ADOLESCENT DEPRESSION AND SUICIDE

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ADOLESCENT DEPRESSION AND SUICIDE

A Comprehensive Empirical Intervention for Prevention and Treatment

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PREFACE

Within the past decade a considerable effort has been made to assimilate information and explain causes of two of the most difficult problems facing America today–adolescent depression and possible subsequent suicide (Harrington & Clark, 1998). Following accidents while intoxicated and homicides, suicide is the third leading cause of death in the 15- to 24-year-old age group (CDC, 2001; National Center for Health Statistics, 1983). The adolescent population is at greatest risk in regard to suicide, and the risk is increasing (McKeown, Garrison, Cuffe, Walker, Jackson, & Addy,1998). Between 1960-1980, the suicide rate rose from 5.2 to 12.3 per 100,000 for this age segment accounting for a 136% increase. The rate is increasing most rapidly for white males, who account for 73% of all teen suicides (CDC, 2001).

Adolescence is a time of growth, stress, and change. This developmental stage affects not only the adolescent but his or her family as well (Gould, Shaffer, Fisher, & Garfinkel, 1998). Adolescents, while in the natural process of establishing autonomy and identity, begin to separate from parents and experiment with a variety of behaviors and lifestyle patterns (Botvin, 1983). It is during adolescence when the relative importance of family and peers begins to shift. The peer group becomes more central for the adolescent, and the adolescent begins to rely more heavily on peers for support, security, and guidance (Belsky, Lerner, & Spanier, 1984; Kandel & Davies, 1991). Establishing peer relationships and peer acceptance are the hallmarks of adolescence, and the need to gain acceptance, approval, and praise is greater during adolescence than at any other time in life (Morrison, 1985).

Traditionally, adolescence has been portrayed as a carefree period in the life span, when enjoyable times are had by all. In reality, however, the transition from childhood to adulthood is fraught with psychological, sociological, and physical changes (Elkind, 1984a, 1984b; Kaslow, Deering, & Racusin, 1994). The Surgeon General's Report (Satcher, 2000) indicates that an alarming one in five children suffers from mental illness! Included in this statistic are the many children and adolescents who suffer from clinical depression who are not diagnosed as suffering from a mental disorder until a serious event, such as a suicide attempt, occurs (Satcher, 2000). The rela-

tionship between depression, suicide, and drugs must be considered, because drugs play a major role in increasing the risk of suicide and even homicide.

Assessment

To effectively intervene to prevent depression in youth, comprehensive assessment must precede the intervention. Standardized assessment instruments should be used to assess and diagnose the youth and his or her family. A complete assessment must include evaluation of the youth's behavior at home, in school, and in the community. Multiple sources should be used to compile a complete profile of a youth's functioning. It is essential that youth be evaluated for disorders and difficulties that are usually correlated with depressed behaviors. These include mood and anxiety disorders, ADHD, substance abuse, learning difficulties and cognitive deficits, peer rejection, and poor social and coping skills. It is necessary to develop assessment and comprehensive empirically appropriate interventions for youth with comorbid behaviors, because comorbidity increases the probability of suicide and other deviant behaviors.

Communities must look for more effective and efficient ways to identify and help youth who are at risk of becoming depressed. Because many causes exist for youth depression and system deficiencies, support is growing for integrated service delivery systems. Community assessment centers show promise in overcoming the obstacles that contribute to inefficiency and ineffectiveness in assessment and the continuum of care (Oldenettel & Wordes, 2000).

Intervention

The problems encountered with assessment and the heterogeneous characteristics of youth continue to pose difficulties when it comes time to intervene to prevent youth depression. No one intervention can be used for every youth, because youth are so diverse (Thyer & Wodarski, 1998). Assessment knowledge with specific empirical guidelines to assign youth to appropriate interventions is lacking. Empirically based programs have been deemed promising and will require further investigation to determine their effectiveness.

Prevention

The prevention approach to intervention has implications for the traditional role of practitioners and for the timing of the intervention. The prevention approach places major emphasis on the teaching components of the intervention process (Wodarski & Bagarozzi, 1979; Wodarski & Thyer, 1998). Social workers attempt to help clients learn how to exert control over their

own behaviors and over the environments in which they live. Practitioners do not take a passive role in the intervention process. Instead, they use their professional knowledge, expertise, and understanding of human behavior theory and personality development in the conceptualization and implementation of intervention strategies. Since their training equips them to evaluate scientifically any treatment procedure they have instituted, there is continual assessment of the treatment process.

Prevention is especially appropriate in dealing with the problems of the adolescent. It provides an early developmental focus for intervention, which may forestall development of future problems. These problems usually intensify later and become harder to alter. Prevention provides a view of the person that is optimistic. The approach is mass oriented rather than individual oriented, and it seeks to build health from the start rather than to repair.

Schools and Peers

Because young people spend most of their time in a school setting, the school system seems to be a natural forum for imparting knowledge and implementing change (Wodarski & Wodarski, 1995). The school setting is a natural link between parents, youngsters, and the community. Educational and preventive programs can be started early to install positive attitudes regarding conflict resolution and substance abuse. Teachers and staff who teach and exhibit these attitudes and behaviors can be positive role models for the youth with whom they work.

The ideal program should have two foci. First, the information transmission approach to provide basic knowledge and awareness, and second, the responsible decision approach that will teach youngsters the basic coping and decision-making skills (Schinke & Gilchrist, 1984). Programs must take advantage of peer pressure in a positive manner. To be nonjudgmental and to develop self-esteem in these vulnerable youths are goals of utmost importance and urgency. In program planning there is a need for youth to provide input regarding what they feel are their greatest stresses; programs need to directly address these issues.

The evidence suggests that intervention and prevention programs need to begin early, need to intervene on many levels, and need to give youngsters specific skills to learn and to use in their environment. The expansive efforts needed to begin such programs will be worth the almost inconceivable benefits.

This text identifies tools appropriate for assessing adolescent depression and substance abuse. The text also illustrates a short-term research-based group outpatient intervention package for the treatment of adolescent depression and prevention of possible subsequent suicide. The treatment factors are depression intervention and substance abuse intervention. The family factor which supports behaviors adolescents learned in groups is included, because accumulated research supports inclusion of the family.

The Teams-Games-Tournaments (TGT) technique has been presented here as an appropriate, effective educational approach that intervenes with young people, their families, and the community to reduce adolescent depression. This cognitive-behavioral group method focuses on helping youngsters make responsible decisions regarding depressive behaviors and substance abuse. In addition, the TGT program emphasizes education of parents about problem solving and communication. This program is realistic and easy to implement.

The TGT curriculum–which concentrates on peer influence–is particularly effective in teaching adolescents about depression behavior and substance abuse. That is because the data have repeatedly indicated that these social problems are related to peer influence and usually occur within a group context. This curriculum provides young people with feasible techniques for resisting peer pressure and improving social skills.

Timing of the Intervention

Recent research executed on various populations indicated that intervention should occur in the fourth, fifth, and sixth grades to psychologically inoculate children for the risks that they are going to face. All of the interventions discussed within this manuscript should be executed as early as possible. Ideally, booster sessions would occur as children move into junior high and high school. The booster sessions should include procedures for the maintenance and generalization of behaviors that have a high probability of being reinforced in natural environments; varying the conditions of training; gradually removing or fading the contingencies; using different schedules of reinforcement; using delayed reinforcement and self-control procedures (Marcotte, 1997; Wodarski, 1980; Wodarski & Wodarski, 1993).

Curriculum

Updates should occur periodically. Material that is included in the curriculum should be easily comprehended and presented in an attractive manner. All updates should include information that is relevant for the skills that are being acquired. Moreover, role-playing exercises that involve overlearning should be included. Such exercises make up the requisites of relevant curriculums. The social skills training paradigm offers social workers an excellent procedure for preparing adolescents to live successfully in contemporary American society. The curriculums are particularly relevant to social group work, because data indicate that peers play a strong role in the acquisition of either social or dysfunctional behaviors. The small-group learning techniques that are explained within the manuscript capitalize on peers as teachers. Thus, social workers are provided with viable techniques that can

capitalize on peer structures to help adolescents acquire necessary social behaviors to deal competently with the requisites of adolescent development.

CONCLUSION

The solution to the problems of depression and possible subsequent suicide among teens requires an all-out effort by those societal forces capable of effecting change. Families, schools, peers, communities, businesses, and the media all possess powers to eradicate this social problem. The campaign cannot be waged from only one front, however. Combined, cooperative efforts are essential. The responsibility must be shared for creating the conditions that have perpetuated the problems and for working toward mutual goals and solutions (Harrington & Clark, 1998).

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CONTENTS

ADOLESCENT DEPRESSION AND SUICIDE

Chapter 1

THE EPIDEMIC OF CHILD AND ADOLESCENT DEPRESSION AND SUICIDE

INTRODUCTION

Statistics provide evidence that teenage depression and suicide are two of the most pressing problems that afflict adolescents today. Currently, 20% of children and adolescents suffer from a mental disorder such as clinical depression (National Plan for Research on Child and Adolescent Mental Disorder (1990), and often these children are not diagnosed until it is too late. Intervention typically does not take place until the individual begins to lead an aberrant lifestyle. Unfortunately, acts such as drug and alcohol use, poor school performance, and even suicide attempts must take place before it is recognized that there is a problem. The Centers for Disease Control (2001) reports that persons younger than 25 accounted for 15% of all suicides in 1998. From 1952 to 1995, the incidence of suicide among adolescents and young adults nearly tripled, with the rate of suicide among persons aged 15-19 years increasing by 11% and among persons aged 10 to 14 years by 109% between 1980 and 1997.

Research indicates that mental disorders and substance abuse often co-exist (Hilarski & Wodarski, in press). Studies have shown that suffering from depression or anxiety disorders doubles the risk for later drug abuse and dependency (Christie, Burke, Regier, Rae, Boyd, & Locke, 1988; Crowley, Mikulich, MacDonalk, Young, and Zerbel, 1998). Co-morbid psychiatric disorder and substance use problems are as critical in adolescent populations as in adults (Bukstein, 1995). Establishing effective treatments for childhood mental disorder, in addition to research on the impact of the co-occurrence with substance

abuse, will contribute to improved care, especially in public sector agencies. Cognitive behavior treatment modifies dysfunctional behaviors and replaces the behaviors with healthier alternatives. Furthermore, research on reducing subsequent drug abuse by early treatment of depression is critical to prevent possible depression and/or substance abuse problems in adulthood (Harrington & Clark, 1998).

THE DEPRESSION, SUBSTANCE ABUSE, AND SUICIDE TRIAD

Alcohol and drug abuse are recognized as a defense mechanism to combat depression (Wodarski & Feit, 1995). Unfortunately, however, severe alcohol ingestion may lead to a loss of control over suicidal impulses (Dorpat, 1975). Grueling and DeBlassie (1980) studied statistics from several large cities and found that more than 50% of teenagers who had committed suicide had a history of moderate to severe drinking and abusive use of drugs before their deaths. Substance use and abuse by adolescents is a widespread problem. One study notes nearly 100,000 children between 10 and 11 years old report getting drunk at least once a week (Fleish, 1996). Almost 40% of adolescents surveyed have tried alcohol before entering high school. Moreover those adolescents who use substances such as alcohol and drugs have a greater vulnerability to accidents, injuries, and dangerous behaviors (Bukstein, Brent, & Kaminer, 1989). The leading cause of death for 15 to 24 year olds is motor vehicle accidents that involved alcohol.

Presence of an affective disorder in adolescence may serve as a risk factor for later development of a substance use disorder (Christie et al, 1988). Psychiatric symptoms may develop as a consequence of substance use disorder. Although there seems to be an association between substance abuse and depression in adolescence, it is unclear whether depression is primary or whether substance abuse is primary. Researchers have suggested that there may be a causal relationship between use and abuse of alcohol and the development of chronic mental illness (Fleish, 1996). It is unclear whether individuals are attempting to "self-medicate" their mental illness, or if their substance abuse precipitates mental illness in certain individuals. This may be particularly important when determining the proper course of treatment for the individual.

Retrospective studies demonstrate a positive relationship between increased incidence of drug use and suicide attempts among adoles-

cents (Crumley, 1990). Although a causal relationship among depressed mood, substance abuse, and suicide has yet to be established, it seems that increased use of alcohol, particularly the progressive use of alcohol coupled with depression, increases the possibility of a suicide attempt. There also seems to be variance between adolescents with depressive illness, substance abuse problem, or the co-morbidity of both and suicidal plan (Suominen, Isometsa, Henriksson, Osfamo, & Loennquist, 1997). Serious behavioral problems are also associated with adolescents who are abusing substances and trying to function in everyday life while being depressed. Examples of high-risk behaviors such clients may engage in are deviant behavior, sensation-seeking behavior, violence, unprotected sex, and abuse of alcohol with peers. Concurrent complications that may occur with adolescents who abuse alcohol are socially deviant behavior, early initiation of sexual behavior and risk for HIV infection, learning problems, and depression (Meyers, Brown, and Mott, 1995; Wodarski and Feit, 1995).

ASSOCIATED FACTORS IN ADOLESCENT SUICIDE

Suicidal behavior is the result of dysfunctional adjustment by the teenager to psychological and environmental circumstances. Aspects of depression and stress have been cited in research studies as prodromal clues in attempted and completed suicides (Davis, 1983). Evaluation of the role of the family and peer involvement have been examined in the same context.

DEPRESSION. Intense depression has been found to be the most prevalent characteristic of suicidal youth (Calhoun, 1972; Carson, 1981; Friedman, Corn, Hurt, Fibel, Schulick, & Swirsky, 1984; Gibbs, 1981; Holinger & Offer, 1981; Marks & Haller, 1977; Miller, 1975; Tishler & McKenry, 1983). It is estimated that 0.14% to 49% of children and adolescents suffer from a depressive disorder (Angold, 1988). Depression naturally occurs in all adolescents as a part of the maturation process. However, the intensity and severity of this depression are factors in the adolescent's psychological health (Nichtern, 1982; Kaslow, Deering, & Racusin, 1994). Vegetative symptoms of depression include mood variations, sleep disturbances, fatigue and loss of energy, and changes in appetite (Rosenblatt, 1981; Tishler & McKenry, 1983). In the school setting, depression is indicated by a decline in academic performance or a withdrawal from peers and extracurricular activities (DenHouter, 1981; Greuling & DeBlassie,

1980; Petzel & Riddle, 1981). Researchers are now noting that "acting out" behaviors and discipline problems exhibited by adolescents may at times mask the depressive condition (Greuling & DeBlassie, 1980; Nielsen, 1983).

In an examination of their backgrounds, the "loner" adolescent, who presents himself or herself with no significant friendships during these critical years, is especially vulnerable to depression and suicidal ideation. Individuals who attempt suicide have been characterized by a high degree of alienation in relation to peer group interaction (Madison, 1978). Miller (1981) and Hawton (1982) have found a number of adolescents who have been depressed for years, either because of earlier deprivation or a profound sense of emptiness in their lives.

STRESS. The debilitating physical and psychological effects of stress on the human body have been studied in depth. Compared with other cultures, American adults traditionally place themselves under an inordinate amount of stress because of extremely high expectations for themselves. This has gradually filtered down to the expectations placed on children. McAnarney (1979) and Herbert (1984) suggest that this emphasis on achievement contributes to the suicidal crisis of today. For example, a correlation between school failure and suicide has been noted. Testing and grading procedures in American school systems tend to label children according to the failure/success model at an early age. School failure contributes significantly to the stressful, helpless feelings demonstrated by teenagers who have a background of poor school grades (Sartore, 1976). White males are viewed as particularly susceptible to performance pressures (Holinger & Offer, 1981; Smith, 1981). The problem is not unique to the United States. In Japan, for example, the high suicide rates of adolescents are linked to the school examination system where adolescents compete feverishly for the coveted selection into college (Farber, 1968; World Health Organization, 1975).

Stress is especially great for U.S. teenagers whose parents live vicariously through the achievements of their children (Madison, 1978). Overachievers, as well as underachievers, are at a distinct risk for suicide. Herbert (1984) found that the unusually high expectations of overachievers led to an unhealthy mental attitude, whereas a sense of futility burdened those adolescents who were labeled as being "learning disabled."

Stress can also be involved in situations in which internal and external conflicts have not been resolved, such as inadequate separation from the parent (Nielsen, 1983). Suicide is seen as a form of conflict

resolution for many disturbed adolescents (Miller, 1980). The adolescent's suicide attempt may signal the need for control over his or her life (Getz, Allen, Myers, & Linder, 1983).

Stress is also precipitated by drastic changes in the life situation of a teenager, e.g., death of a parent, firing from a job, rejection by team/school. Significant others who are aware of these events should be alert to their impact on the teenager's life and be able to recognize certain behaviors as attempts to adjust to the particular circumstances (McBrien, 1983).

FAMILY INFLUENCES. The family as the integral formation model has a distinct effect on the child. In the early years, foundations of trust and love are established for the child within the home structure. The functioning of the individual is largely determined by his or her psychological growth during this period.

The American family has been in a state of flux for the past 20 years. The growing incidence of family dissolutions, and the resulting single and/or female-headed household with its attending lifestyle, make this an especially difficult period. Old patterns of child rearing are being put aside to make accommodations for new parenting situations. Sociological researchers tend to view the phenomenon of adolescent suicide as a reflection of this turmoil in American family living (Hawton, 1982; Petzel & riddle, 1981; Swenson & Robin, 1981). Hendin (1975) posits that there is a trend toward the devaluation of the family and children and an atmosphere in which there is an absence of intimacy and affection. Experiences in environments that are nonsupportive and overly hostile lend themselves to the development of personality characteristics of a suicidal nature.

Studies of suicide attempts by hospitalized patients and of actual suicides within an academic school year have demonstrated that family disruptions and disintegration played a significant role in the maladaptation of these individuals (Herbert, 1984; Keitner & Miller, 1990; Topol & Reznikoff, 1982). Close to half (43%) of the cases reviewed by Litt, Cuskey and Rudd (1983) reported that a family argument preceded a suicide attempt. A family environment in which the possibility of divorce or separation was openly discussed was found to be especially troubling for teenagers and a factor in suicide attempt.

PEER INVOLVEMENT. When the teenager attempts to form a separate identity from his parents, he or she commences earnest involvement with peers. At school, adolescents begin to ascertain their strengths and limitations both academically and socially. Their ability to handle the rigors of this adjustment period rests heavily on their previous

experiences. Sexual identification and the addition of a "significant other" to the life of a teenager creates a push-pull effect, where the teenager is being pushed into adulthood while still desiring the basic security of childhood. Tabachnick (1981) has focused on the fear of the adolescent who feels that he or she cannot make it.

The ability of adolescents to interact with peers significantly influences their later social adjustment. Janes, Hesslebrock, Myers, and Penneman (1979), who studied boys initially in late childhood and early adolescence and 12 years later in a follow-up, concluded that failure to get along with peers is closely associated with a wide spectrum of dysfunctional adult behaviors.

It is in the search for the components of their personality that teenagers scrutinize those around them and determine their own self-worth. When troubled youth are surrounded by seemingly well-functioning peers, this only tends to lower their self-esteem, which in turn may lead to suicidal contemplation (Holinger & Offer, 1981).

THE ROLE OF SOCIETY IN THE ADOLESCENT SUICIDE EPIDEMIC

The epidemic of adolescent suicide closely resembles French sociologist Durkheim's (1951) definition of anomic suicide, which arises from a rapid change in the social order or social norms. Roberts (1975), in *Self-Destructive Behavior*, writes of anomic suicide: "The individual becomes uncertain of the appropriate behavior expected of him/her and experiences a state of anomic normlessness, an unbridgeable gap between aspirations and achievements where individual passions are out of control" (p. 27).

Childhood today is not in the same sphere as was growing up in the 1960s. In the past, most children had the support system of relatively warm, caring families, stable school environments, and trusting adults. Contrary to this, a significant percentage of today's teenagers are maturing in a state of relative fear. Family breakups either are being experienced personally by the adolescent or observed in the homes of their contemporaries (Wattenberg, 1986; Wodarski, 1982). Demographic trends have led to overcrowded schools where an impersonal atmosphere leads to a sense of alienation (Holinger & Offer, 1981; Packard, 1983; Wenz, 1979). Primary emphasis, however, can be placed on the inability of children and teenagers to form close, interpersonal relationships with adults at home and outside the family

structure. The alienation experienced by both children and adolescents has long-term effects on the individual's outlook on both moral and social issues. Alienation itself breeds a lack of distrust within the child (Arnold, 1983; Coles, 1983). Society, in the last three decades, tends to ally children with children and adults with adults in social settings. Felt rejection in adolescence may result from this lack of intergenerational interaction (Kaplan, Robbins, & Martin, 1983; Shiner & Marmorstein, 1998).

Helplessness and hopelessness characterize the environment envisioned by the suicidal adolescent (Berkovitz, 1981; Miller, 1981; Petzel & Riddle, 1981; Tabachnick, 1981). Davis notes that the suicidal adolescent suffers from a helpless feeling of "tunnel vision," in which he or she fails to see other options when placed in highly intensive emotional situations, e.g., break up with boy/girlfriend or conflict with mother/father (Davis, 1983). This constricted view affords the teenager the opportunity to deal only with difficulties in the present frame of reference (Berman, 1984). Topol and Reznikoff (1982) suggest that external focus on the part of teenagers contributes to this sense of hopelessness. However, the suicidal individual's emotional state is indecisive, with the wish to live versus the wish to die playing at his or her emotions. Research on suicide attempters by Kovacs and Beck (1977) found this "internal debate" in more than 50% of the participants tested, using the *Wish to Live/Wish to Die Scale.*

SUMMARY

Factual and theoretical knowledge and research on depressed children have been reviewed. The interrelationship between depression, substance abuse, and suicide has been explained. Factors that may affect the development of depressed behavior and subsequent suicide attempts in children and adolescents were elaborated in an attempt to illustrate the complexity of the phenomenon.

Because parents and peers are primary influences on depressed behavior, preventive efforts should be directed toward these two groups. It is believed that with increased awareness of the warning signs of depressed behavior, intervention in the home on a more personal, day-to-day basis and intervention in the schools and community might take place. Education about how to identify the warning signals and how to deal with the behaviors once exhibited is crucial. Intervention in the home must then be provided in tandem with the extended environment, i.e., the school and community.

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Chapter 2

ASSESSMENT OF DEPRESSION, SUBSTANCE ABUSE, AND SUICIDAL BEHAVIOR IN CHILDREN AND ADOLESCENTS

ASSESSMENT OF DEPRESSION IN ADOLESCENTS

Beginning in the 1980s researchers have become interested in treating depression in adolescents (Marcotte, 1997). Research findings indicate that major depression presents clinically different in children and adolescents compared with adults (Puig-Antich et al., 1989). Interest has been sparked by the recognition that depression in children and adolescents can be diagnosed using the DSM-IV criteria (Marcotte, 1997). It is estimated that 20% to 25% of boys and 25% to 40% of girls report having depressed moods (Petersen, Compas, Brooks-Gunn, Stemmler, 1993), and 4% to 12% of them fit the DSM-IV criteria as exhibiting clinical depression (Reynolds, 1992).

Many research studies use semistructured or structured diagnostic interviews, along with multiple informants, to evaluate depression (King, Katz, Ghaziuddin, Brand, Hill, & McGovern, 1997). A variety of measures with good reliability and validity are available to assess depression in adolescents. Examples include the following, which are described more fully in subsequent sections in the chapter.

