CHAPTER 1

Depression and Behavioral Activation with Adolescents

The Adolescent Behavioral Activation Program (A-BAP) utilizes a behavioral activation (BA) approach to treating depressed adolescents. Designed for adolescents between the ages of 12 and 18, the program typically consists of 12–14 sessions, organized in five modules, and is typically delivered once a week. Although the program is structured, it is designed to be used flexibly following the principles of BA. This treatment manual includes detailed, session-by-session instructions for therapists, as well as handouts for the adolescent and the parent(s) in treatment. Parents are actively involved in the treatment and are oriented to the BA model, educated about depression, and taught strategies to improve communication with the adolescent and ways to support the adolescent's treatment goals. We fully acknowledge the diversity of families and living situations and use the word *parent* throughout to indicate an adult or adults who are actively involved in the life of the adolescent, and who have the legal right to participate in his or her treatment.

The A-BAP approach to treating depression was modified from behavioral activation treatment as developed for adult depression (Martell, Addis, & Jacobson, 2001). Chapters 1–5 of this volume cover background and implementation of the treatment program. In this chapter (Chapter 1), we provide an overview of our understanding of the impact of depression on adolescents, a review of current treatment findings, a description of the behavioral model of depression, and an overview of the A-BAP approach. In Chapter 2, we discuss assessment, case conceptualization, and treatment planning. Chapter 3 provides a hands-on, session-by-session guide to implementing the material in the A-BAP manual. Chapter 4 considers strategies for handling challenges that often arise in treatment, such as suicidal behaviors, and Chapter 5 explores how the A-BAP might be used effectively with other clinical problems or populations, such as youth coping with anxiety

or chronic pain. The actual treatment protocol, including session-by-session outlines of the five modules, follows. The final section consists of handouts to support each session.

The Problem of Depression in Adolescence

Most therapists working with adolescents treat youth with depression or other psychiatric or medical disorders that are complicated by depression. Adolescent depression is widely recognized as a major public health problem (Lopez, Mathers, Ezzati, Jamison, & Murray, 2006). Population-based prevalence rates indicate that at any point in time, 0.4–8.3% of adolescents are struggling with depression, and cumulative prevalence rates suggest that 20% of youth have at least one episode of clinical depression by age 18 (Costello, Egger, & Angold, 2005; Hankin et al., 1998; Lewinsohn, Clarke, Seeley, & Rohde, 1994). Moreover, relapse and recurrence of depression are common. Following an episode of depression, approximately 50–70% of depressed youth experience a relapse within 2 to 5 years of diagnosis, and these youth are at increased risk for recurring depression in adulthood (Curry et al., 2011; Dunn & Goodyer, 2006; Goodyer, Herbert, Tamplin, & Altham, 2000; Lewinsohn, Rohde, Seeley, Klein, & Gotlib, 2000). It is further estimated that 65% of youth experience transient or less severe depressive symptoms during their adolescent years (Lewinsohn, Hops, Roberts, Seeley, & Andrews, 1993); however, studies suggest that even subclinical symptoms of depression are associated with adverse consequences (Fergusson, Horwood, Ridder, & Beautrais, 2005; Lewinsohn, Solomon, Seeley, & Zeiss, 2000). Depression in adolescence represents a risk for substance use and suicide, and more generally compromises psychosocial development and interferes with academic achievement, as well as peer and family relationships (Keenan-Miller, Hammen, & Brennan, 2007). Moreover, long-term sequelae of adolescent depression include a host of broader functional deficits, such as poor global and adaptive functioning, and academic and occupational impairment (Copeland, Shanahan, Costello, & Angold, 2009; Fergusson & Woodward, 2002; Glied & Pine, 2002; Lewinsohn, Rohde, Seeley, Klein, & Gotlib, 2003). These far-reaching consequences underscore the importance of identifying effective prevention and intervention approaches.

Developmental factors may contribute to the increased risk for depression in adolescents. Adolescence is a time of significant neurocognitive development, reorganization, and structural change (e.g., Giedd et al., 1999; Gould & Tanapat, 1999; Hare et al., 2008; Luna, Padmanabhan, & O'Hearn, 2010; Somerville, Jones, & Casey, 2010). Adolescents experience heightened emotionality, perhaps secondary to the hormonal changes of puberty, which can hamper their ability to mobilize executive functioning skills, such as impulse and emotion control, memory, self-monitoring, and planning abilities. They demonstrate limited abilities to process complex tasks due to limitean immature working memory and an inability to inhibit impulsive responses (response inhibition) (Crone, Wendelken, Donohue, van Leijenhorst, & Bunge, 2006; Steinberg et al., 2006; Velanova, Wheeler, & Luna, 2008). The structural brain changes that lay the foundation for more sophisticated skills, such as response inhibition, problem solving, and long-term planning, do not fully develop until late adolescence or early adulthood (Casey, Duhoux,

& Cohen, 2010; Giedd, 2004). The gap between the increase in emotional or affective response during early adolescence and the development of neuroregulatory mechanisms (Davey, Yücel, & Allen, 2008) contributes to problems with affect regulation. This leaves many adolescents vulnerable to biased interpretations of experiences, self-criticism, low inhibitory control, and emotion-focused coping (Giedd et al., 1999; Luna et al., 2010)—all variables that are correlated with depression. Moreover, the brain reactivity of depressed adolescents may differ in important ways from the brain reactivity of depressed adults. Although depressed adults demonstrate increased and sustained physiological reactivity to emotional information, depressed and anxious adolescents demonstrate decreased reactivity, suggesting a shutting down or avoidance of emotional stimuli (Silk et al., 2007). Additional evidence suggests that disruption of reward processing may be part of the physiological changes that contribute to depression regardless of age, and that vulnerability to reward dysregulation may be greater during adolescence because neural reward systems are still developing (Davey et al., 2008; Forbes, 2009).

Awareness of the neurocognitive changes affecting the adolescent brain may inform the development and selection of optimally effective intervention strategies. Research findings suggest that treatment for adolescent depression may need to target the adolescent's ability to (1) experience and respond to reward, and (2) overcome avoidance—both targets that are key components of behavioral activation (Forbes, 2009).

Current Approaches to Treating Adolescent Depression

Most research on the treatment of adolescent depression has focused on the efficacy of cognitive-behavioral therapy (CBT), interpersonal therapy (IPT), and pharmacotherapies, alone or in combination. Both CBT and IPT utilize a short-term therapy approach, with a focus on the "here and now" rather than the past; in both, the therapist plays an active role in providing education about depression and engaging adolescents in structured steps and skill building to reduce their depressive symptoms. Although the findings for both approaches have been promising, treatment challenges persist.

