD; however, it is less clear whether TF-CBT is effective in reducing symptoms of depression. According to Arellano et al. (2014), research shows that 75% or more of children and adolescents experience some form of trauma by the age of 18. Also, "a national survey of children 2-17 years or their caregivers conducted in 2008, found that more than 69%

had experienced at least one type of 33 types of victimization “ (Arellano et al., 2014, p. 591).

Whether TF-CBT is effective is not fully consistent in all studies, since, according to Arellano et al. (2014), out of nine studies that assessed depression, five reported statistically significant effects of TF-CBT compared with control treatments: being on waitlist, client centred therapy, and nondirective supportive therapy (Arellano et al., 2014). Of these studies, three had medium effect sizes and one had a large effect size (Arellano et al., 2014).

Next, I will discuss studies that have examined TF-CBT in depth with specific participant types and using certain measurements. Further, I will discuss what findings of such studies indicated. The studies that I will examine include authors: Mannarino et al. (2012), Lenz & Hollenbaugh (2015) and Holt et al. (2014).

Firstly, Mannarino et al. (2012) used participants that included children ages 4-11 years who had experienced sexual abuse and had been treated with TF-CBT with or without the inclusion of the trauma narrative (TN) treatment model. In addition, using a Child's Depression Inventory (CDI), a validated 27-item self-report instrument, children's depression for children ages 7 and older were assessed. This model consisted of eight or 16 sessions. Results of this study indicated that the overall significant improvement across 14 outcome measures that had been reported at post-treatment were sustained six and 12 months after treatment. Further, on two of these measures, child self-reported anxiety and parental emotional distress; there were additional improvement at the 12-month follow-up (Mannarino et al., 2012). According to Mannarino et al. (2012), these findings were consistent with earlier studies, which demonstrated that TF-CBT treatment gains are sustained for 1-2 years after treatment ends (Cohen Mannarino, 1997, Deblinger et al., 2006, Deblinger, Steer, & Lippmann, 1999).

Next, a study by Lenz and Hollenbaugh (2015) evaluated the effectiveness of Trauma Focused- Cognitive Behavioural Therapy (TF-CBT), specifically the effectiveness of TF- CBT for modifying the symptoms of PTSD and co-occurring depression in children and adolescents with a history of traumatic experiences. The total number of participants across these studies was 1,860 and 1009 of those having received TF-CBT (Lenz & Hollenbaugh, 2015). Specific questions were addressed in this research as well. These questions included: to what degree is TF-CBT effective for decreasing the symptoms of PTSD? To what degree is TF-CBT effective for decreasing the symptoms of co-occurring depression among individuals with PTSD? And, what are the relationships between mean sample age, ethnic identity, reported trauma type and domicile moderated and aggregated effect size? Lenz and Hoolenbaugh (2015) discussed that psychological functioning is a common effect of trauma exposure in children and adolescents. Further, these trauma symptoms, particularly Post Traumatic Stress Disorder (PTSD) for children and adolescents include: academic dropout, physical health, anger, and poor conflict resolution skills with peers and families. Further, as a result of these difficulties Major depressive disorder (MDD) is one of the most commonly diagnosed disorders in combination with PTSD, with research indicating that “almost 40% of adolescents and children diagnosed with PTSD also met criteria for co-occurring major depressive disorder” (p. 19). The authors stated that PTSD and depression put children at a much higher risk of suicidality than does depression alone (Lenz & Hollenbaugh, 2015). Moreover, results indicated that TF-CBT was superior to having no treatment at all. Moreover, this study showed that TF-CBT is beneficial for not only depression alone, but also for co-occurring depression when PTSD is also an issue (Lenz & Hollenbaugh, 2015).

Lastly, a study by Holt, Jensen, and Wentzek- Larsen (2014) discussed the mediating role of parental emotional reactions and depression in the treatment of traumatized youth. In this study, Holt et al. (2014) examined 135 caregivers of 135 traumatized children and youth from the ages 10-18. The purpose for this examination was to look at mechanisms that distinguish this method from TAU, Therapy As Usual. TAU therapists provided a treatment that they thought was helpful for each individual case while describing their approach has using psychodynamic, cognitive-behavioural and family/systemic (Holt et al., 2014). In order to compare these two methods of treatment, parent measures and child measures were used (Holt et al., 2014). Parent measures included: a parent emotional reaction questionnaire (PERQ) and the Centre for Epidemiologic Studies Depression Scale (CES-D) (Holt et al., 2014). In addition, children' measures included: The Clinician- Administered PTSD Scale for Children and Adolescents (CAPS-CA) and Mood and Feelings Questionnaire (MFQ) (Holt et al., 2014). Results of this study indicated, "the parent's emotional reactions and depressive symptoms decreased from pre- to post therapy but no significant differences between the two treatment methods were found" (Holt et al., 2014, p. 2). There were no significant differences in TF-CBT and TAU in child PTSD symptom changes; however, having a mediator was helpful in child depressive symptoms (Holt et al., 2014).

Implications of Studies

Health professionals such as therapists and psychiatrists would benefit from understanding how considering the five components of TF-CBT effectively can aid parents understand a child's trauma and depression as well as effectively treat the child without putting them at danger and re-traumatizing them. The studies above evaluate the effectiveness of TF-CBT that allows health professionals to better understand treatment methods and the various

possibilities of patients. Evaluating effective studies will allow health professionals understand what works in TF-CBT for children with depression and what does not work.