The Children's Depression Inventory (Kovacs, 1981) is one of the most widely used measures of depression to date, with high internal consistency and good test-retest reliability (Kazdin, 1990). The *Diagnostic Interview for Children and Adolescents* (DICA) is a version of the Diagnostic Interview Schedule (Robins, Helzer, Croughan, & Ratcliff, 1981). It is a highly structured instrument that has multiple items cov-

ering diverse symptoms, it is easily administered, and it is available in computerized format.

The *Reynolds Adolescent Depression Scale* (Reynolds, 1992) is a self-report inventory. This scale correlates strongly with the *Beck Depression Inventory* and *Zung's Self-Rating Depression Scale* (Reynolds, 1992).

The *Center for Epidemiological Studies Depression Scale*, a 20-item inventory covering a range of depressive symptoms, has been widely used with both adults and adolescents (Radloff, 1991). Researchers have found this scale to have excellent reliability and have found evidence of the validity of the measure (Chen, Mechanic, & Hansell, 1998).

ASSESSMENT OF SUBSTANCE ABUSE IN ADOLESCENTS

Substance abuse, including alcoholism, has previously been viewed as an adult problem. Thus, most assessment tools have focused on adults. Martin and Winter (1998) found that there is a need for additional research on current assessment tools used for evaluating adolescent substance abuse. Even so, most current tools are based on adult measures (Kazmierczak, Smyth, & Wodarski, 1999).

Brown et al. (1998) examined the *Customary Drinking and Drug Use Record* (CDDR) for psychometric characteristics. This questionnaire is commonly used in assessing drug- and alcohol-related behaviors for adolescents. It is highly consistent and reliable for measures regarding involvement, withdrawal traits, psychological and behavioral dependence traits, and negative consequences for members of this population.

The American Academy of Pediatrics Committee on Substance Abuse (1998) states that the pediatrician can be a key factor in the prevention, diagnosis, and management of substance-related issues for children. To effectively assess an adolescent's usage predicament, the pediatrician must develop an honest and confidential relationship with the adolescent before any such usage is suspected and addressed.

Several interview schedules and assessment measures are available to diagnose substance abuse and dependence or to determine the psychological, physical, and social consequences of use. The measures were reviewed, and those selected were believed to be best based on their reliability, validity, and practicality. The *CAGE* (Ewing, 1984) is a nemonic for a four-item questionnaire that can be given as a self-report or can be administered. The *SASSI* (Miller, 1985) is another

excellent instrument with good test-retest reliability and has an adolescent scale.

The *Addiction Severity Index* (ASI) (McClellan, 1985) is a structured clinical interview that can be used to assess the relative contribution of drug use to problems in various areas of life function. Although originally developed for use with adults, a teen ASI has been developed and used successfully by Kaminer, Buckstein, and Tarter (1991).

ASSESSMENT OF COEXISTING DEPRESSION AND SUBSTANCE ABUSE IN ADOLESCENTS

Recognition and treatment of coexisting substance abuse and depression are essential to reducing the social, familial, psychological, and health consequences common to both disorders. Unfortunately, common clinical features make assessment and diagnosis of the two illnesses difficult. Careful assessment of the chronological development of symptoms is important to determine which disorder (substance abuse or depression) is primary and which is secondary (Schuckit, 1983). A direct interview with the adolescent, as well as with the parent, is important to receive valid information. No specific assessment tool has been designed to assess comorbid depression and substance abuse. Thus, the diagnosis of these two disorders may best be done using biological measures, direct and family interview, and some combination of the aforementioned diagnostic interview and self-assessment measures. Determination of the appropriate combination of assessment measures for comorbid depression and substance abuse in adolescents is one goal for future research (Hilarski & Wodarski, in press).

ASSESSMENT OF ADOLESCENT SUICIDAL BEHAVIORS

McKeown, Garrison, Cuffe, Waller, Jackson, and Addy (1998) explored 1-year transition probabilities and baseline predictors for suicidal behaviors in young adolescents. Participants were categorized into one of four sections based on their level of suicide risk. These sections include attempt, plan, ideation, and none. Participants were then asked to complete questionnaires relating to age, gender, family constellation, and parental education. The researchers found that increasing family cohesion was a protective factor for suicide attempts. Females were more likely than males to disclose plans and ideation of

suicide. Predictors of suicide plans included increasing impulsiveness, prior suicidal behavior, and undesirable life events. The study concluded that suicide and suicidal behaviors result from a plethora of negative factors that demand a multitude of interventions to promote prevention.

Gould, Shaffer, Fisher, and Garfinkle (1998) conducted psychological autopsies of 120 adolescent suicide victims and interviewed relatives and friends of victims to explore effects of parental separation and divorce. The researchers investigated differences in patterns from intact and nonintact families of origin. They found that suicide was more common for adolescents from nonintact families, although the recent increase of adolescent suicide rates seems unrelated to increasing divorce rates.

King, et al. (1997) used the *Diagnostic Interview Schedule for Children* (DISC-2.3) to determine type and concurrent validity of depressive symptoms and diagnosis for 365 adolescents' responses compared with parental responses. Results of this study indicated that parents tended to report observation of more depressive symptoms in their children than the adolescents themselves reported.

Science News (1991) reports that the best way to determine whether an adolescent is contemplating suicide is simply to ask the individual. This article states, "Compared with the controls, attempters reported more drug abuses, depression and behavior problems, as well as poorer peer friendships, self-image and communication skills" (p. 218).

The following measures chosen to assess depression, substance use, and family functioning have been found to be the most reliable, valid, and practical in terms of administration.

Depression Assessment

1. DSM-IV Criteria
2. *A Children's Depression Inventory* (CDI) (Kovacs, 1981)
3. *Reynolds Adolescent Depression Scale* (RADS) (Reynolds, 1992)
4. *Diagnostic Interview for Children and Adolescents* (DICA) (Carson & Cartwell, 1980)

The initial measurement package for depression should consist of the following:

1. **Diagnostic criteria**. Diagnostic criteria for Major Depressive Episode as outlined in DSM-IV (American Psychiatric Association, 1994) include a cluster of at least five symptoms lasting for 2

weeks or more and that represent a change from previous functioning; at least one of the symptoms is either a depressed mood or loss of interest or pleasure. Symptoms include: (1) depressed mood, or in children and adolescents, irritated mood; (2) marked diminished interest or pleasure; (3) significant weight loss or weight gain or decreased or increased appetite; in children, failure to make expected weight gains; (4) insomnia or hypersomnia nearly every day; (5) psychomotor agitation or retardation; (6) fatigue or loss of energy; (7) feelings of worthlessness or excessive or inappropriate guilt; (8) diminished ability to think or concentrate or indecisiveness; (9) recurrent thoughts of death or suicidal ideation.

2. **A Children's Depression Inventory (CDI)**: The CDI can be used with children and adolescents between 8 and 17 years old (Kovacs, 1992). There are 27 items that are scored from 0 to 2. This gives three choices from normal response, moderate level response, and severe problem. It takes about 10 to 15 minutes to complete. The short form of the test contains 20 items (Goldstein, Krasner, & Garfiend, 1989; Matson & Nieminen, 1987). The CDI is based on the Beck Depression Inventory. There is high consistency with the Reynolds Scale in terms of convergent and discriminate validity ($r = 68.73$) (Matson & Nieminen, 1987). The reliability ranges from $r = .57$ to .87 (Saylor, Finch, Spirito, & Bennett, 1984). Internal consistency and validity appear adequate for a research instrument.
3. **Reynolds Adolescent Depression Scale (RADS)**: This assessment tool is used to identify depression within adolescents that are 13 to 18 years of age (Reynolds, 1992). There are 30 items that use a four-point response format (almost never, hardly ever, sometimes, and most of the time) that indicates feelings. It takes 5 to 10 minutes to complete. The questionnaire was not designed to provide a diagnosis of specific depressive disorders. Items are worded at a third-grade reading level so that reading is not a problem. There is high internal consistency, ranging from .92 to .96. There is also high test-retest reliability ($r = .71$ to .89) (Matson and Nieminen, 1987; Reynolds, 1992).
4. **Diagnostic Interview Schedule (DIS)**: The DIS designed specifically for children and adolescents is entitled "Diagnostic Interview for Children and Adolescents" (DICA). This is a semi-structured interview and entails different responses from children and parents, because it is administered to both (Carson & Cartwell,

1983). This assessment tool was developed with the diagnosis used being based on the DSM-III diagnosis and the Research Diagnostic Criteria by the National Institute of Mental Health (Robins, Helzer, Croughan, & Ratcliff, 1981). The diagnosis is from a descriptive, not an etiological, perspective. It is a structured interview that is administered according to a decision tree format, therefore allowing for minimal discretion. It helps in determining the length and duration of the symptoms. The sensitivity is 88%, and the specificity is 94% for abuse and 96% for a dependence identification (Searight, 1992).

Alcoholism Assessment

1. DSM-IV Criteria (American Psychiatric Association, 1994)
2. Adolescent SASSI (Miller, 1985)
3. CAGE (Ewing, 1984)
4. Teen Addiction Severity Index (T-ASI) (Kaminer, Buckstein, & Tarter, 1991)

1. **DSM-IV Criteria** (American Psychiatric Association, 1994). Diagnosis of alcohol and substance abuse in adolescents has certain difficulties unique to the population. DSM-IV criteria place an emphasis on a variety of alcohol- and drug-seeking and taking behaviors rather than on the presence of tolerance or withdrawal symptoms. Alcohol abuse is defined as a maladaptive pattern of alcohol use indicated by at least one of the following: (1) continued use resulting in a failure to fulfill major role obligations at work, school, or home; (2) recurrent use in situations in which use is physically hazardous; (3) recurrent alcohol-related legal problems; (4) continued use despite recurrent social or interpersonal problems. Symptoms of the disturbance must have never met criteria for Alcohol Dependence.

   To diagnose Alcohol Dependence, at least three of the following criteria occurring at any time in the same 12-month period must be met: (1) tolerance; (2) withdrawal; (3) alcohol often consumed in larger quantities over longer period than was intended; (4) persistent desire or unsuccessful efforts to cut down or to control use; (5) a great deal of time spent because of alcohol use; (6) important social, occupational, or recreational activities given up or reduced because of alcohol use; (7) continued alcohol use despite knowledge of having persistent or recurrent social, psychological, or physical problems caused or exacerbated by the use of alcohol.

2. **Adolescent SASSI** (Miller, 1985). This 55-item tool is similar to the adult SASSI in that it is given in subtle (versus a face validity) format. It seeks to be brief and can be administered by a trained interviewer, but not necessarily a professional worker. It was developed for age groups between 12 and 18 years old. The tool's strengths include an ability to identify individuals who are chemically dependent, but either concealing their problem or in a state of denial. Limitations include its length, which is somewhat longer than other instruments available for the adolescent population (Miller, 1985).
3. **CAGE** (Ewing, 1984). CAGE is a mnemonic for four questions that have been used to screen for alcohol problems among adults: Have you ever felt you should *C*ut down on your drinking? Have people ever *A*nnoyed you by criticizing your drinking? Have you ever felt *G*uilty about your drinking? Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (*E*ye-opener)? Yes answers to two of these questions seem to best identify alcoholics (Mayfield et al., 1974). A validation study of 366 hospitalized psychiatric patients demonstrated that CAGE correctly identified 90% of 142 known alcoholics (Mayfield, McLeod, & Hall, 1974).
4. **Teen Addiction Severity Index** (T-ASI) (Kaminer, Buckstein, & Tarter, 1991). This instrument is a subset of the Addiction Severity Index (ASI) but is altered for adolescents age 12 or older. It is a semistructured interview requiring a trained technician, with an average administration time of 30 to 45 minutes. It encompasses seven subscales, including chemical use, school status, employment-support status, family relationships, legal status, peer-social relationships, and psychiatric status. The assessment of co-morbid psychiatric problems and associated life problems gives the T-ASI a broad range. The authors claim that the instrument is designed to be used across different ethnic and demographic population groups and recommended that further research is required (Kaminer, Buckstein, & Tarter, 1991).

Family Assessment Instruments

1. The Index of Parental Attitudes (Hudson, 1982)
2. Family Environment Scale (FES) (Moos & Moos, 1981)
3. Family Assessment Device (FAD) (Epstein, Baldwin, & Bishop, 1983)
4. Multi-Problem Screening Inventory (MPSI) (Hudson, 1997)

Studies have repeatedly supported the contention that there are characteristic patterns of relating that are specific to families with clinically depressed and alcoholic members. The assessment of these patterns, in terms of quality, quantity, and type, is imperative for the appropriate treatment of dually diagnosed adolescents. Adolescents having viable relationships with their parents are less involved with drugs and less influenced by drug-oriented peers (Chassin et al., 1993). Puig-Antich et al. (1993) found significant functional impairment in parental-child and sibling-child relationships in children diagnosed with depression. Familial support of treatment can help promote the process of recovery (Dujovne, Barnard, & Rapoff, 1995). Chatolos (1989) found integration of family intervention into the dual-disordered adolescent's treatment to be essential for recovery. Such family approaches provide the empirically based rationale for the development and testing of a family component.

1. **The Index of Parental Attitudes** (Hudson, 1982) is a 25-item self-report inventory. It can be used for a child of any age. It is rated on a 1 to 5 continuum, which measures extent and severity of parent-child relationship problems as perceived by the parent.
2. **The Family Environment Scale** (FES) (Moos and Moos, 1981) is a 90-item tool intended to measure social climate at three levels: relationship, personal growth, and system maintenance dimensions (Tutty, 1995)
3. **The Family Assessment Device** (FAD) is a 60-item self-support measure that was developed as a screening device that would operationalize the factors from the McMaster Model of Family Functioning (Epstein, Baldwin & Bishop, 1983). The six subscales correspond to the theoretical dimensions in the model: (1) problem solving, (2) communication, (3) roles, (4) affective responsiveness (the ability of family members to experience appropriate affect over a range of stimuli), (5) affective involvement (the extent to which family members express interest in and value each other's activities), and (6) behavior control (the way the family expresses and maintains standards of behavior) (Halvorsen, 1991).
4. **Multi-Problem Screening Inventory** (MPSI) (Hudson, 1997): This 334-item self-report scale measures 27 dimensions of family functioning. Subscales measure depression, self-esteem, partner problems, sexual discord, child problems, mother problems, personal stress, friend problems, neighbor problems, school problems, aggression, work associates, family problems, suicide, non-

physical abuse, physical abuse, fearfulness, ideas of reference, phobias, guilt, work problems, confused thinking, disturbing thoughts, memory loss, alcohol abuse, and drug abuse. Questions are answered on a 7-point Likert scale (from *none of the time to all of the time*). The scale is easily computer scored to develop additional subscales. Available from WALMYR Publishing Co. website: http://www.walmyr.com/

SUMMARY

It is evident that a variety of measurement tools are available for the assessment of adolescent depression and suicide situations. The instruments reviewed here provide quantifiable means of assessment that can significantly augment data collected through traditional procedures. These can be used by practitioners for screening, treatment planning, monitoring client change, and outcome evaluation. In addition, in the context of fiscal constraints and demands for accountability, these instruments can document program effectiveness. Practitioners and agencies are using instruments more frequently as a component in the assessment process as a means of evaluating intervention outcomes.

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Chapter 3

INTERVENTIONS FOR PREVENTION AND TREATMENT

INDIVIDUAL AND ADDITIVE EFFECTS OF ATTEMPTED INTERVENTIONS

Treatment of Depression

The treatment of children and adolescents suffering from depression should be provided in the least restrictive environment, providing for safety and maximum effectiveness. The selection of treatment depends on the severity of the illness, the motivation of the client and/or the client's family toward treatment, and the severity of any coexisting psychiatric or medical conditions (American Academy of Child and Adolescent Psychiatry, 1998).

Pharmacotherapy, although effective and widely used for adult clients with depressive disorder, has not been used as successfully with children and adolescents. Researchers investigating the rate of relapse and placebo response conducted a large study of very depressed youth and concluded that there was no evidence to demonstrate the superiority of medication over placebos (Geller, Fox, Cooper, & Garrity, 1992). Tricyclic antidepressants are not recommended as first-time treatment for adolescents, because they lack efficacy and have serious potential side effects (Ryan, 1992).

Studies with adolescents have examined variations of cognitive-behavioral therapy, skills training, and relaxation techniques (Bukstein, 1995; Hops, & Andrews, 1990; Dulmus & Wodarski, 1996; Kahn, Weltzer, Van Praag, & Asnk, 1988; Kazdin, 1990; Lewinsohn, Clarke, Reynolds and Coats, 1986). Treatment appeared to be more effective than waiting list control conditions, with effects that lasted at

least several weeks. In one impressive study, adolescents suffering from depression received structured learning therapy, a social skills program involving skill instruction, modeling, role playing, and performance appraisal. The treatment was considered moderately successful (Reed, 1994).

Treatment of Substance Abuse

Several studies have evaluated treatment programs for substance abuse in adolescents. Novins, Harman, Mitchell, and Manson (1996) explored factors related to whether Native-American adolescents in need of alcohol treatment would actually receive such services. The results indicate that these adolescents were 15 times more likely to receive treatment if such treatment was recommended to them.

Norbert and McMenamy (1996) explored admissions to an adolescent chemical dependency treatment program. Of these, 26% were involved at some time in special education classes, 12% were described as hyperactive, 57% had not used substances since discharge, and 82% had not used within the past month. Parents tended to attribute more positive outcomes to older adolescents, increased participation and commitment to aftercare, and a smaller amount of time since discharge.

Various pharmacotherapeutic interventions used to treat adolescent drug and alcohol abuse were explored by Solhkhah and Wilens (1998). The writers found that craving reduction, substitution therapy, aversive therapy, and treatment of mental disorders caused by alcohol abuse can be successfully used for this purpose. However, as with other interventions, when using any of the previously stated interventions, the clinician must carefully observe his or her client's progress.

Lochman (1992) reports that cognitive-behavioral therapy has long-term effects for aggressive adolescent boys. In a 3-year follow-up, it was found that improved social functioning and prevention of social deviance, such as drug and alcohol use and abuse, were maintained. These adolescents additionally exhibited improved self-esteem, ability to make social decisions, and an increased sense of family ties.

Treatment of Coexisting Depression and Substance Abuse

Many difficulties arise when determining optimal treatment for the dual-disordered patient. One major treatment obstacle is that clinicians specializing in substance abuse often do not understand psychiatric illness and its appropriate treatment. In addition, the psychiatric

community has only a limited knowledge about the diagnosis and management of substance abuse. Little research has been done on assessing the usefulness or success of different treatment modalities in adolescent populations. Detoxification of the adolescent who is abusing alcohol is a necessary first step in his or her treatment. Once done, the adolescent can then be assessed for additional affective disorders, including dysthymia and major depression. If deemed appropriate, the use of pharmacotherapy may be considered.

Treatment matching has been recommended (Kaminer & Frances, 1991), and emphasis on biological treatment has also been suggested in depression/alcohol abuse intervention (Nunes, McGrath, Stewart, & Guitkin, 1993). In addition, it is important to consider gender differences (Rich, Kirkpatrick, Bonner, & Jan, 1992) as well as racial/ethnic factors (Boles, Casas, Furlong, Gonzalez, & Morrison, 1994; Vega, Gill, Warheit, Apospon, & Zimmerman, 1993) when designing treatment intervention programs.

Treatment of the Family

Research on the family environment of adolescents suffering from depression indicates that adolescents who are depressed tend to come from distressed families (Gould, Shaffer, Fisher, & Garfinkel, 1998; Shiner & Marmorstein, 1998). In many outpatient studies, the families depressed adolescents come from are described as less cohesive, lacking security, less communicative, and less supportive. These families have also been found to exhibit increased tension, more antagonistic behaviors, and more critical exchanges (Kaslow, Deering & Racusin, 1994). Numerous studies have found that depression aggregates in families (Shriner & Marmorstein, 1998). It is also established that parents who are depressed tend to be characterized by poorer parenting, greater marital discord, and lower cohesion than the families with nondepressed parents (Downey & Coyne, 1990). These findings suggest that adolescents with depression may frequently be exposed to parents who are depressed and have related difficulties. Thus, treatment must consider the family environment. For example, a study by Lewinsohn et al. (1990) compared a group of depressive adolescents who received cognitive-behavioral treatment with another group of adolescents who received the same treatment and whose parents also received a complementary treatment. Both forms of treatment produced conclusive improvements at the post test compared with the control group; however, more improvements were made for those who received treatment for themselves along with their parents.

Substance abuse treatment must also consider family influences. Data indicate that adolescents are most likely to consume substances in a manner similar to that of their parents (Wodarski, 1991). Foxcrost and Lowe (1995) found a significant relationship between family environment and self-reported adolescent drinking and substance use involvement.

In light of the significant data to indicate the association between familial alcohol/drug abuse, suicide and depression and adolescent suicide, antisocial behavior, depression and substance abuse, family psychoeducational approaches and interventions must be considered. Not only are these approaches significant to the prognosis for depression and alcoholism in adolescents, but these same approaches also seem important to the treatment of co-morbid adolescents as well (Wodarski & Feit, 1995).

THE SHORT-TERM EMPIRICALLY-BASED GROUP TREATMENT PROGRAM

Although various treatment strategies can be gleaned from the literature, clearly there is scarcity of information regarding appropriate and useful treatment interventions for adolescents with both depressive and substance abuse disorders (Bukstein, 1995). Therefore, development of an effective short-term, empirically-based group treatment program is essential to prevent the serious sequel of the untreated conditions, including suicide. Research on treatment indicates a cognitive self-management model of group intervention is the treatment method of choice. This approach provides life skills training in a peer group experience to maximize both the efficiency of the intervention and the support engendered among the participants therein. Strategies in the treatment process include motivational interviewing (Miller & Rollnick, 1991), a behavioral group work approach using a social skills focus (Feldman & Wodarski, 1995), and a family treatment group adapted from the work of Anderson and coworkers (Anderson, Griffin, Ross, Pagoni, Holden, & Treiber, 1986)

The research indicates that:

1. The combination of both peer group and family treatment results in a greater education of depression/substance abuse than either component alone.
2. An integrated depression/substance abuse treatment model is more effective than either depression or addiction treatment alone in reducing adolescent depression/substance abuse.

Treatment models include the serial model, where one treatment (either psychiatric or addiction) is followed by the other; the parallel model, where both the psychiatric disorder and addiction disorders are treated separately but concurrently; and the integrated model, which applies core concepts and methods from both psychiatric treatment and addiction treatment modules to meet current patient needs (Lysaught & Wodarski, 1996;Ries, 1993).

Life Skills Approach to Interventions for Problem Resolution

On the basis of the foregoing data, a life skills approach with adolescents in middle school grades is posited as the intervention of choice to assuage the problems of adolescents. The theoretical rationales that form the empirical basis for the intervention are based on the literature indicating that teaching adolescent life skills through peer experiences that enhance learning and behavior change and families are important agents in supporting learning and behavior change. This comprehensive package has four components: information about depression and suicide; self-management skills related to depression with the following foci: problem solving, increasing interpersonal skills, self-esteem enhancement, and stress reduction through relaxation; social and family interaction skills; and the maintenance of knowledge and behavior. The program is targeted to provide essential knowledge and skills to adolescents for depression management and suicide prevention. The program uses a peer group experience to increase the likelihood of acquisition and maintenance of knowledge and behavior. In cases in which an attempt has been made, professionals working with a distraught teenager must try to have the entire family respond to the crisis situation through intensive family therapy (Berman, 1984; Pfeffer, 1981; Rosenkrantz, 1978; Shiner & Marmorstein, 1998; Walker & Mehr, 1983).