CBT treatments for adolescent depression, modified from adult CBT treatment programs, have been utilized for many years (Clarke, DeBar, Ludman, Asarnow, & Jaycox, 2002; Lewinsohn, Clarke, Hops, & Andrews, 1990). They include behavioral interventions such as scheduling pleasant activities, problem solving, and relaxation, and they focus centrally on cognitive elements, such as the positive restructuring of negative thoughts (i.e., cognitive restructuring) and examining and challenging underlying beliefs. Although early CBT findings in youth were very positive, recent studies suggest a more muted and delayed response pattern. The Treatment of Adolescents with Depression Study (TADS), for example, found that at immediate posttreatment (12 weeks), adolescents randomized to CBT did not differ from those in the pill-placebo control group and had a significantly lower response rate than adolescents randomized to fluoxetine alone or CBT and fluoxetine combined (TADS Team, 2004). At the 36-week follow-up evaluation, however, the effects of CBT alone and fluoxetine alone converged with those of combined treatment, indicating significant improvement in symptoms for approximately

80% of the participants (TADS Team, 2007). This positive response rate close to a year posttreatment may reflect, in part, the natural course of depression given evidence that depressive episodes remit in most adolescents (60–90%) within 1 year (Thapar, Collishaw, Pine, & Thapar, 2012). As noted earlier, however, recurrence rates remain high, suggesting limits to persistent treatment efficacy.

IPT modified for adolescents (IPT-A) also has demonstrated promising efficacy (Mufson, Weissman, Moreau, & Garfinkel, 1999; Rosselló, & Bernal, 1999) at posttreatment and at 16-week follow-up, as well as in initial effectiveness testing in school-based health clinics (Mufson et al., 2004; Young, Mufson, & Davies, 2006; Mufson, Dorta, Moreau, & Weissman, 2011). IPT conceptualizes depression as a medical illness in an effort to reduce the sense of self-blame that often accompanies it and focuses on the interaction among mood, life events, and interpersonal relationships as key maintenance factors of depressive symptoms. IPT, therefore, focuses on enhancing communication skills using strategies such as encouragement of affect, role playing, and communication analyses to address challenges of role transitions and interpersonal problems as a way to improve the adolescent's relationships and thereby reduce depressive symptoms. This approach has been particularly effective for youth with social dysfunction and parent–child conflict (Gunlicks-Stoessel, Mufson, Jekal, & Turner, 2010; Mufson et al., 1999, 2004). Comprehensive evaluation of IPT-A, however, has been hindered by small sample sizes, the absence of data on long-term outcome and relapse rates, and lack of comparison, singly or in combination, to antidepressant medication (Mufson, 2010).

Parent involvement in the treatment of adolescent depression varies widely. While both CBT and IPT-A employ an individual therapy approach, CBT interventions frequently involve coaching parents to reinforce therapeutic interventions or may include directly teaching parents strategies for parenting, conflict resolution, or communication. IPT-A includes parent psychoeducation in all phases of care and works actively with parents and adolescents together on communication and problem solving when indicated to help improve the adolescent's mood (Mufson et al., 2004). A renewed interest in testing interventions that include a significant family or parent component has emerged over the last decade. Prior findings on the efficacy of including a parental component to treatment for depression have been mixed, but in a recent meta-analysis of treatment across diagnoses, inclusion of a parent–child combined approach yielded a moderate benefit over and above that achieved by individual child treatments (Dowell & Ogles, 2010). Attachment-based family therapy (ABFT; Diamond & Josephson, 2005; Diamond et al., 2010; Israel & Diamond, 2013), based on interpersonal theory, posits that rebuilding interpersonal relationships within families can lead to reductions in depression and suicidality in adolescents. Results from a series of small studies of ABFT suggest clinically significant reductions in depressive symptoms and self-reported suicidal ideation. ABFT is seen as a "promising" intervention approach (David-Ferdon & Kaslow, 2008), and its success underscores the need to revisit parental involvement in treatment of adolescent depression.

Finally, even though pharmacotherapy alone has been shown to benefit approximately 60% of youth and close to 70% of youth when combined with CBT, it has been associated with controversy. Introduction of a new class of antidepressants, the selective

serotonin reuptake inhibitors (SSRIs), in the 1990s, marked a dramatic increase in the prescription of antidepressants to children and adolescents. This rise in the use of SSRIs has presumably occurred because these medications are considered "safe"; they do not have high lethality with overdose or the cardiac side effects found with early antidepressant medication. In 2004, however, the U.S. Food and Drug Administration (FDA) issued a "black box" warning regarding the use of antidepressants with youth due to mood-related side effects, specifically, increases in suicidal thoughts and behaviors (Moreland, Bonin, Brent, & Solomon, 2014). This warning triggered an ongoing debate about the use of antidepressant medications with young people. The data on medication-triggered suicidality has been controversial (Brent & Birmaher, 2004; Mann et al., 2006; Nemeroff et al., 2007), and many stress the idea that emergent suicidality is simply a core risk in all treatment of adolescent depression—psychopharmacology or psychotherapy (Bridge, Barbe, Birmaher, Kolko, & Brent, 2005). Furthermore, a recent meta-analysis of 17 studies of the use of antidepressants in children and adolescents found significant increases in emotional arousal and behavior activation in youth taking antidepressants compared to placebo controls (Offidani, Fava, Tomba, & Baldessarini, 2013). With that said, however, care guidelines are clear about the need to educate adolescents and parents regarding the risk of escalating thoughts of suicide, regularly monitoring suicidality, and engaging in active outreach as indicated (Simon, 2006).

Following the FDA warning, there has been a 25–58% drop in antidepressant prescriptions (Libby et al., 2007; Libby, Orton, & Valuck, 2009). The use of pharmacological interventions for depressed youth is also influenced by many adolescents' negative attitudes about medication use (Williams, Hollis, & Benoit, 1998); many adolescents for whom medications are prescribed fail to receive an adequate treatment trial because they do not take medication as prescribed or they discontinue its use prematurely (Richardson, DiGiuseppe, Christakis, McCauley, & Katon, 2004; Richardson & Katzenellenbogen, 2005). The decline in medication use has in turn led to concern about inadequate treatment of depression and subsequent increases in suicide rates, with reports of a 14% increase in youth suicide in the United States between 2003 and 2004—the largest year-to-year increase in youth suicide rates since 1979 (Gibbons et al., 2007; Simon, 2006). Taken together, these findings suggest that viable alternatives or adjuncts to medication approaches are warranted.

Of great concern is the fact that a significant subset of youth does not respond to any type of treatment, even combined therapy. This was exemplified in the TADS, in which approximately 50% of youth had significant residual symptoms following the initial 12-week treatment, and overall remission (as opposed to response) rates were only 60% by the 36-week follow-up evaluation (Kennard et al., 2006, 2009). Furthermore, it is clear that some subgroups of adolescents are at particularly high risk for poor response to treatment, such as those exposed to early life adversity (Lewis et al., 2010; Nanni, Uher, & Danese, 2012). Even considering adolescents generally, it is clear that more robust interventions are needed. In a recently completed meta-analysis, Weisz and colleagues (2013) compared evidence-based therapies for a variety of child/adolescent mental health problems, including depression, with treatment as usual (TAU). Although evidence-based therapies, including CBT and IPT, were associated with better outcomes when compared

to TAU, the effect size across studies was modest and less robust among youth who actually met diagnostic criteria for a disorder.

It is possible that response to current treatments is limited by a reliance on strategies that are a developmental mismatch for some adolescents. The mechanism of action in CBT is thought to be the remediation of biased cognitive processing through cognitive restructuring. Biased cognitive processing refers to the negative thinking or interpretation of events that commonly comes with feeling depressed. Cognitive restructuring first involves pointing out that what and/or how we think affects how we feel, and in turn, what we do (cognitive triangle), and second, involves working with the adolescent to come up with alternative thoughts that give rise to more neutral or positive feelings (DeRubeis, Siegle, & Hollon, 2008; Siegle, Steinhauer, Friedman, Thompson, & Thase, 2011). For IPT-A, the mechanism of change is thought to be improved social skills and relationships. Both approaches rely on the adolescent effectively learning and implementing sophisticated cognitive and interpersonal skills. Mastery of these skills, however, may be difficult for a substantial subset of adolescents who have not yet developed the cognitive maturity or competence needed for cognitive restructuring, interpersonal problem solving, including the ability to take another person's perspective, and response inhibition, particularly in the face of increased emotional arousal.