Conclusion

Overall, examining TF-CBT components and how therapy works is important to understand for treatment whether treating trauma or depression in children. Also, evaluating what research studies have found helps evaluate the effectiveness of TF-CBT. The various studies in this chapter examined whether TF-CBT is an effective method on its own, whether it is effective in comparison to other treatment methods and whether treatment gains are sustained over the years. Overall, results of these studies indicate that TF-CBT is effective for children who have experienced traumatic events where these traumatic events have lead to depression symptoms as well.

CHAPTER 4- CBT LIMITATIONS AND CRITICISMS FOR ADOLESCENT AND YOUTH DEPRESSION

All mental health treatments have their limitations. In order to maximize the benefits of treatments that help improve lives, one needs to understand and be aware of the associated limitations. Well-known approaches also have been criticized in many ways as researchers look for ways to improve or change modalities. Likewise, many researchers who have studied the effects of Cognitive Behavioural Therapy (CBT) for adolescents and youth with depression have noted some restrictions and criticisms associated with using this therapy. Hence, regardless of whether a scholar is for or against the use of traditional CBT for adolescents and youth with depression, the limitations and criticisms of the approach must be introduced and discussed.

In this chapter, I will begin by investigating what the critics have said about psychotherapy. Next, I will compare psychotherapy with treatment via medication and specifically CBT with other therapy modalities. Further, I will talk about limitations of CBT in different cultures since CBT is not a worldwide therapy method. After introducing cultural limitations, I will describe the components of CBT and their associated criticisms. I will discuss the importance of having skilled practitioners while examining how clients would be impacted if practitioners were not skilled in CBT. In addition, I will consider how depression may require additional assistance when combined with other issues such as substance use, suicidality, and financial restrictions. Lastly, based on my findings, I will examine the limitations and criticisms and discuss whether I think the benefits of CBT for adolescents and youth with depression outweigh their limitations. My intentions are to bring greater awareness and understanding to the limitations and opposing views associated with CBT interventions in order to cover the many perspectives of this research topic and provide an unbiased analysis.

Psychotherapy Criticisms and Limitations

In the early 1900s Sigmund Freud, Alfred Adler and Carl Jung, among others, developed psychoanalysis, the first form of modern psychotherapy. Later, Carl Rogers developed an interpersonal variant of therapy, which popularized counselling—from the early 1900s to the 1960s psychotherapy continually evolved and over 60 different approaches were developed within that time span (Rodríguez, Southam-Gerow; Swift & Callahan, 2009).

Well-known critic psychologists James Hillman and commenter Michael Ventura (1992) created a book with a memorable title, “We’ve Had a Hundred Years of Psychotherapy—And the World’s Getting Worse” and they argued that therapy focused solely on the internal self and internalized emotions while neglecting the external world. Further, in his book, Hillman (1992) documented a conversation he had had with the novelist and cultural critic Michael Ventura. During this dialogue they discussed an example of a person who felt angry by trucks that had almost run him off the road and suggested that therapist’s would say the feeling of anger has to do with inner states and anger from childhood, even though the anger resulted from an external situation, the truck almost running him off the road (Hillman & Ventura, 1992).

In Hillman & Ventura (2012), Hillman stated:

By going inside we are maintaining the Cartesian view where the world out there is dead matter and the world inside is living. Moreover, psychotherapy can be like dealing with feelings as if they are internal and have nothing to do with another person (p. 12).

Hillman and Ventura (1992) argued that psychology and therapies generally focused on thoughts and feelings that lead to actions rather than looking at the situation or the event on the outside and recognizing that the feelings and thoughts result from situations. This critique contradicts the central tenets of CBT as CBT focuses on an individual’s personal thoughts, feelings, and actions

and how these influence one another rather than how an outside situation alone can have a direct effect on one's thoughts, feelings, and actions. Also, Hillman and Ventura discussed the importance of relationships and the conflicts or concerns between relationships, rather than focusing on conflicts or concerns that are occurring inside an individual alone. Again, this is contradictory to CBT as CBT focuses on the individual and how to change her or his thoughts, which ultimately impacts their feelings and behaviours (Hillman & Ventura, 1992).

Other professionals (Berking et al., 2013; Beattie et al., 2009; Hillman & Ventura, 1992) also critiqued CBT, particularly for adolescents with depression, as CBT attempts to change how one thinks and conveys that feeling a certain way is not okay, which may lead to feeling powerless and further having self-esteem issues.

All of these critics (Berking et al., 2013; Beattie et al., 2009; Hillman & Ventura, 1992), have emphasized that we often shift the blame and responsibility for mental suffering solely to the individual and individualize the problem that are often traced to the culture itself. For example, getting angry at the driver of the truck almost running one off the road would frustrate anyone and not just a depressed individual. Also, as a cultural aspect we do not like being told that our feelings are "wrong" and need to be changed; rather, our human rights tell us that we have the right to feel the way we do.