The technique used in the proposed program is based largely on social learning theory (Norman & Turner, 1993; Silverman, 1990). This theory views adolescents' behaviors, both positive and negative, as being learned by modeling and reinforcement within the context in which the individual functions (parents and peers) (Wodarski, 1990; Wodarski & Dziegielewski, in press). Behavior is modeled by engaging in actions after having observed them in others, from whom the observer infers guidelines. It is thus distinct from simple imitation. Patterns of behavior are acquired through this process (Norman & Turner, 1993; Resnicow & Botvin, 1993). If the role models in adoles-

cents' social contexts lack adequate skills in communication or cognition (or both), their behavior patterns are more likely to be maladaptive. As a result, the individual adolescent is at a much higher risk of substance abuse and depression, because he or she lacks the necessary behaviors to function adequately (Norman & Turner, 1993).

The Teams-Games-Tournaments Method

The method used in both the depression management and the substance abuse components of treatment is known as Teams-Games-Tournaments (TGT). This method emphasizes group over individual achievement and uses peer influence as a teaching device. Furthermore, TGT uses games as teaching tools and uses small groups in a task-and-reward framework (Chambers & Abrami, 1991; Wodarski & Wodarski, 1993). By using peer influence in a positive way (Swadi & Zeitlin, 1988), TGT capitalizes on one of the primary elements in an adolescent's life, thereby increasing social attachments and facilitating the acquisition of knowledge and behavior (Wodarski & Wodarski, 1993).

Relevant research (Chambers & Abrami, 1991; Niehoff & Mesch, 1991; Wodarski, 1988) has found that small group techniques, and particularly TGT, are highly effective in preventing alcohol and drug abuse. Compared with those receiving traditional instruction or no instruction, participants receiving TGT instruction obtained superior results on the self-report indicators of knowledge of drugs and alcohol, reduction in drinking, positive shifts relating to drinking and driving, reduced impulsivity, and improved self-concept. Participants viewed the program as positive and productive, and 2-year follow-up studies have found that all knowledge and attitudes gained by TGT were maintained (Wodarski, 1994; Wodarski & Bordnick, 1994).

Research has documented that the most important agent of socialization in an adolescent's life is his or her peers. The use of small peer groups in the classroom has been proved empirically to be an effective method of addressing problems and improving learning of new skills (Wodarski & Wodarski, 1993). The group context offers important benefits over teaching individually. High-risk behaviors such as substance abuse most generally occur in a group setting. Immediate peer feedback in the group setting acts as a reinforcer of new behaviors. Also, the group forum provides a realistic educational setting for students to practice interpersonal skills that can be carried over into other aspects of their lives. Social isolation, a frequent problem for youngsters at risk, is lessened through the group structure. Finally, a greater

number of students may be served effectively through the group format (Wodarski & Wodarski, 1993).

The TGT technique has been developed and been found effective in the adolescents' classroom. As supported in research data, TGT is especially helpful in teaching adolescents about high-risk behavior. It is also helpful in teaching adolescents how to make better decisions regarding these behaviors. With TGT, all students have an opportunity to succeed, because they all compete against members of other teams who are at similar levels of achievement.

In the beginning phase of TGT, students are given a pretest to gauge their knowledge of the material to be covered in the intervention. The results of this pretest provide the basis for dividing the classroom into four-member teams. Teams are organized according to how the students ranked on the test. Each team has one high achiever (a student who demonstrated a high level of knowledge on the pretest), two middle achievers, and one lower achiever. This ensures, as far as possible, that the average level of achievement is approximately equal across teams.

In the game phase of TGT, students compete against members of other teams on instructional games that are provided in the TGT curriculum guide. These games are usually short-answer questions that have been designed to assess and reinforce the material covered in the classroom.

Weekly tournaments provide a forum for students to compete against other teams. Each student is assigned to a tournament table where he or she competes against two other students, each representing a different team. The students at each table are of comparable achievement levels, as determined by the pretest. Points are earned for each game question that is answered correctly, and at the end of the tournament, the top, middle, and low scores get a fixed number of points. In addition, each player receives points for participating in the tournament. The points a student earns are tabulated and used to determine whether the student will move up to the next higher table with higher achieving students, or move down to the next lower table, or stay at the same table for the next tournament. This procedure encourages students to perform at their highest level and to keep working. Each individual score is added to the scores of the other members to compute the final score for the team.

In a typical class, students participate in two phases of the TGT curriculum designed to address depression and substance abuse. The educational units are provided in the curriculum guide for 50 minutes

each day. Again, the first 3 days of each week are to be devoted to learning about high-risk behavior through exercises, discussions, and a variety of participatory activities. The fourth day is designed as a day for the students to practice on worksheets in their teams as preparation for the tournament (assessment), which is to be held on the fifth day of the week.

EDUCATION ABOUT SUBSTANCE ABUSE

Adolescence is the developmental stage in which experimentation with mood-altering substances is most active (Kagan, 1991; Novacek, Raskin, & Hogan, 1991). Short-term consequences of adolescents' substance abuse include premature death in traffic and other accidents, antisocial behavior and its consequences, suicide, increased risk of HIV infection, and school-related difficulties (Oetting & Beauvais, 1990). Long-term consequences of substance abuse in adolescence also include health problems later in life, failure to prepare adequately for adulthood, and problems resulting from arrests while intoxicated (Kagan, 1991; Oetting & Beauvais, 1990; Wodarski & Feit, 1995).

The strong correlation between adolescents' use of drugs and alcohol and depressed behavior (Marohn, 1992; Weishew & Peng, 1993) provides rationale for the units on depression to be followed by units dealing with substance abuse among adolescents. The Substance Abuse program with family components can be found in Wodarski and Feit (1995). This second phase of the integrated approach serves to follow up and reinforce the unit on depression by educating participants about drugs and alcohol, as well as helping them to develop the skills necessary to resist influences that may steer them toward substance abuse.

SUMMARY

This chapter has considered the individual and additive effects of educational programs for adolescents and preventive programs for parents on forestalling adolescent depression and substance abuse. An effective short-term, empirically-based group treatment program has been proposed as a means of treatment intervention for adolescent depression and substance abuse and its tragic consequence, suicide or attempted suicide. This chapter has described four elements of the program: depression and stress management, education about sub-

stance abuse, a mechanism for ensuring maintenance of skills, and a family component. The program provides adolescents with the necessary knowledge, skills, and attitudes to overcome those influences most likely to contribute to depression tendencies and substance abuse. By use of a peer group model, knowledge and behaviors are more likely to be acquired and maintained over time. Thus, the TGT model, which uses peers as teachers and uses games as teaching tools and small groups in a task-and-reward framework, is used in both the depression management and substance abuse units. The program for parents provides them education about drugs, modeling behaviors, means of controlling depression, communication techniques, and problem-solving skills.

Successful interventions offer effective and attractive means for developing new skills and behaviors. The format will provide for the presentation of knowledge and a means of practicing skills and demonstrating knowledge. The program proposed here will provide advanced capabilities to adolescents to help prevent depression and substance abuse. It will also advance our knowledge and understanding of preventive measures that might decrease the prevalence and incidence of depression and substance abuse in adolescents.

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Chapter 4

COPING WITH ADOLESCENT DEPRESSION AND SUICIDE CURRICULUM

OVERVIEW

This comprehensive curriculum is designed to provide adolescents with information regarding the identification, management, and prevention of depression and subsequent suicide. This is accomplished by means of parental communication and a peer group experience within the school or community setting, thus increasing the likelihood that the adolescent will have an enjoyable learning experience and an opportunity to strengthen the relationship with the parent(s). The program is two-tiered. Adolescents focus on education about depression and suicide, skills development, and problem solving. The parent education component ensures that the information adolescents receive is also available to parents who are taught the communication skills necessary to enhance the parent-child relationship as well.

The instructional method of the comprehensive program is the Teams-Games-Tournaments (TGT) technique. TGT allows participants to learn basic knowledge and skills while developing positive peer relationships by having teens share a common goal and help one another learn. Team learning improves self-esteem and feelings of competence by encouraging adolescents to value one another. In addition, team or group learning closely resembles the environment in which adolescents will discuss and make some of their decisions regarding the management and prevention of depression and suicide.

The special value of TGT to teach adolescents is that when TGT is used, all participants have an equal opportunity to succeed, because they compete against members of other teams of similar achievement

levels. Points earned by low achievers are as valuable to the overall team score as those earned by high achievers. Thus, underachieving teens, who may be isolated from other high-achieving peers, are encouraged to learn and contribute to their group. This increases their probability of being socially connected to pro-social group norms. The three basic elements to the TGT technique that promote motivation and interest in learning are teams, games, and tournaments.

TEAMS. Before beginning the education phase of the program, participants are assessed for level of knowledge of depression and suicide. The completion of the pretest of knowledge provides the basis for division of participants into four-member teams. The teams are organized into high achievers (those with a high level of knowledge of depression and suicide high-risk behaviors), middle achievers (those with moderate levels of knowledge), and low achievers (those most lacking in knowledge). Team composition is heterogeneous, with one high achiever, two middle achievers, and one low achiever on each team, so that the average achievement level is approximately equal across teams. The team remains intact throughout the period when TGT is used. The day before the tournament, team members hold a team practice session to study together or to fill out worksheets reviewing the material covered that week. Peer tutoring is encouraged. Activities to promote team spirit are encouraged, such as team names, tee shirts, logos, and so forth.

> *Note:* Teachers may compose from the curriculum material a pretest suitable for their particular class or group, time available for testing, and so forth. If the group consists of an uneven number of participants, teams can be composed with additional "middle" achievers to keep the achievement level across teams approximately equal.

GAMES. Participants compete against members of other teams on instructional games that are provided in the curriculum guide. The games are usually short-answer questions designed to assess and reinforce the material taught in class.

TOURNAMENTS. Participants play the games in tournaments held weekly. Each team member is assigned to a tournament table where he or she competes individually against two other teens, each representing a different team. The participants at each table are of comparable achievement levels. Points are earned for each game question answered correctly, and at the end of the tournament, the top, middle, and low scorers get a fixed number of points. Each player receives certain points for participating in the tournament. The points a partici-

pant earns are used to determine whether he or she will be "bumped" to the next higher table (with higher performing teens), "bumped" to the next lower table, or stay at the same table for the next tournament. This bumping procedure encourages teens who have increased their achievement levels to keep working. The points are added to those earned by other members of the teen's team to compute a team score. The individual and team scores should be ranked and publicized in a tournament newsletter for the class.

The educational units are to be presented for 50 minutes a day for 6 weeks. The first three days of the week are devoted to learning concepts by means of small group discussion, exercises, and various participatory activities. The fourth day is to be devoted to working in TGT teams to prepare for the tournament that is held on the fifth day.

WEEK 1–DAY 1

BEHAVIOR ANALYSIS AND SELF-MANAGEMENT OF DEPRESSION

Introduction

Instructor: Provide the following introductory remarks. Adjust terminology for grade and/or comprehension level.

This session presents an outline of the social learning view of depression. Depression is a learned phenomenon. Because you have learned to be depressed, you can also learn to become "undepressed". These sessions are intended to teach you the skills you need to accomplish this. Except when we are sleeping, we are continuously interacting with the environment. We are always doing something. Our interaction with our environment is continuous and reciprocal. We can put interactions into categories, those that lead to positive outcomes (give an example), those that have neutral outcomes (give an example), and those that have negative outcomes (give an example). (Ask adolescents to give their own examples of each outcome.) When too few of our interactions have positive outcomes and when too many of them have negative outcomes, we start feeling depressed. These routes to depression are shown on this chart. (Draw the following chart on the blackboard or poster board.)

Routes to Depression Chart

Many of your interactions are not associated with satisfying, pleasant, or rewarding outcomes.	Many of your interactions are associated with dissatisfying unpleasant, or distressing outcomes.

You tend to:

1. Feel sad, down, blue, and helpless
2. Feel discouraged from repeating the interactions

(Discuss this chart with adolescents. Ask them for examples of interactions lacking positive outcomes. Ask for examples of interactions associated with negative outcomes.)

Any one of the instances we've discussed might leave you feeling a little discouraged but not necessarily depressed. But when these events are multiplied and when they occur over an extended period of time, they are likely to cause you to feel quite depressed. What determines whether an interaction is going to be experienced positively or negatively depends on the external ("objective") situation and on your subjective interpretation and perception of the situation. (Ask for examples of objective and subjective interpretations.) What we say to ourselves, especially positive and negative statements, is important. We are said to "self-reinforce" when we provide ourselves with something tangible or when we make a positive statement (or mental image) after something we do. Self-reinforcement becomes especially important when we are working on projects that require such long and sustained effort that we may not get any encouraging feedback for a long time. The things you say to yourself while engaged in this activity play a critical role in determining whether an interaction is going to be experienced as rewarding or unpleasant. (Give and ask for examples of projects that require long effort and also examples of things the adolescents might say to themselves during these projects.) People who are depressed are prone to self-reinforce negatively rather than positively. They are less likely to compliment themselves when they do something well and are more likely to criticize themselves during or after an interaction.

Interactions with positive outcomes are those that make us feel liked, respected, loved, useful, appreciated, and worthwhile. (Ask for examples of interactions with positive outcomes and accompanying feelings.) These interactions make us feel good and motivate us to be active.

DEPRESSION CYCLE. Being depressed means you are experiencing too few positive outcomes and too many negative ones. This state of affairs leads to a vicious cycle: when you feel depressed you also feel discouraged and thus are less likely to approach situations that might lead to satisfying outcomes.

With depression, it's rather easy to get into a vicious cycle. Having few interactions with positive outcomes causes you to feel depressed; the more depressed we feel the less motivated we are to engage in the kinds of activities that might have positive outcomes. This causes us to feel even more depressed, which in turn causes us to become even less active. And so it goes on and on. This cycle continues until you feel very depressed and are very passive. (Put the following diagram of the depression cycle on the board and discuss it with the adolescents.)

Feel depressed	Engage in few interactions with positive outcomes
Feel more depressed	Become less active
Feel even more depressed	Do even less

Fortunately, there is a positive cycle for every vicious cycle. Engaging in interactions with positive outcomes leads to an improved sense of well-being, which motivates a person to engage in more activities with pleasant outcomes. A positive cycle is thus set in motion. (Have adolescents draw a positive cycle, making up interactions that would lead to setting a positive circle in motion.

The preceding material was adapted from *Control Your Depression* (Lewinsohn, Munoz, Yougren & Zeiss, 1978).

WEEK 1–DAY 2

COGNITIVE BEHAVIOR MODIFICATION PRINCIPLES

Mood Chart

Instructor: Provide the following introductory remarks.

The purpose of our sessions is to help you learn how to cope with your depression and to improve the way you feel. It will be very important for you to look carefully at your activities and interactions to determine which of your interactions lead to positive outcomes and which are associated with negative outcomes. To help you feel less depressed, you will need to learn how to increase positive outcomes and how to decrease negative ones. To do this, you will have to be able

to pinpoint specific instances associated with positive and negative outcomes.

The general expectation is that you will feel better on days when you have a lot of positive and few negative interactions than on days when you have few positive and many negative interactions. The fact that your mood changes from day to day will be helpful, because it will allow you to become aware of the impact of specific events on your mood.

Our mood varies from day to day and also from hour to hour. Even people who say they feel depressed "all the time" find that there are days when they feel less unhappy. By keeping track of your daily mood, you put yourself in a position to:

1. Identify specific interactions, activities, and situations in which you feel especially good or bad.
2. Evaluate your progress. Since your primary goal is to reduce your depression level, tracking your mood will allow you to evaluate how successful you are in improving it.

Instructor: Pass out and go over the Self-Monitoring Logs and Homework Assignment. Pass out the Daily Mood Rating Form and provide the following explanation.

The Daily Mood Rating Form provides an ongoing tally of your mood and uses a 9-point scale to help you indicate how good or bad you feel. At the end of each day, about an hour before you go to bed, decide what kind of day it has been for you. If it has been a bad day, you would give it a low number; if it has been a good day, you would give it a higher number. You should begin to rate your daily mood today and continue to make ratings at the end of each day as long as you are working on your depression.

Self-Monitoring Log

Name:_____
Date:_____
Positive Activity: (circle the numbers)

1. Meeting someone new of the same sex
2. Playing baseball or softbal
3. Buying things for myself
4. Going to a sports event
5. Pleasing my parents
6. Watching TV
7. Laughing
8. Solving a problem, crossword puzzle
9. Thinking about myself or my problems

10. Going to a party
11. Being with friends
12. Wearing new clothes
13. Dancing
14. Dating, courting, etc
15. Playing in a sporting competition
16. Going on outings (picnic, to a park)
17. Helping someone
18. Meeting someone new of the opposite sex
19. Being noticed as sexually attractive
20. Listening to music
21. Going to a "drive-in"
22. Talking on the telephone
23. Having daydreams
24. Going to the movies
25. Kissing
26. Doing a project in my own way
27. Giving a party
28. Going to a restaurant
29. Visiting friends
30. Talking with people in class
31. Being relaxed
32. Reading the newspaper
33. Running, jogging, exercising
34. Petting, necking
35. Talking about sex
36. Reading magazines
37. Shopping
38. Bicycling
39. Staying up late

Extra space (other activities, comments, etc.)

Day's Mood Rating

0 1 2 3 4 5 6 7 8 9 10

Unhappiest ever Happiest Ever

Self-Monitoring Homework Assignment

Your first homework assignment will be to record your daily mood and daily positive activities. The self-monitoring logs have a place for recording positive activities and mood each day.

The following principles should be followed in self-monitoring. They are also stated on your instruction sheets.

1. Keep the self-monitoring log in a convenient, easy-to-remember place at home (e.g., posted in your bedroom, top desk drawer, at end of a bookshelf, etc.). Make sure that you've recorded all of your "positive activities" in your log by the end of each day. Preferably, you do this just before going to bed.
2. Circle the number corresponding to what the actual activity was. If any activities occur that are not on the list, write these down in

a few words in the section marked "extra space" (e.g., got a "B" on midterm exam, got a letter from a friend, etc.). Emphasis should be on trivial events.

3. At the end of each day record your day's mood. Everyone's mood varies from day to day and even from hour to hour. Try to rate your mood on the average for a given day on a scale from 0 to 10. Zero stands for the worst mood you have ever experienced for a day. Use any and all points in between. Be sure to record even small changes from one day to the next.
4. Use a new log for each day.
5. Bring your logs to each session! They are necessary for the next few meetings.

You may even wish to monitor your mood regularly after you have succeeded in reducing your depression. In this way the mood ratings can serve as a warning signal if you begin to get depressed again in the future.

6. Keep an on-going record on the Daily Mood Rating Form.

The above material was adapted from Control Your Depression (Lewinsohn et al., 1978) and Participant Workbook for the Coping with Depression Course (Brown & Lewinsohn, 1984).

DAILY MOOD RATING FORM

Very depressed ——— Happy

1 2 3 4 5 6 7 8 9

Monitoring day	Mood score	Monitoring day	Mood score
1		14	
2		15	
3		16	
4		17	
5		18	
6		19	
7		20	
8		21	
9		22	
10		23	
11		24	
12		25	
13		26	

27_____	44_____
28_____	45_____
29_____	46_____
30_____	47_____
31_____	48_____
32_____	49_____
33_____	50_____
34_____	51_____
35_____	52_____
36_____	53_____
37_____	54_____
38_____	55_____
39_____	56_____
40_____	57_____
41_____	58_____
42_____	59_____
43_____	60_____

From *Participant Workbook for the Coping with Depression Course* (R.A. Brown & P.M. Lewinsohn, Published by Castalia Publishing Co., 1984).

Cognitive Behavior Modification Principles

Introduction to Self-Change Skills

The purpose of this session is to cover the basic skills that are the foundation for the development of any self-change plan. Self-control is different from willpower. Self-control is a skill you learn. There are three critical ingredients for self-change: (1) the belief that you can change, (2) the recognition that self-change is a skill you learn, and (3) the development of an action plan.

Steps for Making a Self-Change Plan

The first step is pinpointing or specifying the problem and deciding what to change.

1. It should be a behavior or thought (not a feeling).
2. It is important that it be specific, *observable* and/or *countable.* This makes it easier to determine later how much progress you have actually made. For example, "I would like to jog for at least 15 minutes every night" is better than "I would like to get more exercise."
3. The problem you choose should be something you want to decrease or a certain new skill you want to learn.

The second step is baselining–gathering information and keeping track.

1. This is so you know where you stand with this particular behavior now, so you can: (a) set a reasonable goal for change, and (b) keep track of your progress later.
2. Count all of the occurrences of the behavior for a certain amount of time (e.g., a week). This must be done accurately. It is also good to have a portable system for counting (e.g., a 3x5 notecard). Your want to establish how often the behavior is occurring and in what situations.
3. By the end of the baselining period, you should know how you want to change the pinpointed behavior and be able to set a reasonable goal.

The third step is discovering antecedents.

1. Look for events or conditions that may be related to your pinpointed behavior. There will be four kinds of antecedents for which you will be searching:
   a. Social situations (e.g., how you feel with a group of people)
   b. Your own feelings and thoughts
   c. The physical setting (e.g., the place where your problem occurs most often)
   d. The behavior of other people (or being with certain people)
2. You can control antecedents in three ways
   a. Avoid them
   b. Change them
   c. Not respond to them
3. You should try to discover antecedents during the baseline period and think about possible ways of controlling them.

The fourth step is discovering consequences.

1. Consequences are events that happen after we engage in a behavior. They affect how we feel about a behavior and whether we will be likely to do it again.
2. There are two main kinds of consequences.
   a. Reactions from others
   b. Our own reactions (that is, the things we say to ourselves)
3. Consequences may be positive (make it more likely that we will repeat the behavior in the future) or negative (make it less likely that we will repeat the behavior in the future). Neutral consequences are in between; they don't have as much influence on us.

4. When we want to increase a behavior, we want it to be followed by positive consequences with few negatives. To decrease a behavior, we want just the opposite–to not have it followed by positive consequences.
5. As part of your efforts to collect baseline information, try to identify consequences that follow your pinpointed behavior and consider certain possible ways of controlling them.

Your assignment is to identify a particular problem to work on and begin collecting baseline information on the *Record of Behavior Sheets*. Pay attention to antecedents and consequent events. Write these on your tally sheets. (Have adolescents fill out sheets during this session.)