One response to concerns about the possible mismatch between complex strategies and the capacities of adolescents has been the development of more modularized approaches to treatment. These approaches, such as the Practice Wise Managing and Adapting Practice system (MAP; Chorpita & Daleiden, 2009), involve the systematic matching of youth mental health problems and demographic characteristics to associated treatment elements (or modules) that have been identified in the scientific literature as components of empirically supported interventions for particular demographic and diagnostic groups. MAP is based on the distillation and matching model, which states that evidence-based psychosocial interventions can be distilled into sets of content elements, then matched to client problems and individual characteristics (Chorpita, Daleiden, & Weisz, 2005). MAP was developed to simplify the process by which mental health therapists select and implement a treatment plan within busy community-based settings. This approach enables a therapist to deliver treatment elements in each session that are most likely to promote change, thereby increasing the chance that even a small treatment dose might be effective. Weisz and colleagues (2012) have reported that the modularized approach is associated with greater symptom reduction than usual care or standard manualized treatments (CBT for depression and anxiety, behavioral parent training for externalizing problems) in a randomized trial with 174 children between ages 7 and 13. The efficacy of the modular approach underscores the importance of identifying treatment elements that can facilitate treatments tailored to an individual's specific needs and circumstances. It is possible that treatment responses of depressed adolescents might also be improved by focusing on strategies that target the specific functional deficits associated with adolescent development described earlier in this chapter (Forbes, 2009; Forbes et al., 2009). These considerations motivated us to consider testing the value of BA components in the treatment of adolescents.

The BA Model of Depression

BA is based on a behavioral model of depression (Ferster, 1973; see Figure 1.1), which emphasizes the importance of considering positive reinforcement and punishment in the environment, and the function that depressive behaviors serve in an individual's life. The approach is idiographic, considering the specific context in each case to determine possible factors contributing to the depressive behaviors, those that serve to maintain it, and the behaviors/events required to treat it. Two interrelated concepts are central to the theory of change in BA. First is the idea that an individual needs to have the opportunity to experience positive reinforcement for adaptive behavior from his or her environment, and second is the idea that avoidance is a common barrier to engaging in adaptive behavior. Pleasant events scheduling is frequently included in CBT approaches as a strategy to boost mood by encouraging withdrawn individuals to reengage in social and physical activities; this component of CBT has more recently been referred to as *behavioral activation.* Within the CBT model, however, pleasant events scheduling or BA typically follows a nomothetic approach, identifying activities that "should" be pleasant to most people. As noted earlier, however, BA takes a more idiographic approach to identifying the specific events that may both trigger and maintain depression for each individual, countering this cycle by building in specific, rewarding responses/activities to these triggers, with attention to overcoming avoidance that may maintain a negative response cycle. Avoidance behavior often offers short-term symptom relief but is maintained via negative reinforcement (i.e., the strengthening of behavior via removal of a noxious stimulus), therefore serving to maintain depression in the long run. Although avoidance was recognized as central to depression, as well as anxiety disorders, in the early 1970s (Ferster, 1973), treatments for depression, such as CBT and IPT, have not identified avoidance behaviors as primary treatment targets. In this way, the emphasis on avoidance behaviors in the current BA model is unique. BA focuses on providing an in-depth focus on understanding how events in a person's life may both trigger and maintain depression, and the role of avoidance in maintaining this negative response cycle.

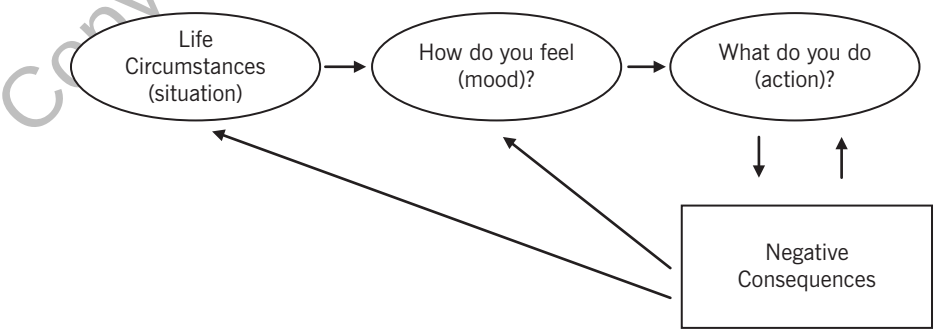

FIGURE 1.1. The BA model of depression.

BA for Adult Depression

In their work on adult depression treatment, Jacobson and colleagues (1996) conducted a component analysis of Beck's cognitive therapy (CT) for depression (Beck, Rush, Shaw, & Emery, 1979). They explored whether the simpler BA component of CT would work as well as the full CT approach that included both behavioral and cognitive interventions. To the surprise of many, the BA component alone worked as well as the full CT approach, and a larger trial was initiated, with BA articulated as a treatment in its own right (Jacobson, Martell, & Dimidjian, 2001; Martell et al., 2001). In this trial, BA was compared with CT, antidepressant medication, and a pill-placebo condition. Results indicated that among more severely depressed adults, BA worked as well as antidepressant medication and had some advantage over CT (Dimidjian et al., 2006). BA for adults is an idiographic approach wherein the therapist works under the umbrella of a behavioral case conceptualization and conducts an analysis of each client's life situation, goals, and the function of his or her daily activities, with a particular emphasis on identifying behaviors that function as avoidance and maintain depressive symptoms. The standard session structure of CBT—namely, identifying treatment goals, collaboratively setting an agenda for each session, and assigning and reviewing homework—is followed, but the treatment strategies utilized with individual clients in BA vary based on the functional analysis and individual client needs.

Why BA for Adolescents?

BA may also represent a promising approach for depressed adolescents. BA targets engagement with possible reinforcers within the adolescent's environment and may be one strategy to enhance outcomes. BA also is consistent with the understanding of adolescent development emerging from recent findings in cognitive and affective neuroscience. The focus on activation is highly compatible with the developmental needs and abilities of adolescents. Unlike existing therapies that call on sophisticated and higher-order cognitive concepts, BA is an idiographic, behavioral approach that uniquely centers on (1) activation to increase a youth's probability of exposure to naturally rewarding experiences, (2) identification and reduction of barriers to activation, and (3) recognition of avoidance patterns coupled with generation of alternative coping strategies that potentiate the experience of reward for the individual adolescent.