CBT: Not World Wide

Similarly, along with low self-esteem issues, in Western culture, feeling powerless and having no control over one's ability to feel, think, and behave would oppose societal liberal views, with its focus on rationality, agency, and responsibility for one's choices as being important for all. Similarly, critics have raised the concern that CBT for adolescents and youth with depression is only effective in Western North American and Anglo-European societies

(Hsieh & Bean, 2014). In North American in particular, we tend to view assertiveness, personal independence, verbal ability, logic and behaviour change as important characteristics of life (Hsieh & Bean, 2014). CBT is not utilized around the world. For example, in countries such as China and India, such cultures have a more collectivistic view as opposed to an individual view for one's thoughts, feelings, and behaviours. In a liberal society, individuals are supposed to self-govern and have control over their lives and are "I" bound rather than "we" bound. This limits CBT for a multi-cultural society with immigrants from across the world. In order to counteract these limitations, Naeem et al. (2014) discussed having a culturally- adapted- CBT (caCBT). Naeem et al. (2014) suggest that caCBT is more effective than traditional CBT for adolescents with depression. The aim of their discussion was to find out the extent to which CBT was consistent with personal, religious, familial, social, and cultural values while the focus remains on psycho-education, changing negative thinking, behavioural activation, problem solving, and managing symptoms. Naeem et al. (2014) suggested that specific adaptations in the format, content, and delivery of CBT need to be applied for clients from non-Western cultures. Following Naeem et al. CBT may not be effective universally for all adolescents and youth with depression.

Research by Hsieh and Bean (2014) suggested that there needs to be clearer, more, clinically -oriented recommendations incorporated into CBT that can be used to effectively treat, for example, Chinese American adolescents struggling with academic pressures and depressive symptoms. Also, since these adolescents often come from a collectivistic culture, (as discussed above) family relations and family therapy needs to be incorporated in treatment since CBT is individual focused and a collectivistic culture includes the input and contribution of an individual and their family members (Hsieh & Bean, 2014).

CBT Versus Other Treatment Methods

Many therapists have incorporated mindfulness practices into their mental health treatment. Many non-Western cultures have been practicing mindfulness and meditation for many centuries (Marchand, 2012). Being aware of the effectiveness and importance of incorporating mindfulness into therapy, researchers such as Marchand (2012) have discussed Mindfulness- Based Cognitive Therapy (mindfulness incorporated into CBT) as mindfulness allows one to be aware of our thoughts and feelings in the present along with understanding the general pattern of our thoughts, feelings, and actions that CBT provides. Also, CBT is ineffective when one's behaviours are changing but not feelings, and ACT (Acceptance and Commitment Therapy) includes the importance of looking at one's values unlike CBT, Marchand, 2012).

Dialectical Behavioural Therapy (DBT) and Acceptance and Commitment Therapy (ACT) are derived from CBT and are called the "third wave" (Thoma, Pilecki, & McKay, 2015). This movement of traditional CBT and integrating acceptance, mindfulness, and non-judgemental awareness to the traditional CBT approaches allowed CBT to become more beneficial for adolescents and youth suffering from depression as broader techniques were available to fit individual needs (Thoma et al., 2015). Further, the authors stated that ACT is based on contextual behavioural sciences and Relational Frame Theory (RFT), "a modern learning theory that is built upon an extensive foundation of basic science and experimental research" (Thoma et al., 2015, p. 431).

In addition, Thoma et al. (2015) discussed "in ACT, all forms of mental illness arise from some form of experiential avoidance or the attempt to escape from or change private experience" (p 431.). This concept is similar to CBT in that it is focused on reducing symptoms and

implementing change as it focuses on analysing thoughts and emotions in order to generate a change in actions (Thoma et al., 2015).

Similarly, research by Hides, Samet, and Lubman (2010) discussed the effectiveness of CBT for the treatment of co-occurring depression and substance use as more effective with a combination of acceptance and commitment therapy and mindfulness-based cognitive therapy. This is important to consider as substance use and depression can be related. Moreover, being aware of the effectiveness and importance of incorporating mindfulness into therapy, researchers such as Marchand (2012) have discussed Mindfulness-Based Cognitive Therapy (mindfulness incorporated into CBT) as mindfulness allows one to be aware of our thoughts and feelings in the present along with understanding the general pattern of our thoughts, feelings, and actions that CBT provides. ACT (acceptance and commitment therapy) focuses on values and does not become ineffective when only one component such as feelings or behaviours change unlike CBT (Marchand, 2012).

In addition to incorporating useful approaches to CBT, a nontherapeutic method for treating mental illnesses has been medication. Pharmaceutical companies have been highly successful at selling drugs for aiding individual with health concerns, and medication such as anti-depressants are effective for depression, although the combination of CBT and anti-depressants has better outcomes for treatment (Thoma et al., 2015).

Similarly, Wagner et al. (2012) discussed how therapy alone may not be sufficient for severe clinical depression and one would need medications, more specifically antidepressants to treat depression. In addition, the author argued that Cognitive Behavioural Therapy is costly and medication may be more affordable for those who have financial difficulties (Wagner et al., 2012). In Wagner et al.'s (2011) study: "Out of the **black box**: Treatment of resistant depression

in adolescents and the antidepressant controversy,” the authors tested three propositions: (1) whether adolescents with depression benefitted from switching their ineffective medication to another type; (2) whether combining CBT with the ineffective medication led to improvement and; (3) whether combining CBT with the alternate medication led to improvement. Ultimately, the authors found that combining CBT with medication was helpful in decreasing the number of days with depression but was much more costly than medication alone. Also, the results suggested that 50% of the adolescents responded well to switching to alternate medication without CBT (Wagner et al., 2012).