Steps for Implementing a Self-Change Plan

1. Setting goals
   a. People who are depressed tend to set unrealistically high goals or standards for themselves. Depressed persons tend to be perfectionistic, they set goals that are distant, abstract, overly general and unobtainable. Partial fulfillment is never satisfying or enough. The result is that such people are never satisfied with themselves and are always depreciating themselves and their efforts (or "putting themselves down"). To overcome depression, it is important to set realistic, positive goals (self-evaluations).
2. Establish subgoals
   The general idea is to break down the overall goal into small steps. To begin with, you may have to think of a whole list of possible steps and then select out of this list the best and most orderly steps. Subgoals should be defined such that they are:
   a. Realistic–something you can actually expect to occur.
   b. In your control–something that is within the span of your own abilities and efforts. Not something that depends on the whim of others, e.g., learning a new skill such as driving a car, typing, painting, etc., could be a realistic goal that is in your control. Being elected president of your class or club may or may not be realistic because it depends on others' votes, not just your own efforts.
   c. Specific–defined in terms that describe specifically what behavior is to performed in a way that would allow anyone to recognize when it has been done.
3. Contracting

   a. Contracting means making a specific agreement to reward yourself if and only if you do certain things (i.e., accomplish certain steps toward goals).
   b. You need to arrange in advance a specific reward to follow the achievement of your goals.
   c. Timing of the reward is also important. Try to make the reward occur as close in time to the achievement of your goal as possible, the sooner the better.
4. Reinforcers
   a. Choose them–material rewards, social rewards, activity rewards, mental rewards.
   b. Important considerations in selecting a reward (reinforce):
      1. Make sure it makes you feel good
      2. Is accessible–otherwise, it won't be used
      3. Is powerful–it should fit your effort
      4. Is under your control–don't rely on an unreliable other.

Hand out the *Goal-Setting Worksheet* and instruct adolescents to develop their own goals. Have them start with only one goal (this will most likely be the pinpointed problem that they identified and began baselining). Next, have adolescents break the goal down into a series of subgoals following the criteria mentioned earlier. (Ignore the "Points" column in this session. Have adolescents complete worksheet during this session.)

Be sure to praise adolescents' efforts to construct goals and subgoals. Emphasize that certain subgoals may require revision, based on how attainable, well-defined, etc., they are. Have adolescents continue collecting baseline data on their pinpointed problem behaviors.

Self-Reinforcement

Instructor: Provide the following comments.

We've spent a lot of time talking about how positive and negative activities affect our moods. Positive events are, by definition, pleasant: we want them to occur more frequently, and when they do, we feel good. So, we tend to do these things that produce pleasant events. Similarly, we want to reduce the occurrence of negative events, and so we will tend to avoid doing things that produce them. For example, if you know that running a red light will result in getting a ticket or, even worse, an accident, you avoid doing that. If you know, on the other hand, that saying hello to a friend will result in him or her smiling and talking to you, you will tend to do that fairly often.

So, what we're saying is that:

1. Behavior is controlled by rewards and punishments. If you want to increase, strengthen, or encourage the activity or behavior, you follow it with reward. If you want to decrease, weaken, or discourage an activity or behavior, you punish it. This is true whether you are talking about training a pet, teaching a child, or influencing an adult. The important point is that the reward or punishment must be contingent. ("Eat your spinach, and then you get dessert.") Rewards and punishments are ways in which behavior is motivated.
2. People may control their own behavior by giving themselves rewards and punishments. When people do something that they are proud of or feel they have done well, they may treat themselves to a reward (e.g., go out to dinner) or they may "pat themselves on the back." When people do something that they are not proud of or feel they have not done well, they may punish themselves (e.g., deny themselves something) or they may "kick themselves." Rewards and punishments can be tangible or verbal (e.g., a medal vs. praise). Self-rewards and self-punishments can be observable or private (e.g., treating yourself to something vs. patting yourself on the back" or "kicking yourself.")
3. People who are depressed tend to punish themselves too much and reward themselves too little. People who are depressed tend to be down on themselves and are constantly punishing themselves either by what they do or say to themselves. The same people may believe it is almost improper or immoral to do something to reward themselves or even think something positive about themselves. The result is that they are not motivated to be more active in pursuing goals.

Someone who is depressed is more likely to focus on what he or she has not accomplished rather than on what he or she has done well, and then punish him or herself for failing rather than reward him or herself for successes. For example, the woman on the diet may slip one day and then punish herself for the rest of the week by saying, "I'll always be fat" or "I'm so weak." She should reward herself for the six good days rather than punish herself for one bad one.

Instructions for Self-Reward Assignment/Exercise

Outline the self-reinforcement procedure for adolescents and then review each step in detail to be sure they understand the assignment. Provide the following comments:

To counteract depression and to motivate progress toward your goals, you are going to set up a self-reward program for increasing your goal-related activity. Note that we will concentrate on self-reward and not self-punishment. Reward tends to be a more effective means of producing change in the long run. Your goal ought to be to replace self-punishment by self-reward in your own life.

Instructor: Pass out the Self-Reward Menu Form.

On the Menu Form, list as many potential rewards for yourself as you can. Rewards should be (1) truly enjoyable, (2) varying in magnitude from large to small, (3) capable of free administration, (i.e., you should be able to decide when and where they occur).

Note that activities and things can be rewards. One place to get some ideas for rewards is to look on your past monitoring logs. The principle that you ought to use is that easy positive activities can be used to reward hard positive activities.

Examples for potential rewards that you can give to yourself may be:

1. Material rewards (clothing, books, etc.)
2. Activities (going to a movie, park, shopping, going to an enjoyable class, swimming, watching a favorite show, eating a favorite food).

Now assign "prices" to your reward menu. Give each item a value from 1 to 10 as how "big" a reward it would be for you.

Now assign point values to your subgoals on your goal-setting worksheets. Give each item a 1 to 10 value in terms of how many points you should earn by this activity. Be generous! You can always reduce these later if they turn out to be easier than you think.

As you earn points by carrying out your subgoals, reward this progress by spending your points on your reward menu.

Reward is more effective if it is immediate, so cash your points in as often as possible. Remember that the principle is that reward should be contingent on performing the behavior. Your reward came because of the behavior. The points simply make it easier to translate one into the other.

Ask for any questions. Have adolescents complete during group time.

Review of Self-Reinforcement (SR) Guidelines

1. Reward positive behaviors rather than criticizing yourself for failures.

2. Reward each positive behavior, that meets or surpasses a subgoal contingently and as soon as possible
3. Be generous with rewards at first.

The above material was adapted from *Cognitive-Behavior Therapy Manual* (Coats & Reynolds, 1982.).

RECORD OF BEHAVIOR (sample)

Name:_____ Date: from_____ to_____
Description of behavior:
_____
_____
_____

Days Tallies
1_____
2_____
3_____
4_____
5_____
6_____
7_____

GOAL-SETTING WORKSHEET (sample)

Goal: Broad or long range.
"I want to increase (or decrease)_____
_____
_____

Subgoals: Points
1._____
2._____
3._____
4._____
5._____
etc._____
_____
_____

Assignment

1. Establish goals and subgoals. The general idea is to break down the overall goal into small, individual steps. To begin with, you may have to think of a whole list of possible steps and then select out of this list the best and most orderly steps. Subgoals should be defined such that they are:
   a. Realistic (or practical)
   b. In your control
   c. Specific
2. Continue to keep track of (e.g., count) your pinpointed behavior. Again, try to pay attention to the events that happen just before and after the behavior.

SELF-REWARD MENU

Self-rewards (enjoyable, different sizes, under your control)	Points Necessary
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	

WEEK 1–DAY 3

COGNITIVE COMPONENTS OF THE DEPRESSION CYCLE

Instructor: Review last session's assignments.

Often people who are depressed have a number of negative, self-critical, or pessimistic thoughts. When you are depressed, you tend to engage in a greater number of negative thoughts than when you are not depressed.

Because they are always with you, you have learned to take thoughts for granted. It will be hard for you to pay attention to them and take seriously the need to change them. Unless you seriously attend to them, of course, you probably won't change them. Because your thoughts are only known to you, there is no way anyone else can directly observe whether they are changing. This means that you will have to be very conscientious about doing the exercises designed to change the way you think. Only you will be able to tell whether you are applying what you learn here. To deal with depression you need to think of yourself as actively learning new ways to think, act, and feel. As you learn new patterns of thought and behavior, you will begin to have different nondepressed experiences.

To begin working with thoughts, you need to learn to identify them. A fairly easy way to do this is to begin to keep track of "positive" and "negative" thoughts. Positive thoughts are those that have a positive effect on your mood and reflect the good points of whatever they refer to. (Ask for examples.) Negative thoughts are those that have a negative effect on your mood, usually they focus on bad points. (Ask for examples.)

Directions for Recording Thoughts

1. Use a 3x5 card, label one side of the card with a plus sign ("+" for positive thoughts) and the other side with a minus sign ("-" for negative thoughts). Use one card per day and date it.
2. Jot down positive and negative thoughts on the appropriate side of the card as soon after they occur as possible. (If you have trouble remembering to do this, make it a habit to take a few minutes before breakfast, lunch, dinner, and bedtime to jot down the important positive and negative thoughts of the last few hours).

You won't be able to write down every thought you have, of course. If you can note 10 positive and 10 negative thoughts each day, you'll be doing well. By the end of the week, you will have a good sample of

positive and negative thoughts. You may find that certain thoughts occur to you repeatedly, that some are more disturbing than others, and in general that some seem to be particularly powerful in influencing your mood. Make a personalized list of the most important thoughts you have found during the week's self-observation on the *Inventory of Thoughts* sheet. Pass out inventory. Place a star next to those that are particularly helpful to you in regard to your mood. Add more thoughts to your list if you remember important ones not already included.

Next week, after you have learned to identify the kinds of thoughts that are most likely to occur to you, it will be easier to count them. Then for one week, tally each positive thought and negative thought as it occurs during the day. Use a 3x5 card labeled with a "+" on the one side and a "-" on the other. Total you tally marks at the end of each day. Record your totals on the *Daily Tally of Negative and Positive Thoughts sheet.*

Instructor: Pass out the Tally Sheet.

If your average of negative thoughts is greater than your average of positive thoughts, you need to change your thinking pattern.

Decreasing Negative Thoughts

When you are depressed, you tend to engage in a greater number of negative thoughts than when you are not depressed. The following techniques have been found helpful in controlling negative thoughts. Choose one of these techniques and try it for a week, keeping a tally of the number of negative thoughts you have each day. If at the end of the week your average is less than your baseline average, the technique is working. If not, you should switch to another technique and test it for one week.

The following material was adapted from *Control Your Depression* (Lewinsohn et al., 1978).

Thought Interruption

Immediately upon noticing that you are producing a negative thought, interrupt it and go back to whatever non-negative thoughts you were having. To interrupt the thought, instruct yourself as follows: "I am going to stop thinking about that now." Then, without getting upset, let your attention flow back into non-negative ideas. This is probably the easiest interruption method and the one we recommend most highly. There are two other methods found useful by some and that we should mention.

One involves a stronger interruption. You should begin practicing this method someplace where you are not likely to be heard. When you are ready to begin, start thinking a negative thought and, as soon as you notice the thought clearly in your mind, yell the word "STOP!" as loudly as you can. You'll notice that the negative thought will be pushed aside for a few seconds by the very force of the act of yelling. You should then go on thinking non-negative thoughts. Repeat the actual yelling technique for about three days, then begin reducing the volume of the yell while at the same time maintaining the force behind it. Continue this process until you can "yell" the word "STOP!" mentally, feeling the full force of the yell without making a sound. Now you are ready to use the technique in public.

The other technique originates from the notion that an act that is punished consistently will show a reduction in its frequency. In this case the act is the negative thought. The punishment is a "slap on the wrist" with a rubber band around your wrist. If you do this consistently, you will soon begin to catch negative thoughts almost at their inception, and the frequency of such thoughts will drop.

For all three of these techniques, remember to record your positive and negative thoughts and inspect the record regularly to ascertain whether the negative thoughts are diminishing. Choose one of the three interruption methods now, and use it for the next week. Remember to record your positive and negative thoughts.

Worrying Time

One of the many sources of depression is an inability to keep certain negative thoughts away. These may be particularly bothersome ideas that intrude into your train of thought again and again, draining your energy and distracting you from the task at hand. This is sometimes called "obsessive thinking." If you feel that you need to spend some time mulling these thoughts over, this technique is exactly what you need. Decide how long you think you should spend on these intrusive but necessary thoughts to interfere with your mood or your work or play or at any other time. If you feel that it is hard for you to set aside a thought completely when it occurs for fear you may not remember to think about it during your "worrying time," then keep a pen or pencil and paper handy to jot down a word or two that will remind you of particularly important thoughts.

The point of this technique is not to avoid thinking about unpleasant subjects completely. Rather, it is to let you decide when is the best

time to devote to what you consider necessary thinking and to free you from having to carry your mental burdens everywhere. Half an hour of worrying time a day should prove sufficient for most people. The technique works best if you refrain from doing anything else except thinking during your "worrying time." For example, pick one particular chair in which to sit and think–no talking, eating, drinking, working, or playing. Knowing you have the daily "worrying time" may make it easier to forego ruminating over worries at other times.

Fill in: My worrying time will start at _____o'clock and last _____ minutes.

Note: If you use this technique, only tally negative thoughts that occur *outside* of your "worrying time" in your daily total.

The Blow-Up Technique

This is a technique designed to reduce the impact of a disturbing negative thought by exaggerating it beyond all proportion and thus making it so ridiculous that it ceases to be fearful. Marsha had been worried about having to tell her supervisor that she had made an important error on an order she had taken care of at the shipping department of a major store. But, to correct her error, she had to tell her. She fretted about it for a few days, losing some sleep over it, and becoming so quiet at work that one of her coworkers even asked if something was wrong.

Marsha realized then that she couldn't put it off any longer and began to ask herself why she feared to tell her supervisor. She decided that she was afraid of having the supervisor think that she was "incompetent" and maybe tell her coworkers, who then would also consider Marsha "stupid" or "careless."

The way Marsha used the blow-up technique was to imagine that her supervisor became terribly upset at her error, began screaming at the top of her lungs, throwing stuff at Marsha, and stomping up and down on the resulting wreckage. Her coworkers heard the commotion and joined in on the ruckus. They finally placed a big sign on her chest, that read "STUPID" and outfitted her with a "dunce" cap. The store's loudspeaker blared out Marsha's error throughout the day, and as Marsha rode on the bus (with her cap and sign still on), she could see newspaper headlines proclaiming her error being read by bus riders. The people in the streets booed her, and little children stuck out their tongues at her. Marsha found the process of letting her imagina-

tion run wild somewhat funny. The ridiculous flavor of the exaggerated images blended with her earlier fear of telling her supervisor and give it a less-threatening tone. She went ahead and did it. And survived!

Managing Thoughts: Increasing Positive Thinking

Reducing the number of negative thoughts will not automatically increase the number of positive thoughts. You need to learn techniques designed to accomplish each of these objectives.

To increase the number of positive thoughts you generate, choose one of the following techniques and keep a daily count of positive thoughts for one week. If your average for the week is greater than your baseline average, the technique is working. If not, choose another technique and test its effectiveness for a week.

Priming

Priming is a technique designed to increase positive thoughts. Its name comes from the phrase "priming the pump" (which originally meant placing water in the barrel of a dry pump to begin the pumping action that would start the desired flow of water). In our case, the word refers to placing positive thoughts in you mind systematically, so that you can break the pattern of thinking negative thoughts and thus you can start the flow of positive thoughts.

First, you need to put together a list of positive thoughts. Add any thoughts you came up with on your index cards. And now add still more. Think especially about thoughts that refer to yourself. If necessary, ask people you trust to tell you what they consider your good points.

Second, write down these thoughts on 3x5 cards, one thought per card. You will then have a deck of positive thoughts.

Third, begin to prime your "positive thought pump" by carrying the deck of cards with you, pulling a card out at random intervals throughout the day, and reading it, paying serious attention to it.

Add new positive thoughts about yourself to the deck as they occur to you. Also, begin placing "wild cards" in the deck. When you get to a card labeled "wild card," you are to generate a positive thought on your own.

Using Cues

Use frequent behaviors as reminders for yourself to have a positive thought. Because positive thoughts are infrequent occurrences in your daily routine, you can increase their frequency by pairing them to things you do frequently.

For example, remind yourself to think a positive thought each time you eat, brush your teeth, talk on the phone, read something, get in your car or on the bus, and so on.

Noticing What You Accomplish

Many depressed people don't give themselves credit for what they do. Instead, they belittle themselves when something doesn't work out right.

To see if this is true in your case, begin to keep track of all the things you accomplish during the day, even things you may consider trivial. Carry a couple of 3x5 cards with you and note every task you complete throughout the day.

A typical list may look like this:

- Got up on time
- Ate a good breakfast
- Dressed neatly
- Finished a project
- Planned out an effective schedule for the day
- Ate a nice lunch
- Had a good conversation with a friend
- Accomplished 3 out of 5 things I wanted to do today
- Saw a TV program I really wanted to see

The object of this technique is to notice what you do during your day. Many people feel that they don't do anything when, in fact, their days are full of activities for which they don't give themselves credit.

Positive Self-Rewarding Thoughts

Hearing someone telling us they appreciate what we have done usually feels good. This may be because our contribution is noticed, our efforts are considered worthwhile, and our value is acknowledged. These three elements can also be present within our thoughts.

The result of being praised or encouraged is usually an increase in the desire to continue to do well. You can often produce a similar effect by praising or encouraging yourself.

If you were to tell other people that they are lazy or incompetent or that their work is unimportant or lousy, they would probably be less likely to feel good about themselves or their efforts. They might give up and stop trying. The same result can take place if you tell yourself those things.

Because one of the problems depressed persons have is that they don't do much, it makes sense to notice if you are encouraging this inactivity by punishing yourself with negative thoughts before, during, and after you do something. For example, when you consider getting together with friends, do you think to yourself "It will be boring" or "I really don't feel like it"? During an outing or a visit do you say to yourself "I don't fit in here" or "Everyone is looking at me"? After you have done something you were looking forward to, do you come down hard on yourself and focus on all the disappointing parts of the experience instead of enjoying the fact that you finally did it? Do you think, for example, "I really could have done a lot better, "I looked like a fool," or "No one really enjoyed it"?

By increasing your level of positive self-reward, you can increase you level of activities and your level of positive thoughts. The trick is to reward yourself silently after you do or think something positive by "patting yourself on the back." For example, let's say you are again considering getting together with friends, you could think to yourself: "That's a constructive idea. Having this type of idea means I am making progress. I am headed in the right direction." Or during an outing: "I haven't done this in so long. It took guts to try it. I am proud of myself." And, afterward: "I did it! Not bad!"

We have found that many people are reluctant to praise themselves, because they see that as being too proud, egotistical, or self-centered. The fact is that all of us need encouragement. If it is good to compliment others for good work, then it certainly makes sense to do the same for oneself.

Time Projection

One of the most frightening things about depression is that while you are thinking, feeling, and acting depressed, you believe that the state you are in is never going to end. The time projection technique breaks through this tendency by having you mentally travel forward in time far enough so that, in your estimation, the stressful period has ended.

The stressful period may be as short as a visit to the dentist or as long as a period of mourning. In the first case, for example, the idea is

to acknowledge the anxiety and discomfort you are experiencing in the dentist's chair, and then "jump forward in time" a couple of hours to when the only discomfort will possibly be residual numbness from the anesthetic, and then again a week or so later, when you won't even be thinking about the fact that you were at the dentist's today.

In the case of mourning or separation, you would acknowledge the memories, the loss, and the pain you now feel, and then think about the fact that the pain–which may be almost unbearable at times now–must decrease as time goes on, and that in a few months the memories will be free from the intense, tear-eliciting pangs that are so common now.

At the same time, we would like to underscore a basic concept often overlooked by many depressed people. Feelings of sadness, pain, and depression are natural parts of life. They come at all levels, from very minor to most intense. It is OK to feel depressed. This in itself will cause no problems. Human beings can bear very intense levels of depressive feelings. It is when you become demoralized, lose hope, and forget that you can endure the pain and go on living that the trouble starts. Time projection acknowledges the pain and helps you see a more satisfying future.

Evaluating Your Efforts

The goal of this session was to help you identify thoughts that make you depressed, learn to count them, and control them.

To do this, we have focused on negative thoughts–those that have a negative influence on your mood; and positive thoughts–those thoughts that have a positive influence on your mood. Your baseline averages can serve as a guide for your self-change project. Your goal is to increase positive thoughts and decrease negative thoughts until you have as many or more positive thoughts as negative thoughts each day. Remember the social learning concepts we mentioned before:

1. **Antecedents:** Note when and where you are most likely to have negative thoughts. Are you in certain places, with certain people, or at certain times of day? If so, devise alternative plans for yourself so you can avoid or deal differently with these situations.
2. **Consequences:** Do you reward yourself for thinking negative thoughts? For example, do you postpone an unpleasant chore because thinking about some unrelated problem has made you too depressed to do it?

3. **Mental factors:** Do you punish yourself mentally when you have positive thoughts? For example, do you label yourself conceited for thinking you do something well? Or do you belittle what you did and tell yourself you didn't really do it well enough?

The preceding material was adapted from *Control Your Depression* (Lewinsohn et al., 1978).

INVENTORY OF THOUGHTS

Negative	Positive

From *Participant Workbook for the Coping with Depression Course* (by R.A. Brown & P.M. Lewinsohn, published by Castalia Publishing Co., 1984).

DAILY TALLY OF POSITIVE AND NEGATIVE THOUGHTS

Thoughts	Number of negative thoughts	Number of positive thoughts
Day 1	_____	_____
Day 2	_____	_____
Day 3	_____	_____
Day 4	_____	_____
Day 5	_____	_____
Day 6	_____	_____
Day 7	_____	_____
Total for the week	_____	_____
Average (total divided by 7)	_____	_____
Day 8	_____	_____
Day 9	_____	_____
Day 10	_____	_____
Day 11	_____	_____
Day 12	_____	_____
Day 13	_____	_____
Day 14	_____	_____
Total for the week	_____	_____
Average (total divided by 7)	_____	_____

From *Participant Workbook for the Coping with Depression Course* (by R.A. Brown and P.M. Lewinsohn, published by Castalia Publishing Co., 1984).

WEEK 1–DAY 4

SELF-MANAGEMENT OF DEPRESSION

Instructor: Discuss previous assignments.

Almost every minute of your conscious life you are engaging in self-talk, your internal thought language. These are the sentences with which you describe and interpret the world. If the self-talk is accurate and in touch with reality, you function well. If it is irrational and untrue, then you experience stress and emotional disturbance. Albert Ellis developed a system to attack irrational ideas and replace them with realistic statements about the world. His basic thesis is that emotions are produced by self-talk. Your own thoughts, directed and con-

trolled by you, are what create anxiety, anger, and depression. The example below shows how it works.

Pass out *Ellis's Irrational Beliefs* sheet and discuss. Pass out *Daily Monitoring Event* sheet and discuss. Have adolescents complete sheet during this session. Lead discussion of how their changed statements changed emotions. Pass out and discuss *Be Your Own Best Friend Activity.*

The preceding material was adapted from *Control Your Depression* (Lewinsohn et al., 1978), *The Relaxation and Stress Reduction Workbook* (Davis, Eshelman & McKay, 1982), and unpublished materials relating to the Depression and Suicide Prevention by Teams-Games-Tournament Method (Wodarski, 1986).

Example

A. Facts and events
   A mechanic replaces a fuel pump he honestly believed was malfunctioning, but the car's performance doesn't improve. The customer is very upset and demands that he put the old fuel pump back.
B. Mechanic's self-talk
   "He's just a grouch–nothing would please him."
   "Why the heck do I get the tough jobs?"
   "I ought to have figured this out by now."
   "I'm not much of a mechanic."
C. Emotions
   Anger and resentment
   Depression

The mechanic may later say to himself, "That guy made me mad." But it is not the customer or anything that the customer has done that produces the anger–it is the mechanic's own self-talk, his interpretation of reality. This irrational self-talk can be changed, and the stressful emotions changed with it.