Moreover, excitement about BA has been driven by the belief that since it relies on a few basic treatment strategies, it is relatively easy to learn and administer effectively. The emerging field of implementation science suggests that barriers to utilizing evidence-based treatments in real-world settings include the therapist's lack of knowledge and skills in applying available interventions (Garland et al., 2010; Palinkas et al., 2008). The ease of learning and using new treatment approaches is enhanced with a simplified treatment design (Aarons & Chaffin, 2013; Rotheram-Borus, Swendeman, & Chorpita, 2012). There is concern that CBT is difficult to disseminate because of the finding that outcomes differ based on treatment location, even in highly controlled research trials

(DeRubeis et al., 2005), and others have noted that CBT can be difficult to teach and administer with fidelity (Kerfoot, Harrington, Harrington, Rogers, & Verduyn, 2004; Weisz, Jensen, & McLeod, 2005). Efforts to deliver CBT in TADS (TADS Team, 2004, 2007), the largest study to date on the treatment of adolescent depression, yielded disappointing results, with CBT not consistently outperforming pharmacological intervention, even with resource-intensive training and supervision (TADS Team, 2003). Subsequent efforts to understand the disappointing performance of CBT in TADS have emphasized the potential problems with using multiple intervention strategies, which precluded sufficient practice and mastery of core skills (Hollon, Garber, & Shelton, 2005). In contrast, BA's focus on only a few core behavioral strategies allows time for repeated skills application and practice tailored to the individualized needs of each adolescent. BA does not introduce too many strategies and does not depend on mastery of complex cognitive components. Thus, it is possible that it may be effectively used by a wide range of providers with varying education and experience levels and practiced in diverse settings, including community mental health centers, schools, and primary care settings in which caseloads are high, resources are limited, and time is at a premium. BA's potential for rapid uptake into clinical practice also supports its relevance for therapists working with depressed adolescents.

Does BA for Adolescent Depression Work?

Initial studies with adolescents using BA adapted to target avoidant behaviors at home, at school, and with peers, have been promising (Chu, Colognori, Weissman, & Bannon, 2009; Jacob, Keeley, Ritschel, & Craighead, 2013; Ritschel, Ramirez, Jones, & Craighead, 2011). Ritschel and colleagues (Jacob et al., 2013; Ritschel et al., 2011) tested the efficacy of the BA approach in two open trials with a small but ethnically diverse group of adolescents and documented significant improvement in depressive symptoms, such that the majority of participants no longer met criteria for depression at the end of their course of treatment (e.g., up to 17 sessions). Likewise, Chu and his team (2009) reported support for the feasibility and efficacy of using a group-based BA approach within the school setting for young adolescents struggling with anxiety and/or depression. Our own research group has shown that our A-BAP approach, based on the adult BA approach, can be delivered successfully, with efficacy, to depressed adolescents. In our study, the A-BAP was evaluated in comparison to a very robust TAU condition in which skilled therapists provided either CBT- or IPT-based care. While we anticipated that there would be a positive response in the TAU condition, we wanted to determine whether the A-BAP would result in an equally positive treatment response. Youth in the A-BAP group demonstrated statistically and clinically significant improvement from pre- to posttreatment as reflected in the primary outcome measure of depressive symptoms, as well as changes in clinical improvement and in overall functional status ratings made by independent evaluators, blind to treatment condition. All change scores fell within the 95% confidence interval, suggesting that the estimates of change were reliable (McCauley et al., 2015). Although more research on A-BAP is needed to examine efficacy, effectiveness, and predictors of

outcome, initial findings suggest that the incorporation of more structured BA strategies could enhance treatment response for depressed adolescents.

In short, BA therapy holds significant potential to expand treatment options for adolescents. In and of itself, BA constitutes an innovative approach to the treatment of depression that is theoretically driven and consistent with the expanding understanding of adolescent development that has emerged from recent findings in cognitive and affective neuroscience. The focus on activation is highly compatible with the developmental needs and abilities of adolescents. Unlike existing therapies that call on sophisticated and higher-order cognitive concepts, BA is an idiographic, behavioral approach that uniquely centers on (1) activation to increase a youth's probability of exposure to naturally rewarding experiences, (2) identification and reduction of barriers to activation, and (3) recognition of avoidance patterns coupled with generation of alternative coping strategies that potentiate the experience of reward for the individual adolescent.

An Overview of the A-BAP

Although this volume presents the A-BAP as a comprehensive intervention, we firmly believe in an individualized approach to treatment. Rather than place the BA approach to treating adolescent depression into a competition with CBT or IPT, we argue the need to draw on strategies that best fit the needs of the individual adolescent. We see the use of BA skills as valuable treatment strategies that can be used as a comprehensive approach or integrated with CBT or IPT strategies as needed.

The A-BAP consists of a series of five modules that can typically be delivered within 12–14 sessions, or as separate "as-needed" components. As noted earlier, detailed session-by-session content is presented in the second section of this volume. There are eight sessions that include a structured didactic component and a set of less structured sessions to be used "as needed" over the course of the intervention. Therapists are encouraged to work collaboratively with the adolescent, take a coaching role, and pace the introduction of skills to match the needs of the adolescent. The program was developed for use with adolescents between ages 12 and 18, and therefore includes materials that are engaging for a younger teen, as well as appropriate for older adolescents approaching adulthood. In an effort to support early engagement and rapid integration of the A-BAP approach, the first two sessions are ideally scheduled in close proximity (e.g., within the same week, if possible). After that, sessions are generally provided once per week, because this schedule seeks to provide optimal care while decreasing the burden of travel time on families and minimizing missed sessions. The sessions are typically 50–60 minutes in length. Therapists can easily modify the session length according to the needs of each adolescent/family and the demands of their practice setting (e.g., school-based work may involve 30-minute encounters, with more limited contact with parents). In most sessions, time is spent with the adolescent alone, followed by a brief intervention with parents. We have suggested some times when the adolescent and parent work together but recognize that this might not work effectively in all settings and with all adolescents, so adaptation may be needed.

The logical progression of A-BAP modules and sessions, outlined in Table 1.1, begins with Module 1, "Getting Started," which typically includes two sessions. In the first session, the overall structure of treatment is reviewed, then therapist and adolescent, with input from the parent(s), work together to establish a shared case conceptualization and an initial set of treatment objectives. The A-BAP model is introduced in this first session and applied to the adolescent's individual circumstances, with activity monitoring being introduced as a "Test It Out" homework assignment (see more details on "Test It Out," p. 14). The second "Getting Started" session is spent mostly with the adolescent, the connection between relationships/activities and mood is presented, and the situation–activity–mood cycle is reviewed. The session ends with a brief meeting with parents to provide some psychoeducation about adolescent depression.

Module 2, "Getting Active," centers on the BA focus and includes material typically covered in two sessions. In Session 3, the concept of goal-directed versus mood-directed behavior is introduced. Additionally, activity–mood monitoring is introduced, building on the concepts of activity monitoring introduced in Session 1. The brief meeting with parents continues the discussion of the parents' experiences parenting a depressed adolescent. The focus on activation for the adolescent is continued in Session 4. Adolescents use a functional-analytic approach to determine what activities work to improve (i.e., "pump you up") their mood and what activities maintain or exacerbate low mood (i.e., "bring you down"), with a secondary focus on identifying the short- and long-term consequences of behavioral choices and how to hold onto a good feeling. In Module 3, "Skill Building" (Sessions 5–8), the A-BAP moves into skills acquisition and reinforcement, with sessions on problem solving, goal setting, and identifying barriers that get in the way of accomplishing goals. Session 8 concludes the module with a focus on strategies for overcoming avoidance that are both introduced and practiced. Module 4, "Practice" (Sessions 9–11), consists of three sessions that are used both to practice and consolidate skills, as needed, according to the adolescent's idiographically determined priorities and goals. Module 5, "Moving Forward," is included to allow time for a review of treatment gains, the adolescent's ongoing goals, and relapse prevention strategies. More specifically, an individualized plan is developed with an eye toward recognizing triggers for depression or other problem behaviors and taking steps to manage mood and avoid escalation of difficulties. This module can be used flexibly over the course of one to three sessions, depending on the needs of the individual adolescent, in order to consolidate treatment gains and terminate therapy.