Clarke et al. (2005) conducted a study to discover whether CBT combined with SSRI based medication would provide better treatment for depression symptoms, lower depression relapse, and better psychosocial functioning. Clarke et al. (2005) stated, “We found only weak evidence of the effectiveness of this collaborative care CBT program when delivered in combination with SSRIs” (p.893). Also, Clarke et al. (2005) predicted the Treatment As Usual (TAU) that consisted primarily of SSRI medication would be less effective in treating depression for children, as there are great controversies on medicating children; however, their predictions were wrong. Moreover, “The TAU control condition itself proved to be a potent intervention, however, with nearly 75% depression recovery by 12 weeks’ follow-up” (p. 893).

In addition to the studies by Wagner et al. (2012) and Clarke et al. (2005), Curry and Hersh (2014) stated that CBT alone was not entirely helpful for depressed adolescents, and that the combination of CBT and medication was not always supportive due to various reasons.

For example, Curry and Hersh (2014) stated:

As CBT investigators worked with more challenging, complex clinical cases, such as depressed adolescents who were abusing substances or engaging in suicidal or self-harm

behaviors, standard components of CBT were augmented by increased emphasis placed on emotion regulation, safety planning, and by more intensive outpatient treatment models (p.15).

Moreover, Curry and Hersh (2014) stated that for complex and severe depression that involves suicidality and substance abuse, medication and CBT together still may not be effective for adolescents and youth with depression.

CBT Components

Along with the above complexities and combination of treatments that contribute to alleviating adolescent and youth depression, in order to analyze CBT further, many critics also examined the components of CBT: thoughts, feelings, and actions. While some researchers have commented on CBT having missed key factors, others have also critiqued the components of traditional CBT as a whole. For example, one's thoughts and beliefs are not easy to change since these thoughts and beliefs have generally been practiced over a long time. It may be too difficult for adolescents and youth to change these thoughts by working on just the emotions and behaviours one is having difficulty with (Hides et al., 2010). Hides et al. (2010) discussed that the traditional CBT model considers altering unhelpful cognitions by changing behaviour and emotions, especially when these unhelpful cognitions may have aroused from a traumatic experience or difficult situation such as a death of a loved one. Both these conditions would require a process to help overcome the trauma, i.e., exposure therapy and expression rather than simply changing one's emotions (Hides et al., 2010).

Iftene, Preduscu, Stefan, and David (2014) also stated that without the adolescent or youth's effort and cooperation, the problem cannot go away. Further, attending regular CBT sessions and carrying out extra work between sessions takes up a lot of an adolescent and youth's time,

delaying her or his recovery. In addition, the structure and nature of CBT may not be suitable for more complex mental health needs such as severe depression (Iftene et al. 2014).

CBT only addresses current internal problem such as self-esteem and feeling low while focusing on specific issues for an individual and do not incorporate external factors such as relationships, family of origin, and situationally based issues—CBT does not include the overall picture for the causes and symptoms of depression (Bru et al., 2013). Moreover, CBT is rigid in the sense that it focuses primarily on a time limited, structured psycho-educational approach; such structuring overlooks possible underlying causes of mental health conditions, such as an unhappy childhood. In addition, although the structure of CBT includes thoughts, feelings, and behaviour, some critics have also stated that the structure is focused on cognitions much more than emotions; hence, a severely depressed emotional adolescent or youth may find that CBT is not be as beneficial while he or she is having great emotional reactions or difficulties (Bru et al., 2013; Iftene et al. 2014; Mychailyszyn et al. 2012).

Need of Skilled Practitioners

Skilled practitioners are extremely important for CBT benefits (Craig & Alessi, 2013). Studies show that CBT is not a quick and easy approach, but a skilled therapist can help the client move from resistance to treatment, which may require a longer therapeutic arc than what short-term CBT approaches offer (Craig & Alessi, 2013). Skilled therapists apply CBT within a good therapeutic relationship; one that adapts to the clients needs rather than a pre-fabricated process that forecloses the needs of varied clinical presentations (Craig, Austin & Alessi, 2013; Rodríguez et al., 2014). Research conducted by Webb, Auerbach, and De Rubeis (2012) focused on process variables such as the therapeutic alliance, patient cognitive change, and therapist adherence to, and competence in, the theory-specified techniques of therapy. The

results indicated that therapist adherence and competency were relegated as highly important when using CBT to treat adolescents with depression.

Depression Combined with Other Issues and Challenges

Not only does treating depression with CBT require strong CBT skills and competency, other issues and challenges that adolescents may have in addition to depression can also make CBT less effective. Having other issues makes things more complicated; however, it is common that depression generally presents with more than one issue (Weitz, 2014). Some of these concerns in using CBT for adolescents and youth with depression include: CBT's effectiveness for severely emotional and suicidal individuals, substance use issues, and financial barriers.