Ellis's Irrational Beliefs

1. **It is an absolute necessity to have love and approval from peers, family, and friends.** In fact, it is impossible to please all the people in your life. Even those who basically like and approve of you will be turned off by certain behaviors and qualities. This irrational belief is probably the single greatest cause of unhappiness.
2. **You must be unfailingly competent and almost perfect in all you undertake.** The results of believing you must behave per-

fectly are self-blame for inevitable failure, lowered self-esteem, perfectionistic standards applied to friends, and paralysis and fear at attempting anything.

3. **Certain people are evil, wicked and villainous and should be punished.** A more realistic position is that they are behaving in ways that are antisocial or inappropriate. They are perhaps stupid, ignorant, or neurotic, and it would be well if their behavior could be changed.
4. **It is horrible when people and things are not the way you would like them to be.** This might be described as the spoiled child syndrome. "Why does this happen to me? I can't take this. It's awful." Any inconvenience, problem, or failure to get your way is likely to be met with such self-statements. This result is intense irritation and stress.
5. **External events cause most human misery–people simply react as events trigger their emotions.** A logical extension of this belief is that you must control the external events to create happiness or avoid sorrow. Because such control has limitations and we are at a loss to completely manipulate the wills of others, there results a sense of helplessness and chronic anxiety. Ascribing unhappiness to events is a way of avoiding reality. Self-statements interpreting the event caused the unhappiness. Although you may have only limited control over others, you have enormous control over your emotions.
6. **You should feel fear or anxiety about anything that is unknown, uncertain or potentially dangerous.** Many describe this as, "a little bell that goes off and I think I ought to start worrying." They begin to rehearse their scenarios of catastrophe. Increasing the fear of anxiety in the face of uncertainty makes coping more difficult and adds to stress. Saving the fear response for actual perceived danger allows you to enjoy uncertainty as a novel and exciting experience.
7. **It is easier to avoid than to face life's difficulties and responsibilities.** There are many ways of ducking responsibilities: "I need to do my school work but I'd rather talk on the phone. . . . A messy room won't hurt anything." If you have used this idea, please add your standard excuses to avoid responsibility here:

Area of responsibility	**Method of avoidance**
_____	_____
_____	_____
_____	_____

8. **You need something other or stronger or greater than yourself to rely on.** This belief becomes a psychological trap in which your independent judgement and the awareness of your particular needs are undermined by a reliance on higher authority.
9. **The past has a lot to do with determining the present.** Just because you were once strongly affected by something, it does not mean that you must continue the habits you formed to cope with the original situation. Those old patterns and ways of responding are just decisions made so many times they have become nearly automatic. You can identify those old decisions and start changing them right now. You can learn from past experience, but you don't have to be overly attached to it.
10. **Happiness can be achieved by inaction, passivity and endless leisure.** This is called the Elysican Fields syndrome. There is more to happiness than perfect relaxation.

DAILY MONITORING EVENT

Date: _____

A. Activating event
(Briefly describe the situation or event that seemed to lead to your emotional upset at C).

B. Beliefs of self-talk
(List each of the things that you said to yourself about A.)
1.
2.
3.
4.
5.
(Now go back and place a checkmark beside each statement that is non-constructive or "irrational.")

C. Emotional consequences
(Describe and rate how you felt when A happened.)
I felt: _____
_____
Rating (0-mildy upset; 5-extremely upset):_____

D. Dispute of self-talk
(For each checked statement in Section B, describe what you would ask or say to dispute your non-constructive self-talk).

NOTE: You should first complete Section C. Then go back and complete Section

A and Section B. After the first week of self-monitoring, also complete Section D.

From: *Participant Workbook for the Coping with Depression* Course (by R.A. Brown & P.M. Lewinsohn, published by Castalia Publishing Co., 1984).

Be Your Own Best Friend Activity

Instruct the adolescents to take out two sheets of paper. On the top of one have them write, "I feel down when. . . ." You can also write this at the top of the blackboard. Next the students should write underneath the heading a list of sentence completions. You can show them how by writing some sample sentence completions under the heading on the board, such as, "I make mistakes," "my friends don't call", or "I don't look good." Give the students time to list five or ten items.

Next, instruct the adolescents to head the other sheet of paper "I can be my own best friend." Under this, they can respond to the sentence completion the way a best friend might, with suggestions and interpretations that show caring. You can respond to the sample items on the blackboard to give examples, as shown below:

I feel down when. . .	I can be my own best friend
I make mistakes.	It's human to make mistakes. If you hurt someone, apologize and do what you can to help. If it hurts you, for give yourself and try again. People will still love you.
My friends don't call.	You could call them. It doesn't mean they're rejecting you; they may be busy. You could call someone you'd like to get to know better. Do some thing you've been wanting to do, like take a a long walk, or browse in a bookstore.
I don't look good.	You can wear what you like: dress sloppy, funky or snazzy. Look in the mirror lovingly, don't be so critical. You could get your hair cut or buy something new to wear. Think of five things you like about your looks.

Next, have the group divide into groups of two or three and help each other think of other things to add to their lists. Near the end of the session, ask for volunteers to share some of their ideas. Discuss how this may relate to suicide prevention.

WEEK 1–DAY 5

REVIEW

Review all assignments from previous sessions. Discuss how skills learned have or have not helped adolescents' depression. Ask adolescents to share any helpful information they've learned during the week. Give them a chance to vent their discoveries about themselves. Clear up any questions they have on the preceding material. Explain the importance of continuing monitoring moods, thoughts, and goals. Explain that next week's session will focus on feelings.

WEEK 2–DAY 1

EXPRESSING FEELINGS

Instructor: Remind adolescents to begin counting positive and negative thoughts and note on index cards. Discuss any other previous assignments.

Feeling Words

Discuss the importance of expressing feelings. Stress that any feeling is OK. There is no such thing as a wrong feeling. Explain that feelings not expressed can contribute to depression. Stress the importance of identifying feelings. Pass out *Feelings Word Crossword Puzzle and the Word Find Puzzle.* Allow time to complete. Discuss afterwards.

ABC's of Feelings

Instructor: Discuss previous assignment and answer any questions from previous sessions. Ask for feedback regarding mood and thought charting.

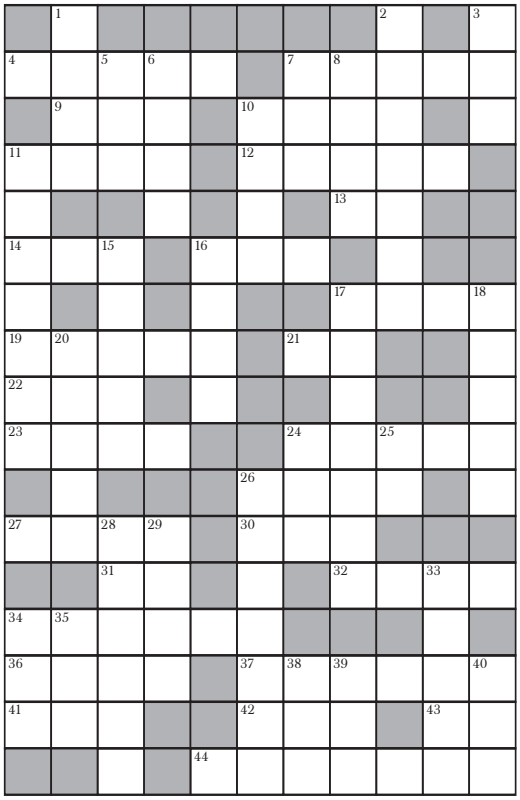
Have an adolescent give the answer to number 10 Across from the crossword puzzle. Now ask the class whether it will always be true that "when someone ignores me, I feel hurt." Are there any circumstances in which this will not be true? For example, a psychopath with a gun, a teacher in class when you're chewing gum, a policeman when you're driving too fast. How would you feel in these circumstances? Example: relieved.

Now write ACTION on the board, and CONSEQUENCES under it, leaving a space in between. Explain that action is "being ignored" and the consequence is the feeling that results. How can the same action result in different feelings? Point out that between A and C must come B. Now see if the students can guess that B stands for

BELIEF. What belief would result in a feeling of hurt; what belief would result in a feeling of relief? (use the term the students used).

See if the adolescents can find other examples from the crossword puzzle that illustrate the ABC principle. For example: 34 Across, 44 Across, 18 Down, 26 Down.

CROSSWORD PUZZLE



Across

(4) It worries me that I might _____ school.
(7) How a clown makes me feel.
(9) To take advantage of.
(10) When someone ignores me, I feel _____.
(11) This emotion makes my palms sweaty.
(12) What I feel when I want to punch something.
(13) Another word for furious is –raged.
(14) Pretend to be someone else.
(16) —' party!
(17) Seven days.
(19) _____ before you act.
(21) Negative.
(22) A few vowels.
(23) Not nervous.
(24) Basic to a good relationship
(26) It's _____ful to be ridiculed.
(27) Scratch it.
(30) Same as 9 across.
(31) _____ and behold.
(32) How a letter starts.
(34) How I feel when I say the wrong thing.
(36) _____ is where the heart is.
(37) When in pain _____ _____ to a friend.
(41) Say this to a friend in need.
(42) Put this under your bed.
(43) You're _____ cute.
(44) How I feel when someone breaks a promise.

Down

(1) How I feel when my friend moves away, also a color.
(2) The worse I perceive things to be, the more _____ my feelings are.
(3) Beauty (and much else) is in the _____ of the beholder.
(5) Our country.
(6) Revenge of the _____s.
(8) Give encouragement.
(10) Opposite of love.
(11) If my best friend disappeared, I would be _____.
(15) One way to learn: _____ and error.
(16) It's unrealistic to think everyone will _____ me.
(17) How I feel when a friend becomes depressed.
(18) When I drop things, I feel like a _____.
(20) When you care about someone, you listen with your _____.
(24) When someone cares about me, I feel fan—tic.
(25) All feelings are natural, none are unnatural.
(26) A _____ _____ makes me feel hurt.
(28) What a klutz is.
(29) Never lose this.
(33) I won't put up with this.
(34) I feel this way when I meet new people.
(35) On the end of my foot.
(38) Safety _____ or diaper.
(39) Another word for "self"
(40) Two peas in a _____.

WORD FIND PUZZLE

Y T R B E T R A Y E D N S I R D A
D A S M A Y T L I U G Y O I O E S
E P I O C D H D X F G I G N N T L
L H L T C I A J F U P R S A T I D
I P L E A S E D T L D W I D U C Y
V N Y N R M N E I F A B U E S X D
I P S S T A A D M I R E G Q V E X
D E S E H L N E I L T E H U M E A
D E J S C Y E A D L E T R A Y L D
Y S A E N U X G D E J E C T E D W
H S U S S O R C Q D P A C E Y N U
D I L E C B S E T H G I T P U R N

Find these words. Be sure you can define and use them.

Pleased	Timid	Silly
Fulfilled	Insecure	Guilty
Dejected	Uneasy	Sad
Dismal	Betrayed	Excited
Inadequate	Uptight	Shy
Tense	Grieved	Livid

Answers to crossword puzzle:

	1 B							2 I		3 E
4 F	L	5 U	6 N	K		7 F	8 U	N	N	Y
	9 U	S	E		10 H	U	R	T		E
11 F	E	A	R		12 A	N	G	E	R	
R			D		T		13 E	N		
14 A	C	15 T		16 L	E	T		S		
N		R		I			17 W	E	E	18 K
19 T	20 H	I	N	K		21 N	O			L
22 I	E	A		E			R			U
23 C	A	L	M			24 T	R	25 U	S	T
	R				26 P	A	I	N		Z
27 I	T	28 C	29 H		30 U	S	E			
		31 L	O		T		32 D	E	33 A	R
34 S	35 T	U	P	I	D				B	
36 H	O	M	E		37 O	38 P	39 E	N	U	40 P
41 Y	E	S			42 W	I	G		43 S	O
		Y		44 A	N	N	O	Y	E	D

Answers to word find puzzle:

Y	T	R	B	E	T	R	A	Y	E	D	N	S	I	R	D	A
D	A	S	M	A	Y	T	L	I	U	G	Y	O	I	O	E	S
E	P	I	O	C	D	H	D	X	F	G	I	G	N	N	T	L
L	H	L	T	C	I	A	J	F	U	P	R	S	A	T	I	D
I	P	L	E	A	S	E	D	T	L	D	W	I	D	U	C	Y
V	N	Y	N	R	M	N	E	I	F	A	B	U	E	S	X	D
I	P	S	S	T	A	A	D	M	I	R	E	G	Q	V	E	X
D	E	S	E	H	L	N	E	I	L	T	E	H	U	M	E	A
D	E	J	S	C	Y	E	A	D	L	E	T	R	A	Y	L	D
Y	S	A	E	N	U	X	G	D	E	J	E	C	T	E	D	W
H	S	U	S	S	O	R	C	Q	D	P	A	C	E	Y	N	U
D	I	L	E	C	B	S	E	T	H	G	I	T	P	U	R	N

WEEK 2–DAY 2

SELF-STATEMENTS

ABC Scenarios

See if the group remembers what A, B, and C stand for (Action, Belief, Consequences) and what the ABC principle is. Ask the class whether they think all of our beliefs are conscious ones. What are certain examples of unconscious beliefs? How do we know they exist? (Example: a person who keeps trying to get something right may believe "I am capable," whereas a person who gives up easily may believe "I am too dumb to figure things out.")

Explain to the group that these kinds of beliefs are called self-statements. They may be conscious or partly conscious, but often we are not even aware of them because they come from early childhood. Whether they are conscious or unconscious, they affect our behavior every day in ways we don't realize. Break the group into small groups and distribute the *ABC Scenarios*. The groups should discuss each Action, then decide on two different Consequences, based on the positive and negative self-statements (Beliefs) provided. Explain that the different outcomes should not be based on luck or magic but should result from the self-statements. These are assumed to be unconscious.

When the groups have completed the stories, conduct a discussion, having the groups present and compare their versions. Would it make any difference if the self-statements were conscious? If the characters became conscious of their negative self-statements, could they change them? How?

Feelings and Self-Statements

Review the connection between self-statements and feelings. Give out F*eelings and Self-Statement Worksheet*. Have adolescents complete in session time. Give each member a turn to share his/her answer with the group. Discuss.

ABC SCENARIOS

(1) A. Joe has failed an exam. After class a bunch of friends come up to him in the hallway saying, "What'd you get?"

B. Joe's negative self-statement: I can't forgive myself if I fail.

or

Joe's positive self-statement: It's OK to fail sometimes.

C. Now finish the story both ways.

(2) A. On the way to the movies with certain friends, Kate runs into some older kids she knows. They offer her a joint and her friends seem to think it would be neat to try some. Kate really doesn't want to.

B. Kate's negative self-statement: If I don't conform, others will reject me.

or

Kate's positive self-statement: It's OK to be myself.

C. finish the story both ways.

(3) A. Kim and Lenny are on their first date. Kim says, "My favorite singer is Eminem." Her date says, "Ugh. I can't stand him."

B. Kim's negative self-statement: If people disagree with me, that means they dislike me.

or

Kim's positive self-statement: People can disagree with me and still like me.

C. Now finish the story both ways.

(4) A. Karen calls Bob and says, "We're playing Trivial Pursuit, and Tom needs a partner. Come on over." Bob says, "Well, I don't know." He really doesn't want to go. Karen says, "Oh, c'mon. Don't ruin our fun."

B. Bob's negative self-statement: I feel guilty if I upset anybody.

or

Bob's positive self-statement: It's OK to say no to requests.

C. Now finish the story both ways.

(5) A. Robby has had a rough time. His parents abandoned him as a baby, and he has lived in three different foster homes. Now he is going to live with yet another family.

B. Robby's negative self-statement: I am not worth living.

or

Robby's positive self-statement: I am worth living.

C. Now finish the story both ways.

FEELINGS AND SELF-STATEMENT WORKSHEET

1. True-False: Certain feelings are unnatural.
2. Why might different people react differently to the same event?
3. True-False: Thinking it through can change our feelings about some things.
4. Define and use in a sentence:
   Dejected: Fulfilled: Insecure:

5. Will the same event always bring the same feelings? If not, why not?
6. Can you think of a situation where a gift of $10 would not make you happy?
7. Unscramble this word: Lesf-mattenset
8. Certain of our beliefs are conscious; some are _____.
9. What does ABC stand for in this class?
10. What is the source of our self-statements?
11. Give two examples of negative self-statements.
12. Give two examples of positive self-statements.
13. Helen's self-statement is "I must please everybody." How might she respond if a neighbor asked her to babysit for free?
14. Jane's self-statement is "I can do it if I try." How might she respond to setbacks?
15. Ken is very bright, but gets C's and D's in school. He usually stands on the sidelines at school dances. What might his self-statement be?
16. Describe a person whose self-statement is "Nothing I do ever turns out right."
17. Can self-statements be changed? How?
18. When bad things happen, I can be my own _____.
19. Name three things you could do to make yourself feel better when you get a bad grade on an important test.
20. Name three things you could do to be your own best friend if your steady split up with you.
21. What could you say to yourself to make yourself feel better if your friend didn't invite you to a party?
22. List five things a person who is considering suicide might say to him/herself to get back on track.

ANSWERS TO FEELINGS AND SELF-STATEMENTS WORKSHEET

1. False
2. They have different beliefs.
3. True
4. Examples:
   - dejected: sad, depressed, down
   - fulfilled: satisfied, content
   - insecure: unsafe, vulnerable, apprehensive
5. No, it depends on our beliefs
6. Examples: when strings are attached, when the money was stolen, when you were expecting $50

7. Self-statement
8. Unconscious
9. Action, Belief, Consequences
10. Things that happened in the past
11. Various answers
12. Various answers
13. She would probably agree
14. She would probably keep trying
15. Examples: "I'm not worth much," "I don't expect good things to happen to me," "Other people can do things I can't."
16. Examples: This person doesn't try hard, gives up easily, expects bad things to happen
17. Yes: become aware of them, identify how they hurt you
18. Best friend
19. Examples: remind yourself of past successes, tell yourself everyone messes up sometimes, plan to study for the next test, take a hot bath
20. Examples: spend time with a friend, plan a day of mourning to get over it, write a loving letter to yourself about what you learned from the relationship, plan an activity you've been wanting to do.
21. Examples: "I can plan my own party," "I have other friends," "I can make new friends"
22. Examples: "Time will pass," "I might feel differently tomorrow," "Maybe there is another solution," "I want to go to college and get married someday," "I don't want to hurt my grandparents."

WEEK 2–DAY 3

"I" MESSAGES VS. "YOU" MESSAGES

Write on the board, "You're never on time." This is a "you" message. Ask the group how a person might respond to this message. Now write, "I feel aggravated when you're late, because I have other things I could be doing." This is an "I" message. Ask the class how a person might respond to this message. Is there a difference between the likely responses to the two messages? What would account for this?

There are three parts to an "I" message. See if the class can identify them from the sample given.

1. The first part is an expression of a feeling. It should be stated as "I feel (an emotion)" or "I'm feeling (an emotion)," not "I feel that. . . ."
2. The second part states what action of the other person caused, is causing, or will cause you harm or will help you.
3. The third part states how you were harmed/helped, are being harmed/helped, or will be harmed/helped in some way. If you can't show any real damage from the behavior, then perhaps you need to reexamine your anger and what the other person's behavior really means to you.

Write a few other "you" messages on the board and ask for volunteers to change them to "I" messages. You could have different adolescents offer the three parts, then have others role play the parts, both the negative "you" messages and the positive "I" messages.

Sample "you" message: You always make a joke of everything. You never buy me any new clothes. You just can't keep a secret, can you big mouth? You left the car a mess again.

The "I" Message Book

Pass out copies of the *"I" Message Book* and have the students cut, fold, and staple the books together. After the students have assembled the books, go back to the sample "you" message on the board and see if the students can further improve the alternative "I" messages.

Results of "I" and "You" Messages

Break the group into small groups. Have them identify and list five or six negative "you" messages that would probably result in aggressive or defensive responses from others. Now have each group pass their list to the next group. The groups can use their "I" Message Book to formulate more positive messages that would foster cooperation rather than conflict. Each group can then present their sets of messages to the class. Adolescents may want to role play some of their situations. This may help to illustrate why "you" messages and "I" messages bring different results.

The "I" Message Book (sample)

The "I" Message Book

The 3 parts of "I" messages:

1. I feel _____.
(an emotion)

2. when you _____.
(action of others)

3. because _____.
(how action affects you)

1

Words for expressing ANGER

annoyed	teed off
put out	bugged
upset with	pissed off
irritated	resentful
burned	furious

Words for expressing HURT

taken for granted	let down
unappreciated	put down
neglected	used
mistreated	betrayed
criticized	crushed
wounded	

2

Words for expressing CONFUSION

uneasy	uncomfortable
bothered	unsure
uncertain	disturbed
frustrated	lost
troubled	mixed-up
puzzled	ambivalent

Words for expressing ANXIETY

insecure	self-conscious
worried	uncomfortable
shy	awkward
shaky	nervous
tense	uptight
defensive	scared
afraid	desperate

3

DIRECTIONS:
1. Cut along solid lines so that you have eight pages.
2. Put pages in order and staple along left edge.
3. Write any additonal feeling words you can think of on the backs of the printed pages.

Words for expressing INADEQUACY uncertain — unimportant small — incapable clumsy — stupid inferior — like a failure helpless — worthless Words for expressing DEPRESSION sad — down low — unhappy lousy — gloomy hopeless — awful rotten — miserable 4	Words for expressing GUILT blew it — goofed at fault — wrong silly — ridiculous foolish — ashamed horrible — humiliated unforgiving — sick at heart Words for expressing LONELINESS excluded — left out shut out — alone rejected — alienated cut off — isolated 5
Words for expressing STRENGTH can cope — up to it important — in control successful — capable able — effective committed — inspired determined — confident Words for expressing HAPPINESS calm — fulfilled satisfied — good wonderful — super enthusiastic — excited terrific — fantastic 6	Words for expressing LOVE accept — like friendly — value trust — concern for admire — respect fond of — affection for devoted to — cherish 7

WEEK 2–DAY 4

ASSESSMENT OF ADOLESCENTS' PRIOR LEARNING

Feelings Worksheet

Instructor: Pass out *Feelings Worksheet*. Allow time for completion. Discuss. Allow time for adolescents to vent how they feel learning new skills may affect their depression.

Note: This worksheet is printed so that it may be used in a game card format

FEELINGS AND COGNITIONS WORKSHEET

T or F? Different people will react the same way to the same event. 1	T or F? Our feelings cannot be changed by anything we do. 2
Name one cirumstance when you would not feel annoyed by someone breaking a promise. 3	What does the B stand for in the ABC principle? 4
Another term for Action is _____. 5	T or F? A consequence of an action may be the feeling that results. 6
T or F? Some beliefs are unconscious. 7	Another name for an unconscious belief is a _____-_____. 8
T or F? Our self-statements can never be changed. 9	The first step in changing a self-statement is to become _____ of it. 10
Name one way our negative self-statements can hurt us. 11	John never tries very hard at anything. What might his self-statement be? 12

Betty's self-statement is "If I get involved, I'll be hurt." How might she respond to new people? 13	Tony is always picking fights. What might his self-statement be? 14
Give an example of a negative self-statement that could keep you from succeeding. 15	Give an example of a positive self-statement that could enable you to be popular. 16
Where do our negative self-statements come from? 17	When I feel down, I can be my _____ _____ _____. 18
Name one thing you could do to be your own best friend when you have a chore you don't want to do. 19	Name two things you could do to make yourself feel better if someone close to you died. 20
Name one thing you could say to yourself to be your own best friend if your parents said they were getting a divorce. 21	Being your own best friend means being _____ to yourself. 22
Identify the following feeling word: b – t – a – ed. 23	Identify the following feeling word: in - d - q -– te. 24
Identify the following feeling word: u - t - ght. 25	Define the following feeling word: livid. 26
Define the following feeling word: insecure. 27	

Anger Questionnaire

Break the class into pairs. Distribute copies of the *Anger Questionnaire*. Tell the students not to write their names on their papers. The pairs of students should discuss the question and agree on an answer between them. Tabulate the results on the blackboard and provide the correct answers.