Although the material in the manual is structured and skills oriented, the intervention is designed to reflect the idiographic nature of BA, such that introduction of skills should be woven into the context of each adolescent's individual experiences. Examples should be drawn from the real-life issues presented by the adolescent. Introduction of a skill may be more general, and the handouts provide hypothetical examples and guidance, but all worksheets include space to add examples specific to the adolescent in treatment. The same principle holds for materials included for parents; a general introduction should be followed by a discussion of examples relevant to the particular family. Throughout the course of treatment, therapists are encouraged to apply concepts flexibly, pulling some skill-building sessions forward and pushing others back, to meet the needs

TABLE 1.1. Structure and Content of the A-BAP

Modules/session	Material covered
Module 1: Getting Started	
Session 1: Introduction to the A-BAP Program	• Review the structure of therapy (confidentiality, roles, use of self-report scale to track symptoms, need for practice outside of sessions). • Review history with both the adolescent and parent for integration into the behavioral activation (BA) model. • Introduce the BA model of depression and treatment. • Using the BA Model and the history provided by adolescent/parent(s), develop a shared case conceptualization. • Introduce activity monitoring.
Session 2: Situation–Activity–Mood Cycle	• Review how relationships and activities impact mood. • Introduce the Situation–Activity–Mood model to the adolescent. • Provide parents with psychoeducation about adolescent depression.
Module 2: Getting Active	
Session 3: Goal-Directed Behavior versus Mood-Directed Behavior	• Introduce the role of activation in mood management—goal-directed versus mood-directed behavior. • Introduce activity–mood monitoring. • Continue to talk with parents about their experiences and concerns as parents of an adolescent who is coping with depression.
Session 4: Introducing Consequences of Behavior	• Introduce functional analysis—the role of reinforcement in maintaining behavior and the importance of evaluating the payoff versus price of behavior choices. • Short-term versus long-term consequences of behavioral choices. • "Pump You Up" and "Bring You Down" activities. • Making the most of good feelings.
Module 3: Skill Building	

Session 5: Problem Solving	• Review the role of stress as a trigger for depression.
	• Introduce problem solving as a way to figure out what to do in stressful situations.
	• Practice using the COPE steps:
	  ○ **C**alm and **c**larify: Calming techniques and problem clarification
	  ○ Generate **O**ptions
	  ○ **P**erform
	  ○ **E**valuate
	• Introduce communication skills to parents and set up communication practice.

Session 6: Goal Setting	• Talk through effective goal setting, the idea of SMART goals. • Introduce the importance of using mini-steps (graded task assignment) to reach a goal. • Set up goal-setting practice for the week. • With parents, walk through ways to show support and set up support monitoring practice.

(continued)

TABLE 1.1. *(continued)*

Modules/session	Material covered
Session 7: Identifying Barriers	• Importance of identifying barriers that get in the way of accomplishing goals. • Internal and external barriers. • Goal-directed versus mood-directed behavior—strategies to overcome barriers. • Goal-setting practice. • Adolescent and parent work together to identify support ideas and set up parent monitoring of their support behavior.
Session 8: Overcoming Avoidance	• Importance of avoidance as a common internal barrier. • Different forms of avoidance—procrastinating, brooding, bursting, and hibernating. • Understanding your Trigger, Response, Avoidance Pattern (TRAP). • Using alternative coping to get back on TRAC. • Review with parent their efforts to practice support.
Module 4: Practice	
Session 9: Putting It All Together	• Review the adolescent's status and identify what he or she wants to focus on for the rest of the therapy sessions. • Review key skills that might be important to helping the adolescent work toward his or her goal—ways to get active, making the most out of good feelings, COPE, goal setting, recognizing barriers, avoidance. • Work with the adolescent to develop an Action Plan to outline priorities, goals, and activities to focus on for the next treatment sessions.
Sessions 10 and 11: Practicing Skills	• Support the adolescent as he or she uses the skills to work on the Action Plan outlined in the previous session. Review the importance of maintaining a focus on working to improve mood/depression.
Module 5: Moving Forward	
Session 12 (or when ending treatment): Relapse Prevention and Saying Good-Bye	• Review and update the Action Plan as needed. • Generate a personal plan for relapse prevention (Doing What Works) to help the adolescent manage triggers and signs of depression. • Review with the adolescent and parent together the adolescent's plans for moving forward and avoiding relapse.

of the particular adolescent and the session-by-session concerns with which he or she presents. It has been our experience, however, that the best way for therapists to become facile with the material and feel comfortable using it flexibly comes with more rigidly applying the protocol a handful of times. Relatedly, it has been the anecdotal report of therapists using the A-BAP that the more facile they become with the material, the more confident they become in taking any of the A-BAP concepts and applying them to the adolescent's unique concerns. Flexibility must also come into play when considering how long to continue working with the adolescent and timing of termination. The A-BAP is written to cover 12 sessions, but getting through the material will differ for each adolescent. Youth seen in settings where only brief contact is possible may still benefit from

being introduced to specific A-BAP skills or constructs, whereas other youth may need more time and support to move through the materials. As is true of all therapy, timing of termination must take the individual adolescent's situation and needs into account. For adolescents, even when the material has been covered adequately, terminating treatment in the face of an upcoming, stressful school transition or relationship break-up is frequently not a good idea. In these cases check-in and/or booster sessions to support the youth's success through a difficult transition or to maintain treatment gains can be very useful.

The session-by-session outlines provide prompts for the therapist and suggested dialogue. This material is intended to help bring the specific interventions to life for the therapist and is offered as a guide rather than as a rigid script. Each therapist is advised to adjust the wording to the needs of the adolescent and his or her own style. Although most of the concepts presented in the A-BAP are straightforward, we have found that therapists appreciate the dialogue and prompts as starting points for application with their own clients.

To provide a predictable structure, each session also follows the same general outline. This approach was taken to facilitate clear communication with adolescents about what to expect in therapy, and as a strategy to increase their comfort and sense of partnership with the therapist. Table 1.2 presents an overview of session structure. Each session begins with a "Check-In," which includes asking the adolescent to complete a short self-report scale to monitor depressive symptoms (e.g., Patient Health Questionnaire [PHQ-9]: Richardson et al., 2010; or Short Mood and Feelings Questionnaire [SMFQ]: Messer et al., 1995), followed by a brief review of the adolescent's responses on the scale, the issues the adolescent wants to include on the agenda, and the topics the therapist would like to spend some time on in the session. This provides an opportunity for the adolescent to collaborate with the therapist on finalizing the session agenda, which is often "prepopulated" with material the therapist wants to introduce. It is essential to customize the A-BAP agenda to reflect the primary concerns of each adolescent.