For example, as suicide and depression can go hand in hand, Weitz (2014) compared the effects of CBT, pharmacotherapy, and placebo on suicidality and found that antidepressants with CBT were more effective in reducing suicidality than CBT alone. In regards to substance use, Weitz (2014) suggested that adolescents and youth use substances to cope with their depression as well. As discussed earlier, having substance use concerns such as alcohol and drug use would require a focus on safety planning, and the involvement of more complex programs similar to Alcohol Anonymous rather than CBT alone.

Another concern is that CBT can be costly, and adolescents and youth who come from families that have financial struggles may not be able to afford the number of required sessions in order to benefit from CBT. Also, Garvik et al. (2014) discussed that in order to effectively evaluate CBT for adolescents and youth with depression, one should also explore other aspects of depressed youth i.e. social functioning and academics, rather than just exploring effects on depressive symptoms.

In addition, apart from other issues that adolescents and youths may face, sexual minority youth including gay, lesbian, or bisexual individuals may already be facing many other challenges including discrimination, stigma towards their group, family disapproval, social rejection, and violence. In order to understand these challenges, Shelley (2013) conducted a study that discussed the importance of being aware of the sexual minority youth, whom may not find CBT as effective.

Shelley stated:

It is important to recognize the limitations of gay affirmative CBT for SMY. While CBT is considered a best practice option for treating depression, anxiety, and substance abuse among the general adolescent population, its efficacy has not yet been tested with SMY. Further, this model may not be appropriate for all clinical situations (i.e., SMY experiencing life-threatening physical abuse) and in no way diminishes support for other psychotherapy approaches for sexual minority populations. Gay affirmative CBT for SMY is presented as a promising clinical option for working with SMY, but empirical research is needed to demonstrate its effectiveness. (p.265).

A clearly defined adaptation of CBT that integrates gay affirmative practices is an initial step toward developing empirically supported interventions to meet the specific needs of SMY (Shelley, 2014).

Limitations Versus Benefits

CBT appears to be effective in many ways and is not eliminated when other treatment modalities are integrated in it. For example, as discussed earlier, culturally adapted CBT, gay affirmative CBT, and trauma focused CBT (Chapter 3), as well as combining medications with

CBT interventions—it appears that each of these adaptations of CBT still incorporate the traditional CBT model within their intervention strategies (Marchand, 2012; Clarke et al., 2005)

In addition to ACT, Dialectical Behavioural Therapy (DBT) involves a longer-term treatment lasting up to several years and learning skills such as emotion regulation and mindfulness. As similar skills are taught in CBT and can occur faster and with the combination of CBT to mindfulness, CBT would be more beneficial than ACT alone (Thoma et al., 2015). Nonetheless, DBT involves clear clinical boundaries and debriefing with the therapist in between sessions. It appears that in ACT and DBT we are actually always doing CBT in ways as well; hence, one cannot conclude that ACT and DBT are more beneficial than CBT.

Concluding Remarks

In conclusion, it is important that counsellors are aware of critics and their views so that these professional helpers may understand CBT and its associated interventions for adolescents and youth experiencing depression better. Thus, combining ACT and CBT allows one to focus on internal and external issues as it incorporates a relational frame theory. Also, although CBT can be costly for some, this therapy approach can be implemented for all if it wears a culture adapted lens. Also, it is important to understand that there can be a combination of other issues- such as substance use and suicidality. In addition, CBT would be effective for sexual minority groups with gay affirmative CBT. Nonetheless, it is important to understand that along with combining CBT with other forms of therapy and modalities, many adolescents and youth may require medication in combination of therapy. Moreover, it is important to have a skilled practitioner along with understanding which components of CBT are more effective for youth and adolescents with depression versus which components are least effective. Ultimately, I believe that based on the research in the previous chapters of this dissertation and the limitations

in this chapter, the usefulness and benefits of CBT for adolescents and youth with depression, outweigh its limitations.

CHAPTER 5: DISCUSSION

The aim of this thesis was to highlight the significance of understanding adolescent and youth depression and to consider the contributions of Cognitive Behavioral Therapy (CBT) for this issue. Further, this document examines the well-researched approach of Cognitive Behavioural Therapy as a treatment for depression. This is a popular clinical approach and can be successfully applied to many issues relevant to the mental health of children and adolescents.

I believe it is easy to look past depressive symptoms in youth and adolescents and erroneously assume that the child is just “acting out” or the teenager is “being a teenager.” However, understanding the symptoms of depression, along with the causes and consequences of depression at a young age, health professionals and care takers can help improve a young one’s quality of life. In addition, based on the research I examined for this thesis and the professional experience I have had as an intern therapist, I noticed a theme, namely that many of my adult clients who suffer from depression disclosed that they felt as though they had been depressed since childhood. The purpose of my study was to engage with relevant research that will add to effective therapy for young people and bring greater awareness to depressive symptoms that children and youth may have which might otherwise go un-noticed. The goal was to provide clarity, understanding and awareness of depression at a young age and ways in which CBT is an effective treatment modality for this issue while considering its limitations.

Summary and Key Findings

The following discussion will summarize the key findings discussed in each chapter, and describe aspects of child and adolescent depression and the effectiveness of Cognitive Behavioural Therapy (CBT) for children and adolescents with depression. I will also highlight factors that play a role in childhood and adolescent depression as well as offer psycho-education

on CBT and depression for this age group so that health professionals and caretakers can provide adequate support. Further, I will reflect upon clinical implications, professional development, and thoughts towards moving forward.