Encourage class discussion when giving the answers, introducing into the discussion the explanations given below.

ANGER QUESTIONNAIRE

True or False?

_____ 1. If you feel anger you are out of control.
_____ 2. If you don't express your anger, you might get sick.
_____ 3. Almost all suicidal people have trouble expressing anger.
_____ 4. Expressing anger to a friend will probably ruin the friendship.
_____ 5. If someone is angry with me, it means he or she is right and I am wrong.
_____ 6. A good way to handle anger is to count to ten.
_____ 7. Anger has positive functions as well as negative ones.
_____ 8. Usually there is a different emotion under the anger we express.
_____ 9. When we are angry with others, we are demanding something of them.
_____ 10. Anger is not reasonable, therefore we can't really learn to overcome it through more knowledge.
_____ 11. When someone is angry with me and expresses it, the best thing to do is withdraw or counteract.
_____ 12. If someone criticizes me, it's often a good idea to agree with the criticism.
_____ 13. In conflict resolution, each person should state the other person's position, as well as his or her own.
_____ 14. Problem-solving doesn't work in resolving conflicts because when people are angry they can't think straight.

ANSWERS TO ANGER QUESTIONNAIRE, WITH EXPLANATIONS:

1. False. Anger is a natural emotion. Just because you feel anger doesn't mean you will be destructive.

2. True. Certain people bottle their anger up inside, afraid that they will explode and hurt someone if they let it out, but the greater danger is that the anger building up inside will result in headaches, back pains, insomnia, ulcers, heart problems, and other physical illnesses.
3. True. Ask the class why this might be so.
4. False. Holding your feelings in will put distance between you and your friend. Relationships grow through honest expression of feelings. See if the class can give any examples of cases illustrating this.
5. False. This is a negative self-statement certain people have, but it is not true, any more than it is true that the person who is angriest is the one who is right.
6. False. Counting to ten may result in an explosive outburst, like counting down to "blast-off." See if the class can think of any better ways to handle anger.
7. True. See if the class can think of any. Examples: it can be an effective reaction to stress, you can let off steam, you can get your point across.
8. True. Ask the class for some examples (embarrassment, frustration, disappointment, confusion, etc.).
9. True. Ask the students for examples of demands that underline anger. Examples: I demand an apology, I demand appreciation, I demand attention.
10. False. We can learn skills to help us analyze and express anger. Ask the class for examples. Here are certain ones:
    Learn to recognize the underlying emotions that came before the anger, and express these instead.
    Learn to recognize what demands you are making of others, then decide whether you really want to make that demand in that way, or whether it would be better to express your underlying feelings.
    Learn to use "I" messages instead of "you" messages.
11. False. These are the usual responses, but not the best. See if the students can think of any better ways. One good response is to ask questions so you can understand the other person's message. Ask for specifics, the who, how, what, when, and where of the situation, then you can decide if the person's anger is reasonable.
12. True. In almost all situations, it's possible to accept the other person's point of view without giving up your own. See if the students can give examples (Yes, I *am* late. Yes, I guess I did embarrass you. Yes, you're right, I am driving too fast.)

13. True. Ask the students why this is important.
14. False. It's usually a good idea to use problem-solving to resolve conflicts. Each person can offer suggested solutions, then they can discuss the pros and cons together before choosing a tentative solution that both persons believe they can live with.

For the remainder of the class, students in small groups can discuss or role play conflict situations, identifying underlying emotions and demands and considering ways to respond. You can write some sample scenarios on the board or let the students formulate their own.

Sample scenarios

Mother to teenager: "Look at this mess! You're always leaving the kitchen a mess."

Sister to teenager: "You've been on the phone for an hour! Don't I have any rights around here?"

Date to teenager: "I can't believe you embarrassed me like that! Coming on to my best friend in front of everyone!"

WEEK 2–DAY 5

ASSESSMENT

Instructor: Pass out the *Anger Worksheet.* Go over questions and answers orally. Give out *Anger Quiz.* Allow time for adolescents to complete. Discuss answers.

Materials for Week 2 were adapted from Wodarski's (1986) *Depression and Suicide Prevention by the Teams-Games-Tournament Method.*

ANGER WORKSHEET

Dealing with Anger and Conflict

1. True/False: All emotions are natural, including anger.
2. Give some examples of physical problems that can result from holding anger inside.
3. How can holding your anger in mess up a friendship?
4. Is counting to ten a good way to handle anger? Why or why not?
5. Name some emotions that often underlie angry feelings.
6. How can we recognize anger in ourselves?
7. When someone is angry with you, what should you do?

8. Identify an underlying emotion and underlying demand in the following scenario: Father to teenager: "Look at these grades! You'll never get into college this way."
9. True/False: You should never agree with a criticism someone makes about you.
10. True/False: Usually the person who is angriest is the one who's right.
11. True/False: A good way to resolve conflicts is to use problem-solving.
12. True/False: Some people are just born with a bad temper and can't learn to control their anger.
13. Name the three parts of an "I" message.
14. Change this into an "I" message: "You have the worst manners I've ever seen. You're always butting in."
15. True/False: An "I" message should tell how the other person's behavior harms or helps you.
16. Why are "I" messages better to use than "you" messages?
17. Change this into an "I" message: "Why don't you watch where you're going!"
18. Name three adjectives you could use to express feelings of inadequacy.
19. Name three adjectives you could use to express caring feelings.
20. True/False: "I" messages work better with your peers than with your family.
21. Compose an "I" message to tell how you feel about tomorrow's tournament.

ANSWERS TO ANGER WORKSHEET

1. True
2. Examples: headaches, back pains, insomnia, ulcers, heart problems.
3. Examples: it isn't honest, doesn't promote trust and closeness, puts distance between you, relationships need honest expression of feelings to grow.
4. No. It may end with a "blast-off" outburst.
5. Examples: embarrassment, frustration, disappointment, confusion.
6. Examples: heart beats faster, muscles tense, breathing quickens.
7. Examples: ask questions to get the facts, try to understand the underlying feelings and demands.

8. Underlying emotion: disappointment, shame, let down, etc. Underlying demand: be successful, make me proud of you, don't reflect poorly on me.
9. False
10. False
11. True
12. False
13. A) I feel (an emotion)
    B) when you (action of others)
    C) because (how action affects you)
14. Examples: I feel bugged when you interrupt because I don't get to finish what I started to say.
15. True
16. "You" messages bring defensive reactions; "I" messages are more likely to bring cooperation.
17. Example: I feel irritated when you don't watch where you're going, because we might have an accident.
18. Examples: clumsy, incapable, stupid, worthless.
19. Examples: like, value, respect, admire, fond of, cherish.
20. False
21. Example: I feel excited when tournament day is near because it's fun to play.

ANGER QUIZ

1. True/False: Anger is a natural emotion.
2. A person who holds anger in may get _____.
3. True/False: Most suicidal people express anger easily.
4. True/False: The angrier a person is, the more likely that person is right.
5. What negative outcome can result from counting to ten to handle anger?
6. Name one positive function of anger.
7. Name the underlying demand in the following exchange: I've had it! You're late again!
8. True/False: When someone is angry with you, it's a good idea to ask questions.
9. True/False: You shouldn't agree with a criticism unless you are ready to change your position.
10. In conflict resolution, each person should state his or her own position and also that of _____.

11. Give three examples of other emotions that underlie anger.
12. True/False: If you feel anger, the best thing to do is hold it in so you don't hurt anyone.
13. Name one good way to respond if a friend says to you, "You embarrassed me."
14. When you feel angry, what should you do?
15. True/False: Problem solving is not appropriate when people are feeling very angry.
16. True/False: Expressing anger to a friend may make you closer.
17. True/False: Anger is a demand.
18. Name three parts of an "I" message.
19. Change this into an "I" message: "You left my bike out in the rain, you brat."
20. Why might "I" message get better results than "you" messages?
21. Why might it be difficult to make good "I" messages out of these: "You watch too much TV" or "You look awful in that shirt."
22. Name one positive emotion you can express using "I" messages.
23. Give two examples of words that express hurt.
24. One good way to express your anger is to use an "___" "_____."
25. Change this into an "I" message: "You never call me anymore."
26. True/False: It's OK to use an "I" message even if you can't say how someone's behavior hurts you.
27. Name one way we can recognize anger in ourselves.
28. What's wrong with this "I" message: "I feel annoyed when you don't answer me because it's irritating."

ANSWERS TO ANGER QUIZ

1. True
2. Sick
3. False
4. False
5. The "blast-off" outburst
6. Examples: let off steam, let people know you are upset, release stress so you don't get sick.
7. Examples: I demand consideration, I demand attention.
8. True
9. False
10. The other person
11. Examples: embarrassment, shame, frustration, confusion, disap-

pointment.
12. False
13. Examples: ask how you embarrassed him or her, get the details to see if the complaint is reasonable.
14. Example: take time to cool off, think about what you should do, then do it.
15. False
16. True
17. True
18. A) I feel (an emotion)
    B) when you (action of other)
    C) because (how action affects you)
19. Example: I feel ticked off when you leave my bike out in the rain because it gets rusty and I can't ride it.
20. They are less likely to put others on the defensive.
21. Difficult to show how these actions hurt you.
22. Examples: love, caring, happiness, strength.
23. Examples: used, betrayed, let down, unappreciated.
24. "I" message.
25. Example: I feel neglected when you don't call, because we're supposed to be going steady, but it seems you don't think about me often.
26. False
27. Examples: heart beats faster, muscles tense up, breathing quickens
28. Doesn't tell how the action hurt you.

WEEK 3–DAY 1

PROGRAM TO INCREASE PLEASANT EVENTS AND REDUCE NEGATIVE EVENTS

The purpose of this session is to allow you to observe for yourself the degree to which your daily mood is related to your daily activities and to assist you in setting a goal and in pinpointing specific pleasant activities to be increased

Instructor: Pass out Pleasant Events Inventory. *Have adolescents circle the numbers beside the events they find to be pleasant. Have them add other activities they find pleasant. Lead discussion of how these events make adolescents feel.*

The preceding material was adapted from *Cognitive Behavioral Therapy Manual* (Coats & Reynolds, 1982).

PLEASANT EVENTS INVENTORY

Name:_____ Date:_____

Positive activity (circle the numbers):

1. Meeting someone new of the same sex.
2. Playing baseball or softball
3. Buying things for myself
4. Going to a sport event
5. Pleasing my parents
6. Watching TV
7. Laughing
8. Solving a problem, crossword puzzle
9. Thinking about myself or my problems
10. Going to a party
11. Being with friends
12. Wearing new clothes
13. Dancing
14. Dating, courting, etc.
15. Playing in a sporting competition
16. Going on outings (picnic, to a park)
17. Helping someone.
18. Meeting someone of the opposite sex.
19. Going to a "drive-in"
20. Talking on the telephone
21. Having daydreams
22. Kissing
23. Doing a project in my own way
24. Giving a party
25. Going to a restaurant
26. Visiting friends
27. Talking with people in class
28. Being relaxed
29. Reading the newspaper
30. Running, jogging, exercising
31. Listening to music
32. Talking about sex
33. Reading magazines
34. Shopping
35. Bicycling

Other Activities

_____

_____

_____

_____

Instructor: Pass out Activity Schedule. Have students fill out their activities for the day and rate as positive by putting a "+" and negative with a "-". Then pass out Social Activities to Increase and Decrease Sheet *and explain that they are to list events from the Activity Schedule on the appropriate sheets. Then pass out* Weekly Plan Sheet *and have adolescents fill in goal for next week. Also give adolescents* the Chart for Recording Daily Pleasant Activities and Mood Scores. *Ask them to fill this in every day so they can monitor the relationship between the number of pleasant activities they experience and their mood.*

The above material was adapted from the *Participant Workbook for the Coping with Depression Course*, 271–273 (Brown & Lewinsohn, 1984).

ACTIVITY SCHEDULE

Activity	Day																													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
1.																														
2.																														
3.																														
4.																														
5.																														
6.																														
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16.																														
17.																														
18.																														

From *Participant Workbook for Coping with Depression Course* (by R.A. Brown and P.M. Lewinson, published by Castalia Publishing Co. (1984).

SOCIAL ACTIVITIES TO INCREASE LOG

Month:_____

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20.							
Daily totals:							

Goal for increasing: _____ per _____.
Average increase achieved: _____ per _____.

From: *Participant Workbook for the Coping with Depression Course* (by R.A. Brown and P.M. Lewinsohn, published by Castalia Publishing Co. 1984).

INTERFERENCES: ACTIVITIES TO DECREASE LOG

Month:_____

Item Date:							
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							
Daily totals:							

Goal for increasing: _____ per _____.
Average increase achieved: _____ per _____.

From: *Participant Workbook for the Coping with Depression Course* (by R.A. Brown and P.M. Lewinsohn, published by Castalia Publishing Co. 1984).

WEEKLY PLAN

Date:							
Time:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8:00							
9:00							
10:00							
11:00							
12:00							
1:00							
2:00							
3:00							
4:00							
5:00							
6:00							
7:00							
8:00							
9:00							
10:00							

Contract for Increasing Pleasant Activities

My goal for the next week is to bring my total pleasant activity count for that period up to_____. This means that I will try to engage in _____ pleasant activities each day. I will also try to keep my pleasant activities level from falling below _____ on any given day.

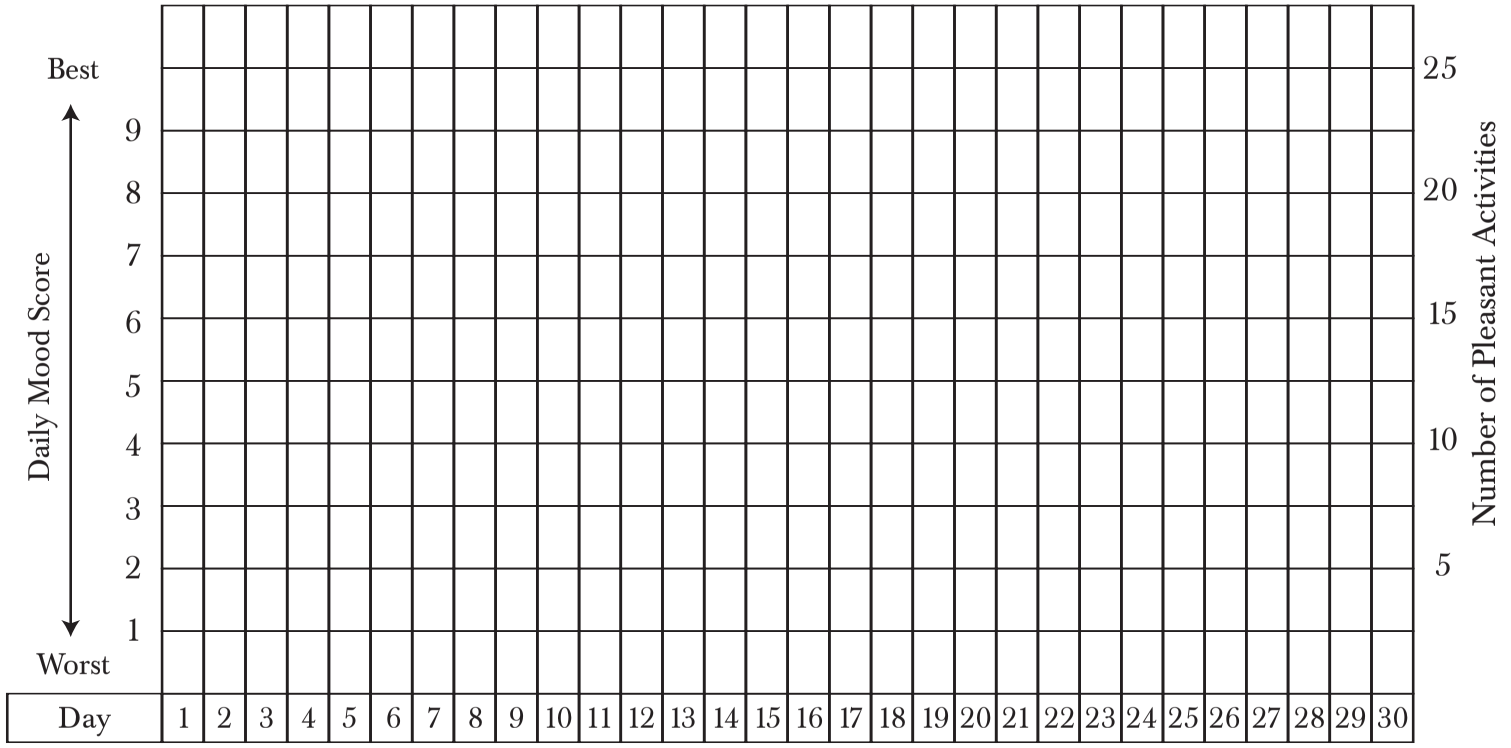
If my daily total is _____, I will reward myself by _____.

If my total for the week is _____, I will reward myself by _____.

Signed_____ Dated_____.

From *Participant Workbook for Coping with Depression Course* (by R.A. Brown and P.M. Lewinson, published by Castalia Publishing Co. (1984).

CHART FOR RECORDING DAILY PLEASANT ACTIVITIES AND MOOD SCORES



From *Participant Workbook for Coping with Depression Course* (by R.A. Brown and P.M. Lewinson, published by Castalia Publishing Co. (1984).

WEEK 3–DAY 2

SUICIDE MYTHS AND FACTS

Suicide needs to be demythologized and deromanticized by discussing it in the same way other sensitive issues are discussed. Emphasizing understanding rather than avoidance can teach self-defense against suicidal ideation and can alert adolescents to suicidal behavior in their peers. Information on the causes, symptoms, and alternatives to suicide are first presented to the adolescents in the form of group competition on the *Suicide Questionnaire.*

Myths and Facts

Break the group into pairs. Distribute copies of the Suicide Questionnaire. Tell the adolescents not to write their names on their papers. Tabulate the results on the blackboard and provide the correct answers.

Encourage group discussion, paying particular attention to those questions that were answered incorrectly by some of the members. Incorporate into the discussion the explanations given below and encourage the adolescents to fully express their opinions. Explore with the group why misconceptions about suicide are so prevalent. See if the group can identify any additional misconceptions the public may have about suicide.

SUICIDE QUESTIONNAIRE

Myth or Fact?

1. _____ People who talk about suicide seldom do it.
2. _____ A person who has attempted suicide once and failed will eventually succeed.
3. _____ Usually, a clear warning signal is given before a suicide attempt.
4. _____ Most adolescents who think about suicide have some form of mental illness.
5. _____ You should not ask a person directly if he or she is thinking about suicide because this might put the idea in his or her mind.
6. _____ Suicide is the third most common cause of death among adolescents.

7. _____ An adolescent who admits to thinking about committing suicide will most likely be placed in a mental hospital.
8. _____ Adolescents who are considering suicide are more likely to confide in a friend than in a parent, teacher, school counselor, or minister.
9. _____ If a friend expresses suicidal inclinations but does not wish to seek professional help, that wish should be respected.
10. _____ Most adolescents who attempt suicide are responding to a specific crisis rather than to an ongoing life situation.

ANSWERS TO SICIDE QUESTIONNAIRE, WITH EXPLANATIONS

1. Myth. Those who talk about suicide are at risk. Ask the class why this might be so.
2. Myth. Only 1% of all survivors of suicide attempts kill themselves within one year; only 10% within ten years. This indicates that suicidal crisis is temporary, whereas suicide is irreversible. Mention cases of teens whose attempts were "unsuccessful" who are glad to be alive now.
3. Fact. Most suicidal adolescents give some kind of warning to a friend, peer, or teacher. He or she may say such things as, "My folks would be better off without me," or "Nothing will matter anyway after tomorrow." Ask the class in what other ways a suicidal state might be indicated (such as radical changes in appetite, moods, grades, etc).
4. Myth. Most suicidal adolescents are normal teens trying to cope with a perilous part of life's journey. Ask the students what factors make adolescence so difficult. Studies show that depression is not at all uncommon among adolescents, being reported second only to colds, sore throats, and coughs in frequency. Approximately one-third of teens reported moderate to severe depression levels. There is no reliable way to predict which adolescents will attempt suicide.
5. Myth. The cardinal rule of suicide prevention is DO SOMETHING NOW, and the first thing to do is get the person talking about his or her problems and plans. Start by asking if something is bothering him or her, then empathize and ask outright "Have you been thinking of killing yourself?" It is important not to phrase this in a judgmental way: "You're not thinking of killing yourself, are you?" because this approach will most likely bring a

denial. Have the group discuss why teens who have just one person who will really listen can usually work out their problems.

6. Fact. Accidents and homicides are officially first and second. Most researchers, however, believe suicide is actually the number one killer of young people, since many deaths attributed to other causes are probably suicides. Have the students generate possible examples.
7. Myth. Adolescents commonly fear that if they seek help they will lose control over their lives, that they will be "locked up" or given a psychiatric record which could haunt them ever after. The best way to allay these fears is to provide detailed descriptions of the resources available to adolescents. There are hundreds of suicide prevention resources in the U.S. Almost all of these offer, at the minimum, a 24-hour-a-day, 7-day-a-week telephone hotline manned by specially trained personnel. Find out what services are available in your locality and report fully to your students on the procedures.
8. Fact. In one study of high school students, "friend" was the first choice in 91% of the responses. Yet adolescents are woefully inadequate as rescuers. In many cases of teen suicide, a friend knew of the intent but did not know what to do about it and refused to betray a confidence by seeking assistance. Ask the students what factors make this such a difficult problem.
9. Myth. All suicide threats should be taken seriously. Keeping the secret may mean losing the friend. Ask the class what a true friend would do.
10. Myth. The crisis that precedes the suicide attempt is typically not very different from the long term problem situation. This text focuses on skills that can help all teens cope with the stresses of everyday life.

WEEK 3–DAY 3

THE MEDIA AND SUICIDE

Pass out copies of the newspaper reprint "Suicide in the News." Have the group discuss whether the parents should win the suit. Why or why not? Should such lyrics be banned? What about books that give instructions on how to commit suicide?

Every time the newspaper reports on the suicide of a famous person, the suicide rate goes up. Should newspapers stop reporting such suicides, or report them less prominently?

Response to Suicidal Peers

Pass out *Responses to Suicidal Peers* sheets and *Answers to the Response to Suicidal Peers* sheet. The adolescents take turns deciding whether the printed response would be a good or poor response to make to a troubled peer. When all the members have participated, conduct a class discussion around the activity.

Note: The responses are printed to use in a game card format.