Between-session practice (i.e., "homework") is a core part of the A-BAP and is called "Test It Out." The "Test It Out" component of the A-BAP helps adolescents apply and generalize skills, concepts, and strategies discussed in sessions to practical, everyday problems and situations. Therefore, one of the first agenda items addressed in each session is a review of the "Test It Out" activity generated in the prior session. Following this review, new material is presented, including a clear rationale for each concept or skill introduced, which sets the stage for in-session application or practice of the skill, customized to focus on the concerns raised by the adolescent at the start of the session or in past sessions. A "Test It Out" activity for the coming week is then presented and tailored such that the skill or strategy to be practiced fits the individual adolescent's needs. Even if there is only time to cover part of the material in the session outline, it is important to maintain the overall session structure, with a focus on monitoring symptoms and progress, reviewing practice material, engaging in some in session practice/application, and setting up practice for the upcoming week. The unique needs and concerns of each adolescent must be woven into all skills training and practice exercises.

TABLE 1.2. A-BAP Session Overview

Check-In
- Complete the mood/problem monitoring form.
- Review the monitoring form with the adolescent.
- Check in regarding events/issues that need attention.
- Review/develop a session agenda with the adolescent's input.

Review Practice
- Go over "Test It Out" practice from the last session.

Key Concepts
- Present rationale for work of the session.
- Tie in with the adolescent's individual concerns.
- Tie in with the material/skills covered in prior sessions.

Teach/Skills
- Introduce new material or skills using the adolescent's concerns and examples.

Practice Exercise
- Set up "Test It Out" practice for the coming week.

For time spent with the parent alone

Check-In
- Welcome and invite the parent's questions, observations, concerns.
- Review the session agenda/topic.

Review Practice
- Review "Test It Out" practice if given in the past session.

Teach/Skills
- Present new material.

Practice Exercise
- Set up "Test It Out" practice for the coming week when indicated.

Note. Some sessions also include time for the parent and adolescent to work together and/or time for the parent alone.

Key Intervention Strategies

The A-BAP calls on a set of key components or strategies as the central elements contributing to behavioral changes that in turn lead to improvement in mood and resolution of depression. BA is based on a behavioral model of depression and intervention. Therapists interested in a review of the basics of behavioral psychology might turn to Baum (2005) or Kazdin and Rotella (2013). The essential concepts used in BA include understanding types of reinforcement, particularly response-contingent positive reinforcement, functional analysis, and overcoming avoidance. These are briefly explained on the following page, along with the rationale for the core structural components (monitoring and

practice/behavioral rehearsal) and skills included in the program. Finally, the collaborative partnership of the adolescent and care provider, another essential component of the A-BAP, is discussed in the context of techniques for increasing collaboration and enhancing the adolescent's motivation for change.

Reinforcement

For behavioral and cognitive-behavioral therapists, the concept of reinforcement is well understood. However, therapists trained in other therapeutic orientations may be less familiar with the terminology and misunderstandings abound regarding reinforcement. First, reinforcement is not a thing; rather, it is a process. When circumstances are such that the likelihood of a behavior occurring again under similar circumstances is increased, we say that the behavior has been reinforced. Reinforcement can be positive (i.e., something is added to the environment as a consequence of the behavior), or negative (i.e., something is removed). An example of positive reinforcement occurs when a young man goes to gym class, is chosen by his friends to be on their team, then continues to show up on time to class, dressed and ready to participate. We would say that under the circumstances (gym class), the reward he has received from his classmates (being chosen to be on the team) may have reinforced his behavior of reporting on time for class. An example of negative reinforcement occurs in the situation when another boy feels highly anxious about gym class because of his history of little participation in athletic activities. As he approaches the gymnasium for class, he begins to feel a "pit" in his stomach and a mild headache. Instead of going into the gymnasium for class, he goes to the nurse's office and receives a pass to miss class due to illness. He immediately feels less anxiety and the "pit" in his stomach disappears. The next day, he is more likely to have the same sick feelings when he shows up for gym class and may look to be excused from class. We would say that feeling sick has been reinforced because of the reduction (removal) of his anxiety and would expect a subsequent increase in feeling sick and going to the nurse's office.

Behavior can also be shaped through punishment. Positive punishment involves the addition of something following a behavior that decreases the likelihood that the behavior would occur under similar circumstances. A parent tapping a child on the shoulder and giving a stern look when the child is fidgeting in church may extinguish the fidgeting behavior, and we would say the behavior was positively punished. Should the parent take away the child's toy for making noise in church, and the child's noisiness is extinguished, we would say that the behavior was negatively punished.

Lewinsohn (1974) emphasized the impact of response-contingent positive reinforcement in the environments of people who become depressed. Specifically, he proposed that a reduction in response-contingent positive reinforcement may result in depression. Therapists are often confused by the wording and do not fully understand what *response-contingent reinforcement* means. Put very simply, it means that something occurs following the behavior of an adolescent (the response) that reinforces (increases the likelihood to occur again) the behavior. The occurrence of the reinforcing event is contingent on the behavioral response. There are many reasons for reductions in response-contingent

positive reinforcement, including the loss of important people in one's environment through death, a move, family separations, or being in an impoverished environment that does not have available rewards. Therapists are also often confused by terms such as *reinforcement,* thinking that positive reinforcement means giving goodies for good behavior, and conflating negative reinforcement and punishment; we hope that we have cleared up these misconceptions. In the A-BAP, while there is never an extensive discussion of reinforcement with the adolescent, a core concept in BA is to work with adolescents to assess how their behavior serves them, and whether it is reinforced or punished; we do this through the process of functional analysis.

Functional Analysis

We refer to a *functional analysis* in BA as a process through which the therapist works with the adolescent to understand how various behavior patterns make sense given the context of the adolescent's life, and also the factors that may maintain depressive behaviors or extinguish positively rewarding behavior. Technically, a functional analysis requires that an experimenter be in control of all variables in the environment in order to understand what contingencies are influencing a behavior. Skinner (1953) himself pointed out that this is not possible when working with human beings in a natural setting, and particularly when working with people who live in the general community as opposed to a controlled environment (e.g., inpatient wards, jails). Nevertheless, less controlled functional analysis is at the heart of BA. Functional analysis is first introduced in Module 2, "Getting Active," and from then on is woven into ongoing discussions with the adolescent about how he or she evaluates options and decides what actions to try. In functional analysis, behavior is not taken at face value because it serves a variety of functions for different people, as well as for the same individual under varied circumstances. For example, "surfing the Internet" as a broad class of behavior can serve many functions. If an adolescent spends 2 hours on the Internet researching dates and important events in ancient Rome, "surfing the Internet" serves an educative function, and in this circumstance, functions as a tool to increase knowledge. That same adolescent may surf the Internet and find friends on Facebook or in other social media. If he or she is doing this during free time, after completing homework and other chores, the behavior functions as a social outlet, and as a pleasurable social activity. Should the circumstances change and the adolescent spends time on Facebook after being told to clean his or her bedroom, the time on the Internet functions as avoidance, procrastination, or willfulness. Finally, should the same adolescent react to teasing at school by feeling blue, self-critical, and unmotivated, and spend time looking on the Internet for stories about famous rock stars or sports figures, lapsing into flights of fancy that he or she will someday be famous and never be teased again, the same activity is functioning as, perhaps, emotional avoidance, numbing, or escape behavior. In addition to attending to functional analysis of the adolescent's behaviors, therapists should teach the adolescent to do a functional analysis of his or her own behavior. This can be done simply by examining the circumstances that occasion particular behaviors and observing the consequence of the behavior. To

use less technical language, in the A-BAP, the youth learns how to recognize connections between "situations," his or her behavior, and the consequences, including effects on mood. The consequence can have many components. Emotionally, the behavior may improve or worsen mood; physically, the behavior may bring relief from nervous tension, and there may be consequences that affect others (e.g., parents stop asking the adolescent to do homework) or have other circumstantial consequences (e.g., throwing one's cell phone across a room in a fit of rage might result in the phone breaking). Adolescents can learn to identify the consequence of their behavior and begin to set goals to act in ways that will result in consequences that they desire.