Summarization of Chapters

In Chapter 1, I found that many studies conclude that depression is important to study in children and adolescents and, in fact, if left untended, this nascent condition may lead or develop into more severe mental health illnesses in adulthood (Bru et al., 2013; Stikkelbroek et al., 2013). Also, research shows that depression is important to study in the young population because depression is highly prevalent and a serious mental health problem in adolescence overall, and “is associated with a range of problems such as problematic peer and family relationships, school difficulties and drop out, health problems, increased substance abuse and suicide” (Garvik et al., 2014, p. 196). Further, it is important to treat depression as “there is an increased risk for development of social problems, learning problems, substance use, negative life events, physical problems, teenage pregnancies and suicide as a result of depression” (Stikkelbroek et al., 2013, p. 4). In addition, I discussed my interest in studying this topic and can say I have satisfied my interest throughout my research journey.

Moreover, I discovered that my thesis contributes to professional development in that this document can be used to provide information that health professionals could pass along to parents/caretakers of children and adolescents that suffer from depression. As such it could provide further psycho-educational material for dissemination. As CBT is a well-known form of psychotherapy, I discussed how this thesis provides crucial information on the effectiveness of CBT on children and youth with depression and how treating depression at an early age to prevent serious mental health problems in later adult life is important.

In Chapter 2, I found that the factors that relate to depression include: biological changes as a result of depression, developmental concepts that propose risks for depression, such as child attachment and maternal depression, and the impact of unhealthy environments on children as they grow up. Further, my findings indicate that understanding biological changes that range from cognition, the brain itself, hormonal changes, and developmental concepts aid health professionals and caretakers to better understand the impacts of depression (Levesque, et al., 2011; Haigh & Baber, 2012; Beck et al., 2012; Harpur et al., 2015; Cicchetti et al., 2010; and Cantón-Cortés et al., 2015). To do this effectively, it was important to focus on young children, pre-adolescent and adolescents (ages 0-18) so as to establish developmental trajectories and the risks of leaving depression untended and untreated.

Nonetheless, I learned that to gain ample knowledge on factors that add to adolescent depression, health professionals and caretakers need to understand the developmental and biological effects in childhood and pre-adolescence. For example, research has shown that maltreatment or substantial amounts of emotional stress can cause damage to the brain and neuro-hormonal system (Harpur et al., 2015; Legesque et al., 2011). Moreover, I reviewed research on the cognitive theory of depression by Beck (1976), which stated that cognitive structures known as schemas are constructs that one utilizes to derive conscious meaning of things and to establish basic beliefs; hence negative memory schemas, whether they are present in pre-adolescence, adolescence or adulthood, could lead to depressive symptoms (Haigh & Barber, 2012). Similarly, understanding the biological changes in the brain such as how the amygdalas function in emotional processing and understanding the MPFC-medial prefrontal cortex region, an area that allows one to have internal representation of the

self, helps caretakers and adolescents become aware of the biological changes that occur during depression.

Along with biological changes, to understand developmental concepts and a child's internal working model, interpersonal relationships and social support quality described by Bowlby's (1969) attachment theory are important to understand (Cantón-Cortés et al., 2015). Further, being educated on attachment styles—secure, avoidant, and ambivalent—as well as being well-informed of how important secure attachment is, allows for healthy regulation of negative effects and proper emotional regulation, caretakers can help prevent child and adolescent depression. In addition, I found that maternal depression, environmental factors such as family income and socioeconomic status, and stressful life events such as child abuse, trauma, and divorce, are factors that add to child and adolescent depression (Cantón-Cortés et al., 2015; Borelli & Fox, 2015) Thus, of the many negative life events, childhood trauma results from physical and sexual abuse that further results in depression (Cortés et al., 2015).

Next, in Chapter 3 CBT is examined as an effective treatment method for children who have been exposed to traumatic events and have experienced trauma related mental health issues, such as depression. Specifically, I examined Trauma Focused Cognitive Behavioral Therapy TF-CBT. In addition, my findings indicated that childhood traumatic events can leave painful memories that further lead to depression; hence, the TF-CBT model is used to discuss PTSD symptoms associated with sexual abuse such as depressive symptoms, behavioral problems (including aggression and inappropriate sexual behaviours) and unhealthy thoughts and feelings about the abuse (Arellano et al., 2014). Further, TF-CBT is also used to treat symptoms of child maltreatment, abuse and other traumas such as physical or emotional abuse or neglect

and witnessing community or domestic violence, traumatic loss, war or natural disasters (Arellano et al., 2014).

Further, researchers have evaluated several studies to test the effectiveness of TF-CBT (Lenx & Hollenbaugh, 2015; Choen- Mannarino, 1997; Deblinger et al., 2006; Deblinger, Steer, & Lippmann, 1999). In this chapter, I used various studies to assess the effectiveness of TF-CBT in comparison to other treatment methods and TF-CBT's treatment gains over the years were examined to check if they are sustainable. Results of these studies indicated that TF-CBT is effective for children who have experienced traumatic events where these traumatic events have led to depression symptoms as well. Evaluating effective studies will allow health professionals to understand what works in TF-CBT for children with depression and what does not work. These studies and a study by Cohen et al. (2007) explored the five core components of the TF-CBT model: psycho-education, gradual exposure, behaviour modeling, coping strategies, and body safety skills training. Moreover, I believe health professionals such as therapists and psychiatrists would benefit from understanding how considering the five components of TF-CBT effectively can aid parents to understand a child's trauma and depression as well as effectively treat the child without putting them at risk and re-traumatizing them.