The above material was adapted from Wodarski's (1986) *Depression and Suicide Prevention by the Teams-Games-Tournament Method.*

SUICIDE IN THE NEWS

Suit: Rock Lyrics Pushed Teen to Suicide

*United Press International**

Los Angeles–A teenage fan of rock star Ozzy Osbourne shot himself to death with his father's gun after listening to a "death lullaby" of heavy-metal music, and his parents say the lyrics pushed him over the edge.

Osbourne was named Monday in court papers amending a lawsuit originally filed in October claiming that the lyrics to his songs "Suicide Solution" and "Paranoid" helped push John McCollum, 19, over the brink and kill himself.

The Superior Court suit claims McCollum shot himself with his father's .22-caliber pistol in October 1984 after listening to Osbourne albums for several hours. He was still wearing stereo headphones when his body was found.

The lyrics in "Suicide Solution" include: "Breaking laws, knocking doors, but there's no one at home. Make your bed, rest your head, but you lie there and moan. Where to hide, suicide is the only way out. Don't you know what it's really all about."

The suit was amended Monday to include these words of "Paranoid": "Think I'll lose my mind, if I don't find something to gratify, can you help me? Oh, won't you blow my brains, Oh yeah!, and so as you hear these words, that in you now, if I state, I tell you to end your life I wish I could mine, it's too late."

Attorney Thomas Anderson said the suit, which also names CBS records, relies on a California law prohibiting assistance or encouragement of suicide. He said he means to "teach record companies a lesson" by forcing them to take responsibility for lyrics that encourage

suicide. (Copyright 1986 by *United Press International*, 278-281. Reprinted by permission.)

RESPONSES TO SUICIDAL PEERS

I think I know how you feel. Would you like to talk about it? (a)	I don't believe you'd really do it. (b)
You're not thinking of killing yourself, are you? (c)	Have a drink, it'll make you feel better. (d)
What if you fail and end up brain damaged or paralyzed? (e)	How would you carry it out? (f)
Suicide is immoral. (g)	Suicide is selfish. (h)
You're being ridiculous. (i)	Everything will be all right tomorrow. (j)
Have you been thinking about killing yourself? (k)	Suicide is irreversible. (l)
I know someone who tried to commit suicide and failed– now she is glad to be alive (m)	It's just a phase you're going through. (n)
Many teens who have been equally or more depressed have gotten through it. (o)	Well, if that's what you want to do, it's your business. (p)
Cheer up, it can't be that bad. (q)	You're not alone. A lot of teenagers think about suicide at times. (r)
I would feel awful if something happened to you. (s)	

ANSWERS TO THE RESPONSE TO SUICIDAL PEERS SHEET

(A) Good. This response could get the person talking.
(B) Poor. This comes across as a challenge.
(C) Poor. This response tends to bring denial.
(D) Poor. Drinking increases impulsive behavior. Almost half of the adolescents who commit suicide are drunk or high shortly before death.
(E) Good. This is a real risk that suicidal persons need to consider.
(F) Good. This response could lead the person to a consideration of the pain involved.
(G) Poor. Laying on guilt will just make the person feel worse.
(H) Poor. The person feels bad enough already.
(I) Poor. Why don't you give the person a gun while you're at it?
(J) Poor. Glossing over the person's difficulties just belittles the problem.
(K) Good. This is a good way to let the person know you are concerned and want to help.
(L) Good. Some teenagers (and adults too) imagine they are really immortal and will be able to watch people suffer at their funeral.
(M) Good. Sometimes it is hard to believe that serious problems will ever be resolved. Telling about cases where they could help the person in finding other alternatives.
(N) Poor. This belittles the problem.
(O) Good. Talking about such cases can help the person put his or her problems in some perspective.
(P) Poor. This response says, "I don't care."
(Q) Poor. This response belittles the problem.
(R) Good. Let the person know it is not abnormal to think about it at times.
(S) Good. This says, "I care."

WEEK 3–DAY 4

COPING WITH SUICIDAL BEHAVIORS

"Dear Abby" Format Letters

Have each group member write a response to one of the *"Dear Abby" format letters.* Then break the group into small groups. The members of

each group should have worked on the same letter. Instruct each group to read all the responses of their members. Discuss the best response (probably a combination of several of the individual responses) and write down this new, improved response. Have each group present its response to the rest of the adolescents and tell why they think their response is a good one. See whether the others agree that the response would help the person who wrote it. Are there other ways of responding that might be more helpful?

Suicide Worksheet

Divide the adolescents into groups and let them work on the *Suicide Worksheet* in their small groups. Instruct the groups to discuss each question, coming to a consensus answer for each question. Circulate through the members to check the groups' progress and answer any questions. When all groups are finished with the worksheet, go over it and provide them with correct answers so that they may study for the quiz tomorrow.

The preceding material was adapted from Wodarski's (1986) *Depression and Suicide Prevention by the Teams-Games-Tournament Method.*

SAMPLES OF "DEAR ABBY" FORMAT LETTERS

Dear Abby,
My father moved out three weeks ago and I don't think he is coming back. I am sick worrying about this. I can't talk to my mother at all or anyone else either. Lately I have been thinking a lot about dying, because I don't want to live like this. I don't really want to die, but sometimes I think I won't be able to stop myself. I am 15 years old. Please help.

Desperate

Dear Abby,
I don't know what to do. My friend has hinted a couple of times that she might kill herself. I am scared she really might. I have tried to get her to go to the school counselor, but she won't go. If she died I would feel awful. What can I do?

Worried

Dear Abby,
I should be happy. My family is nice and I'm not ugly. But I find myself thinking about suicide sometimes. I'm not dumb either, and I

know you can't come back once you die, but I fantasize about it. I think I must be crazy. No one knows about this. What can I do?

Confused

SUICIDE WORKSHEET

1. The cardinal rule of suicide prevention is _____.
2. Give three examples of warning signals a person thinking about suicide might give.
3. True/False: Suicide is officially the No. 1 cause of death among adolescents.
4. True/False: In the past 25 years, the suicide rate among young people has tripled.
5. Who is a teen considering suicide most likely to confide in?
6. True/False: A good thing to say to someone thinking about suicide would be "Cheer up, it can't be that bad."
7. True/False: 50% of survivors of suicide attempts will kill themselves within 10 years.
8. Name three reasons why a teenager should not commit suicide.
9. Name three emotions you might feel if a friend committed suicide.
10. Research shows ____% of teens report being depressed.
11. Scenario: A friend has given a clear warning signal the he or she is thinking about suicide. What should you do?
12. Name two resources in the community that a suicidal person might contact for help.
13. Would you say a teen who thinks about suicide is abnormal?
14. Unscramble this word: THO-NEIL
15. Should songs or books that advocate suicide be banned?
16. True/False: One-fourth of adolescents who commit suicide are drunk or high shortly before death.
17. Name two realities of attempting suicide that teens often don't consider.
18. True/False: You shouldn't tell a suicidal peer that you have also considered suicide, because it might encourage him or her to go ahead with it.
19. True/False: It's a good idea to remind a suicidal peer that suicide is immoral and selfish.
20. Unscramble the following and identify what it refers to: "UDICESI TOLUSINO"
21. Why is it a bad idea to tell a suicidal peer that "Everything will be all right tomorrow?

ANSWERS TO SUICIDE WORKSHEET

1. Do something now.
2. Examples: radical change in appetite, sleeping habits, grades, mood, etc.; verbal clues such as "It won't matter after tomorrow anyway" and "They'll be sorry when I'm gone."
3. False
4. True
5. A friend
6. False
7. False
8. Examples: things change, people will grieve, too young to be sure, too much life ahead, people who survive attempts are glad later.
9. Examples: grief, sadness, guilt, anger, helplessness, inadequacy.
10. 33
11. Answers should include: ask outright if the person is thinking about suicide, don't leave the person alone, get adult or professional help.
12. Answers varies by community.
13. A lot of teenagers think about suicide at times.
14. Hot-line
15. No right or wrong answer
16. False. One half are.
17. Examples: suicide is final, a failed attempt may result in brain damage, paralysis, etc.
18. False
19. False
20. "Suicide Solution"–Ozzy Osbourne song
21. Example: it belittles the problem.

WEEK 3–DAY *5*

ASSESSMENT OF WEEK'S LEARNING

Instructor: Distribute *Adolescent Suicide Quiz.* After the group has completed the quiz, discuss the correct answers.

Material for Session 5 was adapted from Wodarski's (1986) *Depression and Suicide Prevention by the Teams-Games-Tournament Method.*

ADOLESCENT SUICIDE QUIZ

1. True/False: Suicide is officially the third leading cause of death among adolescents.
2. True/False: The suicide rate among teens has stayed about the same over the past 25 years.
3. Should people who talk about committing suicide be taken seriously?
4. What percentage of survivors of suicide attempts will kill themselves within 10 years?
5. True/False: Suicide crises are temporary.
6. Do most suicidal adolescents give some kind of warning?
7. True/False: A radical change in sleeping or eating habits can be a warning of suicidal intentions.
8. If you're worried about someone, is it a good idea to ask "Have you been thinking about killing yourself?"
9. _____ is common among teens, being reported second only to colds, sore throats, and coughs in frequency.
10. What is the cardinal rule of suicide prevention?
11. What's wrong with asking, "You're not thinking of killing yourself, are you?"
12. Many researchers believe suicide is actually the number ____ cause of death among adolescents.
13. A teen considering suicide is most likely to confide in a _____.
14. True/False: If you admit to thinking about suicide, you will most likely be hospitalized.
15. A 24-hour-a-day telephone service that takes calls from suicidal persons is called a _____.
16. True/False: A true friend would never tell about the suicidal thoughts of a person who asks you not to.
17. What percentage of teens who commit suicide are drunk or high shortly before death?
18. Is it a good idea to point out to a suicidal peer that failed attempts can result in brain damage or paralysis?
19. True/False: A person has to be crazy to think about suicide.
20. True/False: Sometimes you may just have to give up on a person and say, "Well if that's what you want to do, it's your business.
21. True/False: Sometimes you can shame a person into forgetting about suicide by saying, "I don't believe you'd really do it."
22. True/False: You should not offer a suicidal person alcohol.

23. Is it ever a good idea to ask a suicidal peer how they would carry it out?
24. What percentage of teens report being moderately to severely depressed?
25. Would it be a good idea to tell a suicidal person that suicide is selfish and wrong?
26. True/False: You should never tell a suicidal peer that you have thought about suicide at times.
27. Why is Ozzy Osbourne being sued?
28. Should you tell a suicidal peer about someone you know who failed in a suicide attempt and was glad later?
29. True/False: If a person threatens suicide, you should leave him or her alone to sleep on it.
30. Give three reasons why it is especially tragic when a young person commits suicide.
31. True/False: Some people threaten suicide to get attention, and the best thing to do is ignore them.

ANSWERS TO ADOLESCENT SUICIDE QUIZ

1. True
2. False
3. Yes
4. 10%
5. True
6. Yes
7. True
8. Yes
9. Depression
10. Do something now
11. Tends to bring denial
12. One
13. Friend
14. False
15. Hot-line
16. False
17. 50%
18. Yes
19. False
20. False
21. False
22. True
23. Yes
24. One-third (33%)
25. No
26. False
27. His rock lyrics are said to have pushed a teen to commit suicide.
28. Yes
29. False
30. Answers approved by class are acceptable
31. False

WEEK 4–DAY 1

RELAXATION

The development of systematic techniques in which the adolescent can alternate between tensing and relaxing muscle groups not only aids the physiological systems of the adolescent, but helps him or her to identify by body signals those situations that are anxiety and anger provoking (Bernstein & Borkovec, 1973). Studies have connected suicidal behavior to stress. Adolescents should thus be trained in progressive muscle relaxation procedures to reduce the effects of stress. To facilitate this training, adolescents are also taught proper breathing for relaxation, imagery, and methods of monitoring the effectiveness of their relaxation.

Breathing

Instructor: After the following breathing exercises, lead discussion on how the deep breathing made adolescents feel. Ask for examples of when this would be beneficial for them.

The following material was adapted from *The Relaxation and Stress Reduction Workbook* (Davis, Eshelman & McKay, 1982).

Instructor: Provide the following narrative:

Breathing is essential for life. Proper breathing is an antidote to stress. Although we all breathe, few of us retain the habit of natural, full breathing experienced by an infant or by primitive man.

Let's examine what we all take for granted–a breath. When you inhale, air is drawn in through your nose and warmed by the mucous membrane of your chest, separating your chest from your abdomen. Although you can voluntarily expand and contract your diaphragm, it operates largely on an automatic basis. When the diaphragm relaxes, the lungs contract and air is forced out.

Symptom Effectiveness

Breathing exercises have been found to be effective in reducing anxiety, depression, irritability, muscular tension, and fatigue.

Time for Mastery

Although a breathing exercise can be learned in a matter of minutes, and some immediate benefits experienced, the profound effects of the exercise may not be fully appreciated until months of persistent practice have passed. After you have tried the exercises presented in

this session, develop a breathing program incorporating those exercises you find most beneficial, and follow your program with patience and persistence.

Breathing Awareness

1. Lie down on a rug or blanket on the floor in a "dead body" pose–your legs straight, slightly apart, your toes pointed comfortably outward, your arms at your sides, not touching your body, your palms up, and your eyes closed.
2. Bring your attention to your breathing, and place your hand on the spot that seems to rise and fall the most as you inhale and exhale. Note that if this spot is in your chest, you are not making good use of the lower part of your lungs. People who are nervous tend to breathe many short, shallow breaths in their upper chest.
3. Place both of your hands gently on your abdomen and follow your breathing. Notice how your abdomen rises with each inhalation and falls with each exhalation.
4. It is best if you breathe through your nose. If possible, clear your nasal passages before doing breathing exercises.
5. Is your chest moving in harmony with your abdomen, or is it rigid? Spend a minute or two letting your chest follow the movement of your abdomen.
6. Scan your body for tension, especially your throat, chest, and abdomen.

Deep Breathing

1. Although this exercise can be practiced in a variety of poses, the following is recommended: lie down on a blanket or rug on the floor. Bend your knees and move your feet about eight inches apart, with your toes turned outward slightly. Make sure your spine is straight.
2. Scan your body for tension.
3. Place one hand on your abdomen and one hand on your chest.
4. Inhale slowly and deeply through your nose into your abdomen to push up your hands as much as feels comfortable. Your chest should move only a little and only with your abdomen.
5. When you feel at ease with step 4, smile slightly, inhale through your nose and exhale through your mouth, making a quiet, relaxing whooshing sound like the wind as you blow gently out. Your mouth, tongue, and jaw will be relaxed. Take long, slow, deep

breaths that raise and lower your abdomen. Focus on the sound and feeling of breathing as you become more and more relaxed.
6. Continue deep breathing for about five to ten minutes at a time, once or twice a day, for a couple of weeks. Then if you like, extend this period up to 20 minutes.
7. At the end of each deep breathing session, take a little time to once more scan your body for tension. Compare the tension you feel at the conclusion of the exercise with that which you experienced when you began.
8. When you become at ease with breathing into your abdomen, practice it out of your lungs and the feeling of relaxation that deep breathing gives you.
9. When you have learned to relax yourself using deep breathing, practice it whenever you feel yourself getting tense.

The Relaxing Sigh

During the day you probably catch yourself sighing or yawning. This is generally a sign that you are not getting enough oxygen. Sighing and yawning are your body's way of remedying the situation. A sigh is often accompanied by a sense that things are not quite as they should be and a feeling of tension. A sigh releases a bit of tension and can be practiced at will as a means of relaxing.

1. Sit or stand up straight.
2. Sigh deeply, letting out a sound of deep relief as the air rushes out of your lungs.
3. Don't think about inhaling–just let the air come in naturally.
4. Repeat this procedure eight to twelve times whenever you feel the need for it, and experience the feeling of relaxation.

WEEK 4–DAY 2

PROGRESSIVE RELAXATION

Instructor: Have adolescents practice breathing techniques they learned in the last session.

Have the adolescents do the following exercises and discuss the effects of progressive relaxation. Let them describe how it felt to them.

The following material was adapted from *The Relaxation and Stress Reduction Workbook* (Davis et al., 1982).

Importance of Relaxation

Instructor: Provide the following narrative:

You cannot have the feeling of warm well-being in your body and at the same time experience psychological stress. Progressive relaxation of your muscles reduces pulse rate and blood pressure, as well as decreases perspiration and respiration rates. Deep muscle relaxation, when successfully mastered, can be used as an anti-anxiety pill.

Edmond Jacobson, A Chicago physician, published the book *Progressive Relaxation* in 1929. In this book he described his deep muscle relaxation technique, which he asserted required no imagination, willpower, or suggestion. His technique is based on the premise that the body responds to anxiety-provoking thoughts and events with muscle tension. This physiological tension, in turn, increases the subjective experience of anxiety. The habit of responding with one blocks the habit of responding with the other.

Symptom Effectiveness

Excellent results have been found in the treatment of muscular tension, anxiety, insomnia, depression, and fatigue.

Instructions

Most people do not realize which of their muscles are chronically tense. Progressive relaxation provides a way of identifying particular muscles and muscle groups and distinguishing between sensations of tension and deep relaxation. Four major muscle groups will be covered:

1. Hands, forearms, and biceps.
2. Head, face, throat and shoulders, including concentration on forehead, cheeks, nose, eyes, jaws, lips, tongue and neck. Considerable attention is devoted to your head, because from the emotional point of view, the most important muscles in your body are situated in and around this region.
3. Chest, stomach, and lower back.
4. Thighs, buttocks, calves, and feet.

Progressive relaxation can be practiced lying down or in a chair with your head supported. Each muscle or muscle grouping is tensed from five to seven seconds and then relaxed for 20 to 30 seconds. This procedure is repeated at least once. If an area remains tense, you can practice up to five times. You may also find it useful to use the following relaxing expressions when untensing:

- Let go of the tension.
- Throw away tension–I am feeling calm and rested.
- Relax and smooth out the muscles.
- Let the tension dissolve away.

Once the procedure is familiar enough to be remembered, keep your eyes closed and focus attention on just one muscle group at a time. The instructions for progressive relaxation are divided into two sections. The first part, which you may wish to tape and replay when practicing, will familiarize you with the muscles in your body that are most commonly tense. The second section shortens the procedure by simultaneously tensing and relaxing many muscles at one time so that deep muscle relaxation can be achieved in a very brief period.

Basic Procedure

Get in a comfortable position and relax. Now clench your right fist, tighter and tighter, studying the tension as you do so. Keep it clenched and notice the tension in your fist, hand, and forearm. Now relax. Feel the looseness in your right hand, and notice the contrast with the tension. Repeat this procedure with your right fist again, always noticing as you relax that this is the opposite of tension–relax and feel the difference. Repeat the entire procedure with your left fist, then both fists at once.

Now bend your elbows and tense your biceps. Tense them as hard as you can and observe the feeling of tautness. Relax, straighten out your arms. Let the relaxation develop and feel the difference. Repeat this, and all succeeding procedures, at least once.

Turning attention to your head, wrinkle your forehead as tight as you can. Now relax and smooth it out. Let yourself imagine your entire forehead and scalp becoming smooth and at rest. Now frown and notice the strain spreading throughout your forehead. Let go. Allow your brow to become smooth again. Close your eyes now, squint them tighter. Look for the tension. Relax your eyes. Let them remain closed gently and comfortably. Now clench your jaw, bite hard, notice the tension throughout your jaw. Relax your jaw. When the jaw is relaxed, your lips will be slightly parted. Let yourself really appreciate the contrast between tension and relaxation. Now press your tongue against the roof of your mouth. Feel the ache in the back of your mouth. Relax. Press your lips now, purse them into an "O". Relax your lips. Notice that your forehead, scalp, eyes, jaw, tongue, and lips are all relaxed.

Press your head back as far as it can comfortably go and observe the tension in your neck. Roll it to the right and feel the changing locus of stress, roll it to the left. Straighten your head and bring it forward, press your chin against your chest. Feel the tension in your throat and the back of your neck. Relax, allowing your head to return to a comfortable position. Let the relaxation deepen. Now shrug your shoulders. Relax your shoulders. Drop them back and feel the relaxation spreading through your neck, throat, and shoulders–pure relaxation, deeper and deeper.

Give you entire body a chance to relax. Feel the comfort and the heaviness. Now breathe in and fill your lungs completely. Hold your breath. Notice the tension. Now exhale, let your chest become loose, let the air hiss out. Continue relaxing, letting your breath come freely and gently. Repeat this several times, noticing the tension draining from your body as you exhale. Now place your hand on your stomach and relax. Feel the contrast of relaxation as the air rushes out. Now arch your back, without straining. Keep the rest of your body as relaxed as possible. Focus on the tension in your lower back. Now relax, deeper and deeper.

Tighten your buttocks and thighs. Flex your thighs by pressing down your heels as hard as you can. Relax and feel the difference. Now curl your toes downward, making your calves tense. Study the tension. Relax. Now bend your toes toward your face, creating tension in your shins. Relax again.

Feel the heaviness throughout your lower body as the relaxation deepens. Relax your feet, ankles, calves, shins, knees, thighs, and buttocks. Now let the relaxation spread to your stomach, lower back, and chest. Let go more and more. Experience the relaxation deepening in your shoulders, arms, and hands. Deeper and deeper. Notice the feeling of looseness and relaxation in your neck, jaws, and all your facial muscles.

WEEK 4–DAY 3

RELAXATION TAPE

Instructor: Encourage adolescents to practice relaxing for at least 15 minutes twice a day, using progressive relaxation and breathing techniques. Play relaxation tape and have adolescents follow instructions on tape. Discuss the effects of the relaxation on the adolescents' bodies and feelings.

WEEK 4–DAY 4

IMAGINATION FOR RELAXATION

The following material was adapted from *The Relaxation and Stress Reduction Workbook* (Davis et al., 1982).

Instructor: Provide the following narrative:

You can significantly reduce stress with something enormously powerful: your imagination. The practice of positive thinking in the treatment of physical symptoms was popularized by Emil Coue, a French pharmacist, around the turn of the century. He believed that the power of the imagination far exceeds that of the will. It is hard to will yourself into a relaxed state, but you can imagine relaxation spreading throughout your body, and you can imagine yourself in a safe and beautiful retreat.

Coue asserted that all of your thoughts become reality–you are what you think you are. For example, if you think sad thoughts, you feel unhappy. If you think anxious thoughts, you become tense. To overcome the feeling of unhappiness or tension, you can refocus your mind on positive, healing images. When you predict that you are going to be lonely and miserable, it is likely your prediction will come true, because your negative thoughts will be reflected in asocial behavior. Coue recommended to his patients that they repeat 20 times to themselves on walking, mechanically moving their lips, the now-famous phrase, "Every day in every way I am getting better and better."

Coue also encouraged his patients to get into a comfortable, relaxed position on retiring, close their eyes and practice general relaxation of all their muscles. As they started to doze off in the "stage of semi-consciousness," he suggested that they introduce into their minds any desired idea, for example, "I am going to be relaxed tomorrow." This is a way of bridging your conscious and unconscious minds, and allowing your unconscious to make a wish come true.

Guided Imagery

Guided imagery is another way to use your imagination to create relaxation. You should read the exercise into a tape recorder and then experience it. If a tape recorder is not available, perhaps a friend or family member could read it to you.