Overcoming Avoidance

Adolescents are also taught about the nature of avoidance, with particular attention to validating the natural tendency to avoid aversive circumstances or feelings. We recognize and acknowledge that avoidance works. On the day of a dreaded examination, staying home sick successfully allows one to avoid taking the test. Sadly, avoidance does not make the dreaded test disappear, and it only postpones the need to take the test, or worse yet, results in a poor grade, which makes an overall bad situation worse. We also can avoid, or try to escape from aversive feelings. In the A-BAP, as in BA in general, we include escape behaviors under the heading of "avoidance" for the sake of simplicity rather than always saying "escape/avoidance." Should one feel sad and depressed, engaging in activities that minimize the feelings or allow one to distract from the feelings (e.g., by spending hours gaming on the Internet) is a logical way to deal with negative emotions. Unfortunately, avoidance tends to keep one stuck in a depressive spiral. One may temporarily escape from or avoid aversive feelings, but one is not actively engaging in activities that could, in the long run, change contexts that may provide the necessary environmental shift that will have antidepressant effects.

The A-BAP teaches the adolescent to recognize when his or her behavior is serving the purpose of avoidance. Once one recognizes that behavior is functionally avoidance behavior, one can experiment with an alternative behavior that is approach- rather than escape-focused. Thus, the adolescent who stayed home sick on examination day may recognize the tendency to avoid studying and take steps to prepare better for a future examination. The adolescent who spends hours gaming to escape from or avoid aversive feelings may call a trusted friend and seek social support that leads to a sense of being connected and cared for, and therefore less depressed.

Key Structural Elements

Monitoring

There is growing evidence of the importance and utility of routine monitoring of symptom change in response to treatment (Bickman, Kelley, Breda, de Andrade, & Riemer, 2011; Goodman, McKay, & DePhilippis, 2013; Lyon, Borntrager, Nakamura, & Higa-McMillan, 2013). Routine progress or symptom monitoring has been associated with

"higher rates of reliable and significant symptom change" in studies of adults, college students (Lambert et al., 2002; Miller, Sorensen, Selzer, & Brigham, 2006), and youth (Bickman et al., 2011). Monitoring symptom or behavioral change provides valuable feedback to the therapist, adolescent, and parent about progress being made or the need to consider revisions to the treatment approach. In addition progress or symptom monitoring has been demonstrated to improve communication between care providers and clients (Carlier et al., 2012). For these reasons, regular symptom monitoring has been included in the A-BAP. Collaborative and routine review of the symptoms or behaviors that are the target of treatment facilitates discussion of what symptoms/problems are most troublesome to the adolescent and in turn guides the focus of care. This process also ensures that the adolescent and therapist understand the kinds of behavior change toward which they are working. This in turn makes the therapy process more transparent and enhances the collaborative nature of the adolescent–therapist relationship. Monitoring also provides a way to track the status of critical areas in addition to the emergence of new problems, such as increases in suicidality through a weekly review of high-risk behaviors. Monitoring additional targets, such as self-harming behavior, anxiety, or poor school attendance, may be useful with some adolescents and can be easily incorporated as long as assessments are brief and used judiciously so as not to overburden the adolescent or cause confusion regarding treatment goals.

Behavior Rehearsal/Practice

Throughout the history of behavioral skills training, the importance of having clients practice or rehearse behavior has been emphasized. The A-BAP program encourages rehearsal and practice of all new behavior. Practice may occur during the session, and it most certainly occurs between sessions through encouragement and administration of "Test It Out" activities. There is evidence that homework adherence is a critical component of CBT for adults (Kazantzis, Whittington, & Dattilio, 2010), as well as CBT for adolescent depression (Clarke et al., 1992; Gaynor, Lawrence, & Nelson-Gray, 2006). We consider behavior rehearsal to be important for two reasons: First, it allows the therapist and adolescent to assess the adolescent's skill level during implementation of new strategies; second, it serves as an experiment for the adolescent to test different strategies to determine what is useful. We do not expect adolescents to take our word that changing their behavior will change their mood, so we ask them to try out new behaviors using the "Test-It-Out" practice and pay attention to or observe the impact on mood. As part of this, we emphasize that even a small change in mood for a brief moment in time can be a building block for more significant change overtime.

Skill Building

The A-BAP includes a focus on the introduction and practice of a set of concepts, skills, and strategies that are central to the BA model, such as functional analysis and overcoming avoidance, as discussed earlier. Problem solving and goal setting were included in the skill-building component, because these skills were significantly associated with

improved response in prior studies of the treatment of depression in adolescents (Kennard et al., 2009); furthermore, these skills provide the adolescent with clear strategies or a set of steps to take when approaching a wide variety of problems and can be used to guide resolution of social (peer pressure, bullying), communication (family, teacher, peer conflicts), and emotion regulation (anger, impulsivity, anxiety) issues, thus covering broadly the bases of challenging situations faced by most youth.

Involvement of Parents in the A-BAP

The A-BAP actively includes parents as key collaborators in the treatment process. Parents play a unique role in three specific ways that may influence a course of the A-BAP. First, parents hold decision-making authority about many of the adolescent's activities that may be considered during A-BAP sessions. Similarly, they hold access to practical resources such as transportation that may influence an adolescent's ability to do certain activities. This may be even more the case among younger adolescents, who may not yet be allowed to take public transportation independently and cannot drive for themselves. It is essential to engage parents as collaborators in the selection and utilization of activities to support their adolescent. Second, parents may be part of the communication and interaction cycles with the adolescent that serve to maintain the adolescent's depression over time. Thus, engaging parents in understanding and modifying these cycles is also important. For these reasons, the A-BAP conceptualizes treatment as a team-based approach in which each member (therapist, parent, and adolescent) plays a critical and unique role. Third, adolescents may underplay or ineffectively communicate the level of distress they experience, and it is important to have multiple sources for assessing how treatment is working. Therefore, regular contact and teamwork with the parent(s), as well as using both parent and adolescent ratings of the adolescent's symptoms if feasible, is important for ongoing assessment and planning.

The A-BAP engages parents early in treatment with psychoeducation about adolescent depression and the BA model. Later sessions also include education about specific strategies to improve communication with adolescents and concrete actions to support adolescents' efforts to reach treatment goals. Parents are asked to participate in the majority of sessions, including spending time with the therapist and adolescent together, as well as spending parts of sessions alone with the therapist. Having the adolescent and parent together in a session is feasible with only some adolescents/families, so this is, of course, optional. Parents are encouraged to support adolescents practicing skills outside of sessions and, at times, they too are given "Test It Out" activities to complete between sessions.