In Chapter 4, I include research and discussion on CBT and its limitations in order to maximize the benefits of treatments with CBT for children and adolescents with depression. Based on the information presented in earlier chapters of this thesis, CBT is effective in many ways and not rejected as a therapeutic approach, rather it works solely as well as in combination with other treatment modalities. For example, as discussed earlier in this thesis, culturally adapted CBT, gay affirmative CBT, and trauma focused CBT (Chapter 3), as well as the issue of combining medications with CBT interventions; thus, it appears as if each of these

adaptations of CBT still merge the traditional CBT model within their intervention strategies (Marchand, 2012; Clarke et al., 2005).

While examining the possible limitations of CBT, I found that studies that compared CBT to other therapies such as Acceptance and Commitment Therapy (ACT) and Dialectical Behavioural Therapy (DBT) (Thoma, Pilecki & McKay, 2015), concluded that DBT involved a longer term treatment lasting up to several years and learning skills such as emotion regulation and mindfulness than when teaching these similar skills in CBT (Thoma et al., 2015). Also, these studies stated that combining CBT with mindfulness in addition to ACT would be more beneficial than ACT alone (Thoma et al., 2015). Nonetheless, DBT involves clear clinical boundaries and debriefing with the therapist in between sessions. Thus, it seems like in ACT and DBT therapists are actually always doing CBT in ways as well; hence, one cannot conclude that ACT and DBT are more beneficial than CBT.

Chapter 4 discussed the limitations of CBT with the aim of helping counsellors become aware of the criticisms and shortcomings of CBT and its associated interventions for adolescents and youth experiencing depression with the aim of providing better overall treatment plans. These treatment plans might move beyond CBT and encompass other relevant modalities or merge other practices with CBT to improve results. For example, combining ACT and CBT allows one to focus on internal and external issues as it incorporates a relational frame theory. This combination allows for greater contextualization than traditional CBT with its focus on internal thought schemata. Also, although costly for some, as many individuals need to seek private counselling, the CBT approach can carry out a culturally adapted lens (Thoma, Pilecki & McKay, 2015). Nonetheless, it is important to understand that issues such as substance use and suicidality may result from depression. In addition, it is important to understand that along

with combining CBT with other forms of therapy and modalities such as ACT, many adolescents and youth may need to combine medication with therapy. I closed my fourth chapter by stating that ultimately, I believe, based on the research in the earlier chapters of this thesis and the limitations in this chapter, the usefulness and benefits of CBT for adolescents and youth with depression outweighs its limitations.

Expanding My Knowledge, Limitations and Future Research Opportunities

Expanding My Knowledge

Throughout this thesis process I have learnt and discovered many things. My research has taught me that stressful life events at an earlier age can contribute to depression later during adolescence. Therefore it is valuable to examine childhood and pre-adolescent factors that may have contributed to adolescent depression. Further, as a therapist, I understand that many issues such as childhood trauma from physical abuse or sexual abuse, neglect and attachment issues, maternal depression, divorce and family income and socio-economic status relate and contribute to childhood and adolescent depression. Thus, with so many issues that can occur at a young age that lead to depression, as a therapist, it is important to be aware of what particular therapeutic approach would be most beneficial to young people as well. Nonetheless, I believe it would also be beneficial to educate my clients on the importance of treating depression and understand the risks associated with it, since young people would become aware of the many issues associated with depression that are mentioned above, and other issues such as: increased risk for development of social problems, learning problems, substance mis-use, negative life events, physical problems, teenage pregnancies, and risk of suicide.

CBT is a well-known therapy, and a treatment method I have witnessed as being effective for adults suffering from depression. Research has shown that CBT is an effective therapeutic approach for children and adolescents as well (Arellano et al., 2014; Lenx & Hollenbaugh, 2015; Choen- Mannarino, 1997; Deblinger et al., 2006; Debliner, Steer, & Lippmann, 1999). What became clearer, as my research progressed, were the various combinations of treatments and hybrid forms of CBT that can be used as well, such as: TF-CBT, Mindfulness based CBT, CBT with the use of medication, and other expressive combinations such as with play therapy. Having this clarity of options has benefited myself and can be useful to other health professionals for adequately using CBT as a therapeutic approach when working with children and adolescents with depression. Using different CBT approaches is useful since depression comes in many forms and it is important to have a client centred approach in that the type of approach required would depend on the client's needs. Along with discovering ways for health professionals to enhance treatment for children and adolescents with depression, researching this topic has inspired me to gain clarity on attachment styles and being aware of risk factors for depression in childhood that can aid caretakers in improving a child's life.