Involvement of family members helps others in the home to understand the behavioral model of depression and to be aware of the strategies that the adolescent will be using to engage in his or her life and break out of the depressive cycle. For example, adolescents are taught about effective goal setting and identifying barriers to goals. During this discussion, the therapist inquires about how the adolescent's parent may facilitate or interfere with accomplishing a goal or a mini-step within a given goal. If an adolescent

identifies a parent's behavior as creating a barrier toward the goal, the therapist and adolescent may consider how best to engage the parent in a discussion about how to resolve this problem. The parent joins the session and together they problem-solve about how the parent can best support the adolescent's goal. After spending time all together, there is time for the therapist and parent to meet alone, without the adolescent. This provides the therapist and parent a chance to discuss any important concerns or collateral information that may be further complicating the adolescent's ability to move toward a goal. This time also may involve the therapist providing psychoeducation about the need for many parents to alter their expectations of a depressed adolescent or reframing how they think about "support," such that they are facilitating their adolescent's efforts to increase and change behaviors.

The amount of personal information about the adolescent that is shared with the parent or family member in individual contacts must be negotiated with the adolescent in treatment, as issues of confidentiality need to be considered, and maintaining a trusting and collaborative relationship is important. Therapists can involve the parents in general discussions of BA, teach them skills for listening to their adolescent, and help them learn new ways to be supportive without divulging personal information that the adolescent may not wish to have disclosed. Parents also can receive support for the challenges of raising an adolescent and the particular difficulties of dealing with a depressed adolescent. More specifically, therapists can help parents reframe the adolescent's irritability, which is sometimes extreme, as a function of his or her depression. This in turn can help parents put in perspective what their teen is going through and, instead of becoming punitive in the face of perceived disrespect, take a more supportive stance. Parents can also sometimes fall into extreme categories, from those who are mostly uninvolved with their child's life to those who micromanage their son or daughter. It is understandable, particularly in the case of suicidal adolescents, that a parent's concern can result in overprotection that is experienced as intrusive by the adolescent. Therefore, it is essential that therapists establish a collaborative environment in which to negotiate levels of involvement that are tolerable, practical, and helpful for all involved.

Collaborating with the Adolescent and Enhancing Motivation for Change

Collaboration between the therapist and the adolescent is at the heart of the treatment. In relation to the adolescent, the A-BAP therapist is more like a "coach" than a medical expert. The coach serves as a collaborative partner who teaches and supports the adolescent in learning and engaging in the BA approach. Coaches work with athletes to discuss, teach, and support a plan for engaging in a sport or athletic endeavor, but it is the athlete who must undertake the play. This is true in the A-BAP as well. The therapist, as a coach, instructs the adolescent in the concepts that are central to treatment, and works with the adolescent to develop a plan that the adolescent will test out by implementing it between sessions. Just as a coach and athlete review the execution of a play in a sport, the A-BAP therapist and the adolescent (or parent) debrief the activities that have occurred

between sessions, make necessary adjustments, and collaborate on any changes that will be attempted over the following week. Similar "debriefing" occurs with parents when they practice with "Test It Out" exercises between sessions. Over the course of treatment, the therapist shares responsibility with the adolescent for the work, assuming that the adolescent will take greater responsibility over time, thereby promoting the adolescent's sense of self-efficacy for doing the work.

Activating depressed adolescents is a challenging task. The symptoms of depression often include lack of motivation, low mood, inertia, and fatigue. Engaging in usual activities may have become both psychologically and physically more difficult than it was prior to the onset of depression. Lack of motivation may, in part, reflect the adolescent's diminished capacity to experience previously enjoyable activities as rewarding, and may require careful attention to enhancement of motivation to initiate behaviors. To this end, motivational strategies are used throughout the course of the A-BAP (Naar-King & Suarez, 2011). The BA model assumes that behavioral patterns persist because they are reinforced. Thus, adolescents may engage in very reinforcing behaviors that in the long run maintain their depression. It is incumbent upon the therapist to use strategies that motivate the adolescent to change such behaviors, so that new, antidepressant behaviors have the possibility of being reinforced in the environment. The A-BAP draws on some of the motivational techniques developed as part of the Motivational Interviewing (MI) treatment approach (Miller & Rollnick, 2002). *Evocation,* or recognition of the adolescent as the expert, and *collaboration* to elicit the adolescent's understanding of intervention strategies, and particularly the ways in which the strategies are relevant to the adolescent's situation are two MI-based principles the A-BAP employs.

Although there is clearly a didactic component to many of the A-BAP sessions, they are intended to be presented by therapists who, again, draw on motivational principles to engage the adolescent effectively (Naar-King & Suarez, 2011). This includes demonstrating optimal *empathy* and understanding of the adolescent's life context and potential struggles. The therapist also is encouraged to use the core MI communication approach using *open-ended questions*, *affirmations*, *reflective listening*, and *summaries* to clarify the "take-home messages" in order to enhance motivation. For example, when talking with an adolescent about skipping class to avoid feelings of anxiety about math, the therapist asks in an open-ended, neutral fashion about any disadvantages of this approach, points out how it makes sense given how uncomfortable the adolescent feels in class, summarizes what he or she is hearing, checks with the adolescent to be sure he or she is on track, and ends each encounter with a brief summary of what they have learned together and a review of the next steps. In this collaborative approach, therapists are encouraged to "check-in" frequently with the adolescent, as well as his or her parents, to assess the goodness of fit of specific strategies being implemented. Adolescents and families are more likely to follow through if they agree that the treatment strategies are appropriate in their particular situation. Therefore it is important that the A-BAP therapist makes every effort to assure that the behavioral conceptualization of depression, presented in their BA working model, is relevant to the adolescent and family. There is no better way of knowing whether one is on the mark than to check-in with the adolescent directly.

Summary

The A-BAP is designed to increase systematically the adolescent's engagement in activities so as to alter his or her avoidance patterns, and to help him or her learn and practice skills for problem solving and for managing difficult emotions. The program emphasizes reducing problematic behaviors, as well as increasing positive behaviors. Therapists may follow the program as written, keeping each session in the order presented in the manual. However, the program was intended to allow enough flexibility that therapists can skip topics that may be less relevant to a particular adolescent. If the therapist determines that following a different sequence of sessions makes more sense given an adolescent's needs, he or she needs to be mindful that the "Test It Out" homework exercises are consistent between sessions assuring that this essential ingredient of therapy is not overlooked. Therapists are strongly encouraged, if possible, given the work setting, to include parents or at least provide them with materials that teach about adolescent depression and include tips for supporting their adolescent. Helping parents understand their adolescent's depression and learn strategies to improve their communication and support can be essential to a successful therapeutic outcome in some cases.

Throughout treatment the therapist should keep in mind that the ultimate goal is transfer of training into the adolescent's real life, and generalization of in-session content to the adolescent's daily life is important from the beginning of treatment onward. The final sessions are meant to be flexible in terms of number, because some adolescents need more time and support to overcome their depression, and the timing of important life transitions, such as starting a new school or breaking off a relationship, needs to be considered when moving toward the conclusion of therapy. Related to this, therapists can schedule maintenance or "check-in" sessions periodically, following completion of the program, as a way to ensure that the adolescent maintains treatment gains and is not falling back into the trap of avoidance behaviors in the face of life transitions and stressors.

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