Limitations

Some of the limitations of this document include the research used and the possible biases while researching. For example, while researching I analyzed research primarily on the effectiveness of TF-CBT and less so on the ineffectiveness of TF-CBT. Nonetheless, more research on using TF-CBT in treating childhood and adolescent depression would better confirm my findings. For example, although a study by Holt et al. (2014) concluded that there are significant differences between TF-CBT and TAU (Treatment As Usual—treatment that included a psychodynamic, cognitive-behavioural, and family/systemic approach) in that TF-

CBT was more effective when treating children and adolescents with depression than TAU, I did not provide specific information on the reasons behind this and what specific limitations there were in using TF-CBT that may have been suggested by the authors. At the time I did not seem to find research on the barriers to using TF-CBT. Likewise, to emphasize the difference between secure children and depression, and insecure children and depression, more research needs to be presented on this topic. Thus, this document provided information on the importance of having a secure attachment as a child in order to be resilient during stressful events but did not present research on the effectiveness of CBT on young individuals with depression who were securely attached to their caretakers and young individuals who were insecurely attached to their care takers (Cantón-Cortés et al., 2015). My intentions were to bring awareness to the importance of secure attachment in being resilient to the kind of stress that may lead to depression; however, I could have benefited more by providing direct research on CBT and securely attached children and insecurely attached children as attachment is not the only factor that determines depression in a young person. Nonetheless, as maternal depression and its relation to childhood and adolescent depression was discussed in this thesis, it would be beneficial to study paternal depression and its relation to childhood and adolescent depression as well as other close family members with depression, i.e., siblings and their relation to childhood and adolescent depression since children and adolescents are also affected by other family members and close relationships.

Along with the biases present while researching, I think my personal biases favouring CBT also influenced this thesis. For example, before writing this thesis I had a positive experience with CBT at my internship site where I saw many adults with depression benefiting from it. Being able to see their gradual changes made me feel hopeful and positive about CBT and its treatment for children and adolescents with depression. Also, understanding CBT as a

well-known and popular therapy, I was confident in its effectiveness for young people, especially young people with depression as I think positive thoughts, feelings, and actions can function to uplift depression.

Moreover, I believe there are limitations in writing a manuscript style thesis, as there is no experiment conducted, and CBT has relied on the experimental data generated by cognitive psychology more broadly, rather this type of document brings together information from previous literature and conclusions are formed from reviewing earlier research. Also, it is easy to leave out important scholarly texts when researching and forming the manuscript thesis, as there are so many scholarly articles available on many databases.

Future Research

Although I believe that this thesis provides greater awareness and understanding of depression in young individuals and ways to treat depression, in future studies I would include analysis of other known or suspected causes of depression in childhood and adolescents. For example, immigration in North America is common, whether it is the entire family immigrating and the young person's direct effect of immigration or having immigrated parents while the children are born and raised in North American. Thus, there is a lot of stress and challenges involved for the child in either case (Zayas et al., 2015; Jagers & MacNeil, 2015). It is important to bring awareness to cultural adaptation processes and the antecedent stress it causes families and children.

In addition to more research on causes of depression, future research could also focus on ways and at what times mindfulness would be important to include in therapy, since mindfulness is becoming a more popular treatment for depression. For example, Kallapiran & Kannan (2015)

conducted a study on the effectiveness of mindfulness-based intervention (MBI) on children and adolescents with mental health disorders. For this study, the authors looked at 12 studies that compared mindfulness approach to other therapies and medication use to evaluate the effectiveness of MBI for children and adolescents with mental illnesses. Moreover, based on Kallapiran and Kannan's (2015) research, MBI and mindfulness based cognitive behavioural therapy was most effective for children and adolescents with various different mental health issues, including depression. As my thesis was not primarily focused on mindfulness based CBT, for future research I would examine the effectiveness of mindfulness based CBT with CBT to compare these to other relevant therapies (Irving, Farb & Segal, 2015).

Similarly, this thesis discussed secure attachment styles in children and caretakers as a resilient factor for children and adolescents; however, I was not able to find research on depression in children and adolescents who had different attachment styles and their resiliency in comparison to one another. This future research may be difficult to do as based on my understanding of attachment styles and depression, there would be much less information on securely attached children and depression versus insecurely attached children (Carriere & Richardson, 2009; O'Gorman, 2012). Future research into TF-CBT's limitations in order to effectively use this therapeutic approach for depression would also be helpful. For example, to test the effectiveness of TF-CBT, many studies use participants who are diagnosed with PTSD (according to DSM-V) and have depression, while other traumatic experiences that children with depression may experience may not be included in these studies (Lenz & Hollenbaugh, 2015; Salloum et al., 2015).

Final Conclusion

In conclusion, I am hopeful that bringing awareness and understanding effective treatment methods such as CBT will help treat depression at an earlier age. My hopes are that understanding the CBT approach and the combination of treatment modalities that are specifically helpful for children and adolescents (i.e., TF-CBT and mindfulness based-CBT) will help health professionals in effectively treating depression in young individuals. In addition, as health professionals and caretakers, having ample knowledge on many causes, risks and consequences of depression in childhood and adolescents, one can help these young individuals live better lives, as well as treat it at an early age. Nonetheless, as all studies have limitations, the limitations discussed in this document also bring awareness to these limitations for future research. Moreover, future research on mindfulness as an approach for young individuals and research on bringing awareness to other causes of depression as well, such as immigration and cultural adaption for families would add to this field of study.

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