Mountain Path

Close your eyes. . . . Imagine yourself leaving the area where you live. . . . Leave the daily hassles and the fast pace behind. . . . Imagine yourself going across a valley and moving closer and closer to a mountain range. . . . Imagine yourself in a mountain range. . . . You are going up a winding road. . . . Find a place on the winding road to stop. . . . Find a path to walk up. . . . Start walking up the path. . . . Find a comfortable place to stop on the path. . . . At this place take some time to examine all the tension and stress in your life. . . . Give the tension and stress shapes and colors. . . . Look at them very carefully and after you have done this, put them down on the side of the path. . . . Continue walking up the path until you come to the top of a hill. . . . Look out over the hill. . . . What do you see?. . . Find an inviting, comfortable place and go there. . . . Be aware of your surroundings. . . . What is your special place like?. . . Be aware of the sights, smells and sounds. . . . Be aware of how you are feeling. . . . Get settled and gradually start to relax. . . . You are now feeling totally relaxed. . . . Experience being relaxed totally and completely. . . . pause for three to five minutes. . . . look around at your special place once more. . . . Remember this is your special place to relax, and you can come here anytime you want to. . . . Come back to the room and tell yourself that this imagery is something you have created, and you can use it whenever you want to feel relaxed.

Listening to Music

Instructor: Play soft music and have adolescents practice the following exercise.

Listening to music is one of the most common forms of relaxation. Each person gives his or her own meaning to music. It is important, therefore, that you select music for the purpose of relaxation. If possible, make a half hour tape of uninterrupted relaxing music that you can play daily, or just when you decide to use music to relax. Repetition of the same music that helped you to relax in the past carries with it a positive association that is likely to be beneficial in the future.

To get the most out of your music session, find one half hour of uninterrupted time alone. Put on the music you have chosen, settle back in a comfortable position and close your eyes. Mentally scan your body, noticing areas of tension, pain, and relaxation. Be aware of your mood as you focus your attention on the music. Each time an unrelated thought enters your head, note it and then discard it, remembering

your goal of focusing on the music and relaxing. When the music ends, allow your mind to again scan your body and become aware of how it feels. Is there any difference compared with how your body felt before you started? Is there any difference in mood from before you started?

WEEK 4–DAY 5

CHARTING RELAXATION

Now that you have learned some relaxation techniques it is important that you have a way to compare your progress. This measurement will also allow you to identify particular situations and/or times of the day when you are most tense.

Instructor: Pass out the *Daily Monitoring–Relaxation* form.

Use this scale to measure how tense you are. On this scale, a "10" equals the most tense or anxious you have been, and "0" equals the most relaxed you have been.

Each day you write three scores on the form:

1. Your average relaxation score for the day (how relaxed you felt most of the day).
2. The relaxation score for when you felt the least relaxed during the day. Also, be sure to note the time, location, and a brief description of what you were doing.
3. The relaxation score for when you felt the most relaxed during the day. Again, be sure to record the time, location, and a brief description of what you were doing when you felt this relaxed.

In addition to these scores, you should keep track of any specific tension-related symptoms you might have each time it occurs.

Examine your daily monitoring forms in order to identify particular times in your day or particular situations that seem to produce the most tension. When you have identified these situations, write them down on the *Daily Monitoring–Relaxation in Problem Situations* form. Then each day for each situation that occurred, rate the degree of your relaxation in that situation. A rating of "10" should indicate that you were completely relaxed and comfortable. After several weeks of careful monitoring you can compare scores to see if you are making progress.

The preceding material was adapted from *Control Your Depression* (Lewinsohn et al., 1978) and *Participant Workbook for the Coping with Depression Course* (Brown & Lewinsohn, 1984).

DAILY MONITORING–RELAXATION

Relaxation Rating: 0 = Most relaxed you have ever been
10 = Most tense you have ever been

Date: _____ to _____

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Average score (add your scores & divide by 7)
Average score for the day								_____
Least Relaxed Time: Score								_____
When								
Where								
Situation								
Most Relaxed Time: Score								_____
When								
Where								
Situation								
Occurence of tension symptoms H = Headache SA = Stomach ache SP = Sleep problem								
Relaxation practice: When								
For how long								
Score before								_____
Score after								_____

From *Participant Workbook for Coping with Depression Course* (by R.A. Brown and P.M. Lewinson, published by Castalia Publishing Co. (1984).

DAILY MONITORING–RELAXATION IN PROBLEM SITUATIONS

Relaxation Rating: 0 = Most relaxed you have ever been
10 = Most tense you have ever been

Date: _____ to _____

Problem Situations	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

From *Participant Workbook for Coping with Depression Course* (by R.A. Brown and P.M. Lewinson, published by Castalia Publishing Co. (1984).

WEEK 5–DAY 1

COMMUNICATION

Data have shown that one significant component of depression and suicide prevention should alter the dissatisfaction about the teenager's interpersonal relationships with others and their perceptions as lacking in social skills. The participant should learn how to interact with others in meaningful and satisfying ways. Facets of the program developed by Lange and Jakubowski (1976) are included in the intervention. These involve the use of appropriate communication skills (Week 5), the development of assertive behavior to decrease stress that may be produced by inadequately met social needs, and problem-solving skills (Week 6).

Instructor: Distribute copies of the Communication Questionnaire. *After the adolescents have completed the questionnaire, give the answers. Before presenting each answer, first ask all those who answered "true" to raise their hands, then all who answered "false." Then discuss the correct answers using the expanded answers provided below as a guide. If many adolescents incorrectly answered a particular question, explore with the class what misconceptions might account for this.*

COMMUNICATION QUESTIONNAIRE

True or False?

_____1. A person who simply walks into a room and takes a seat is not communicating.
_____2. A person sitting still with arms folded and mouth shut is not communicating.
_____3. Communication can occur even if no one receives it.
_____4. A person who just listens is communicating.
_____5. Studies show poor listeners are less intelligent.
_____6. Listening is hard work and takes energy.
_____7. Active listening means listening while walking or running.
_____8. Studies have found that 80% of people surveyed considered themselves shy at one time or another.

Expanded Answers to Communication Questionnaire

1. False. Have volunteers demonstrate how the way one walks into a room and sits down can express arrogance, timidity, depression, pleasure, etc.

2. False. Have a student model the behavior described, then prompt the other students to identify what message they are receiving.
3. False. Communication occurs between persons; it is not one way. Example: if a person sends a letter but it does not arrive, there has been no communication.
4. True. Sometimes the best communicator is the one who just listens. Ask the class what message is being sent by a person who is really listening.
5. True. Studies also show good listeners are more emotionally mature.
6. True. Ask the class what it means to listen. Does it mean hearing the words, or does it mean hearing the meaning?
7. False. Active listening occurs when a person listens for the meaning of a message, then tries to express it in his or her own words. Example:
   John: It's been a terrible week. My dog died and now my car isn't working.
   Sara: Sounds like you've had a rough time this week.
8. True. Ask the class what this means for those who consider themselves shy now.

Overcoming Shyness

Have the adolescents gather into an even number of small groups. Instruct half the groups to list as many characteristics of a shy person as they can. Instruct the other groups to list as many characteristics of a snob as they can. Then write contributions from each group on the board under the headings "shy" and "snob." Have the adolescents compare and contrast the components they named. Explore with the group any similarities in the two lists. Why might shy people and snobs be perceived similarly?

Next have the groups brainstorm ways to overcome shyness. Have each group present several ideas to the class. If none of the groups mention the following components, you should present them for discussion:

- Choose conversation topics ahead of time
- Plan with whom you will converse at a social gathering
- Practice conversation skills with friends
- Increase eye contact gradually
- Practice active listening

WEEK 5–DAY 2

SELF-DISCLOSURE

Self -Disclosure Checklist

Instructor: Distribute copies of the Self-Disclosure Checklist. *Tell the adolescents they will not be collected and need not be shared with other students. The top half of the page may be folded over the bottom half to ensure privacy. For each statement you read, students should check ONE box.*

To whom would you be willing to reveal each of the following (if it were true):

1. The story of your first kiss.
2. That you have stolen something, with details.
3. What you don't like about your best friend.
4. That one of your parents is an alcoholic.
5. A serious health problem.
6. That you have (or have not) used marijuana.
7. That you have considered suicide.
8. That you cheated on a test.
9. What you think of the president.
10. That you cut school.
11. How you feel about the way you look.

SCORING**.** Score one point for each check in the "self" box, two for each check in the "best friend" box, three for each in the "friends" box, and four for each in the "stranger" box.

A score of 18 or less is considered low self-disclosure; a score of 19 to 35 is considered moderate self-disclosure; a score of 36 or above is considered high self-disclosure. The students should keep their scores in mind as levels of self-disclosure are discussed in the next activity.

Levels of Self-Disclosure

Write these terms on the board in the wrong order, then ask the group which one involves the lowest level of self-disclosure, which the next highest, etc., until they are arranged in the following order:

Small talk
Facts
Opinions
Feelings

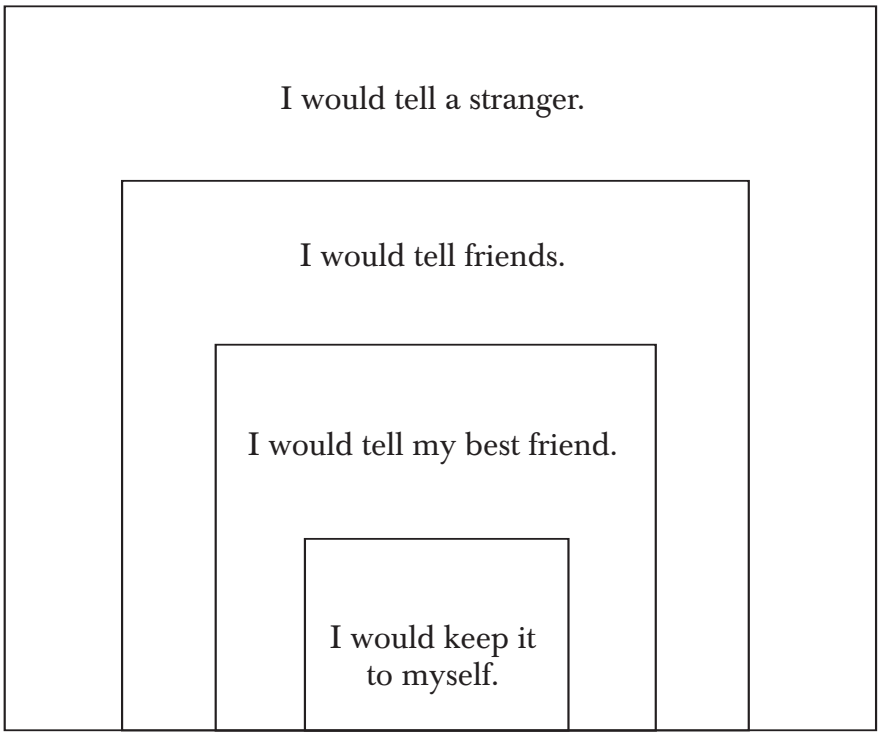
Next discuss each level. Is small talk ever appropriate? Is it appropriate with strangers?. . . friends?. . . best friends? See if you can get the group to mention these points about small talk:

- It can help when you meet new people.
- It can give you a chance to know whether you will hit it off.
- It can say "I'm interested in talking with you."

When is it appropriate to exchange facts such as activities, where to find something, where you are from, etc? Generally, exchanging facts lets you find out enough about another person to know whether you share common interests. What about sharing opinions? What do a person's opinions tell you about that person? Can you really know a person who doesn't share his or her opinions?

Can a relationship become close without disclosing feelings? What's the difference between sharing opinions and sharing feelings? (Hint: one uses feeling words.) Discuss this statement: "You cannot know yourself without disclosing yourself to another person." Ask the adolescents why a person might be afraid to self-disclose. What would help low self-disclosures to open up to someone? How could this relate to suicide prevention and managing depression?

SELF-DISCLOSURE CHECKLIST (sample)



WEEK 5–DAY 3

COMMUNICATION

Instructor: Divide groups into small groups. Each group should work through the Communication Scenarios *listing various possible approaches for each scenario. When all the groups have completed the exercise, discuss each scenario as a class. Then have members from each group role play the scenarios to demonstrate how different approaches can achieve the same goal.*

The adolescent may want to explore these considerations:

1. What is(are) the goal(s) of each stage?
2. What are some ineffective ways of communicating that could cut off a friendship before it begins.
3. What could happen if one character used self-disclosure too soon? Some students may want to role play this possibility.
4. What could happen if the characters use small talk exclusively?
5. How could knowledge of the levels of self-disclosure be applied to suicide prevention and managing depression?

Communication Scenarios

Scenario 1 (Level 1)

Pat and Sandy are in the same school and grade, but not in the same class. They do not know each other. One day Pat is taking a bulky science project to school and has some difficulty getting through the doorway with it. Sandy notices Pat's problem and helps by holding the door, then accompanies Pat to the classroom, helping with other doors on the way. (Pat and Sandy may be both male, both female, or of the opposite gender.)

List some appropriate topics Pat and Sandy might small talk about on their way down the hall. Then pick one or two and write dialogue that could take place. Be sure it is one *you* would feel comfortable using in this situation.

Scenario 2 (Level 2)

A few days later, Pat sees Sandy in the cafeteria and they talk for a few minutes before the bell rings.

List some facts Pat and Sandy might want to exchange at this point. How could the exchange take place in a natural (comfortable) way? Write down a sample dialogue.

Scenario 2 (Level 3)

That weekend they see each other again when they are standing in line to see the same movie. They are both alone, so Sandy, who was ahead in the line, moves back to Pat and they talk while the line moves slowly.

List some opinions that Pat and Sandy could exchange at this point. Again, be sure they are ones *you* would be comfortable expressing in this situation. Write down a sample dialogue in which Pat and Sandy find they have at least one interest in common.

Scenario 4 (Level 4)

Pat and Sandy consider themselves friends now. Because they share a common interest, Pat asks Sandy to come over on Saturday to share that interest (for example, play frisbee, show off a collection, etc.).

List some examples of feelings (needs, worries, hopes, etc.) they might self-disclose. How could they start without embarrassment? Write a sample dialogue that would not feel uncomfortable to *you* in this situation.

WEEK 5–DAY 4

COMMUNICATION SKILLS WORKSHEET

Instructor: Distribute Communication Skills Worksheet and have adolescents complete. Discuss answers.

Communication Skills Worksheet (sample)

1. When is communication occurring?
2. Billy is sitting on the edge of his chair, drumming his fingers. What is the communicating?
3. Can communication occur when only one person is involved?
4. Is listening communicating?
5. What is the difference between hearing and listening?
6. True/False: Good listeners are no more intelligent or mature than poor listeners.
7. True/False: It doesn't require any effort to just listen.
8. Listening for the meaning of a message and then expressing it in your own words is called _____ listening.
9. True/False: Studies have found that 40% of people surveyed considered themselves shy at one time or another.

10. Shy people might be perceived as _____.
11. Name three ways to overcome shyness.
12. Unscramble this word: fles-crulissode.
13. Name the four levels of self-disclosure discussed in class and put them in order from lowest to highest levels.
14. Is small talk ever appropriate? If so, when?
15. What is the main purpose of exchanging facts with a new acquaintance?
16. Name five facts that you would disclose to a person you want to know better.
17. What do a person's opinions tell you that facts can't?
18. Can you become close to another person without disclosing your feelings?
19. What is the difference between sharing opinions and sharing feelings?
20. Why would a person be afraid to disclose feelings?
21. Name a situation in which small talk would be inappropriate.
22. What could happen if potential friends use small talk exclusively?
23. Name five topics suitable for small talk.
24. Name a situation where disclosure of feelings might be inappropriate.
25. What could happen if you use self-disclosure too soon in a relationship?
26. Which level of self-disclosure is most appropriate if you are dealing with a suicidal person?
27. Give three examples of feelings you might disclose to a friend

Answers to Communication Skills Worksheet

1. Any time a message is sent and received, whether intentionally or unintentionally.
2. Nervousness or impatience
3. No
4. Yes (it communicates interest)
5. Hearing may take place without understanding; listening involves trying to get at the meaning of the words.
6. False
7. False
8. Active
9. False (80%)
10. Snobs

11. Examples: Choose topics for conversation ahead of time, plan who to talk with ahead of time, choose models and role play them, practice conversation skills with a friend, increase eye contact gradually, practice active listening.
12. Self-disclosure
13. Small talk, facts, opinions, feelings
14. Yes, when you meet new people or to open a conversation.
15. To find out enough about the other person to know whether you share common interests.
16. Various answers.
17. Examples: what the person thinks about a topic, what a person's interests are, whether something is important to the person.
18. No
19. Examples: opinions tell what a person thinks, feelings tell what a person feels and uses feeling words.
20. Examples: fear of rejection, fear of looking stupid, fear of being misunderstood, fear of closeness.
21. Examples: when a friend discloses feelings, when you are hurting, when you want to get closer to someone.
22. They would not be able to get close.
23. Various answers.
24. Examples: with a stranger, in a crowd, when the other person is in a hurry, when the other person is a gossiper.
25. You could scare off the other person.
26. Feelings
27. Various answers.

WEEK 5–DAY 5

COMMUNICATION SKILLS QUIZ

Instructor: Distribute Communication Quiz *to adolescents. Allow time for completion. Discuss answers and ask for questions.*

Week 5 material was adapted from Wodarski's (1986) *Depression and Suicide Prevention by the Teams-Games-Tournament Method.*

Communication Quiz

1. True/False: A person who looks at you blankly is not communicating.
2. True/False: A person speaking to him/herself is not communicating.

3. Is a person communicating who falls asleep in class? If so, what is he/she communicating?
4. True/False: A person who is just listening is not communicating.
5. Is listening the same as hearing?
6. Good listeners are more _____ than poor listeners.
7. What is active listening?
8. True/False: 80% of people surveyed considered themselves shy at one time or another.
9. True/False: Most people who were shy at one time got over it.
10. If you are shy, you might be considered a _____.
11. One way to overcome shyness is to _____ conversation skills with a friend.
12. True/False: Self-disclosure mean showing off.
13. Name four levels of self-disclosure.
14. True/False: Small talk is useful for finding out a lot about a person.
15. Identify the level of self-disclosure of the following: "I think that book is awful."
16. Identify the level of self-disclosure of the following: "I moved here from New York."
17. True/False: The main purpose of exchanging facts with a new acquaintance is to see who is smarter or richer.
18. Identify the level of self-disclosure of the following: "I worry about failing."
19. Which can tell you more about a person, sharing facts or sharing opinions?
20. True/False: You can be close friends without ever disclosing feelings.
21. The highest level of self-disclosure involves sharing _____.
22. Give one reason why a person might be afraid to disclose feelings.
23. True/False: Small talk should never be used at all if you can avoid it.
24. Identify the level of self-disclosure of the following: "They say it will rain today."
25. True/False: It is usually not appropriate to disclose feelings to a stranger.
26. True/False: Everyone needs at least one person to share feelings with.
27. Put these in order from lowest to highest level: opinions, small talk, feelings, facts.

Answers to Communication Skills Quiz

1. False
2. True
3. Yes, communicating boredom or tiredness
4. False
5. No
6. Intelligent or mature
7. Listening for the meaning of the message, then expressing it in your own words
8. True
9. True
10. Snob
11. Practice
12. False
13. Small talk, facts, opinions, feelings
14. False
15. Opinions
16. Facts
17. False
18. Feelings
19. Sharing opinions
20. False
21. Feelings
22. Examples: fear of rejection, fear of looking stupid, fear of being misunderstood, fear of closeness
23. False
24. Small talk
25. True
26. True
27. Small talk, facts, opinions, feelings

WEEK 6–DAY 1

ASSERTIVENESS

Ask the adolescents what they do when someone cuts into line in front of them in the store or in a movie line. (Pass out *Assertiveness Information Sheet* and discuss.) See if they can identify these three responses: passivity, assertiveness, and aggression. Have them give examples or role play each response. What is the difference between

assertive and aggressive behavior? (Assertiveness is expressing your needs clearly and directly to others without putting them down; aggression is expressing yourself at the expense of others).

Pass out copies of the *Alternative Action Scenarios*. Break the group into small groups and have them identify passive, assertive, and aggressive responses to the scenarios. When the groups have completed the exercise, have volunteers role play various responses.

Next discuss as a group whether one approach is better than the others. Why? See if you can get the class to generate the following factors:

- The passive approach leaves you feeling angry, and you might take it out on others and then feel guilty.
- The aggressive approach leads to hostility and conflict, and acts against honest relationships.
- An assertive approach doesn't guarantee results, but gives a better chance for a happy ending, and maintains the self-respect of both parties.

Ask the class why some people have difficulty saying "no." Could this be related to our self-statements? Can the students give examples? For instance: "I must please everyone in every way," or "I must meet everyone's needs."

Pass out *Self-Monitoring of Assertiveness* sheet. Under the heading "situation," write a list of situations in which you have a problem being assertive. For each situation, rate how comfortable you are (from 0–10) and how skillful you are in asserting yourself (0–10). The reason we want to keep track of your behavior is so you can see how it changes over time as you use the suggested assertion techniques.

Material for this session was adapted from *Control Your Depression* (Brown & Lewisohn, 1984) and *Relaxation and Stress Reduction Workbook* (Davis, Eshelman, & McKay, 1982).

Assertiveness Information Sheet

The first step in assertiveness training is to identify the three basic styles of interpersonal behavior:

Aggressive Style.

Typical examples of aggressive behavior are fighting, accusing, threatening, and generally stepping on people without regard for their feelings. The advantage of this kind of behavior is that people do not push the aggressive person around. The disadvantage is that people do not want to be around him or her.

Passive Style.

A person is behaving passively when he lets others push him around, when he does not stand up for himself, and when he does what he is told, regardless of how he feels about it. The advantage of being passive is that you rarely experience direct rejection. The disadvantage is that you are taken advantage of, and you store up a heavy burden of resentment and anger.

Assertive Style.

A person is behaving assertively when he stands up for himself, expresses true feelings, and does not let others take advantage of him. At the same time, he is considerate of others' feelings. The advantage of being assertive is that you get what you want, usually without making others mad. If you are assertive, you can act in your best interest and not feel guilty or wrong about it. Meekness and withdrawal, attack and blame, are no longer needed with the mastery of assertive behavior. They are seen for what they are–sadly inadequate strategies of escape that create more pain and stress than they prevent. Before you can achieve assertive behavior, you must really face the fact that the passive and aggressive styles have often failed to get you what you want.

Alternative Action Scenarios

1. A friend who borrowed $10 three weeks ago has not yet paid you back.
2. You order rare steak in a restaurant, and it comes burned.
3. You observe a classmate steal another student's prize possession.

SELF-MONITORING OF ASSERTIVENESS (sample)

Situtation	Day	1	2	3	4	5	6	7	8	9	10
1.	Comfort:										
	Skill:										
2.	Comfort:										
	Skill:										
3.	Comfort:										
	Skill:										
4.	Comfort:										
	Skill:										
5.	Comfort:										
	Skill:										
6.	Comfort:										
	Skill:										
7.	Comfort:										
	Skill:										
8.	Comfort:										
	Skill:										
9.	Comfort:										
	Skill:										
10.	Comfort:										
	Skill:										

From *Participant Workbook for Coping with Depression Course* (by R.A. Brown and P.M. Lewinson, published by Castalia Publishing Co. (1984).

4. You take your car in for a tuneup, and when you go to pick it up, the mechanic hands you a bill for $400.
5. Your aunt is trying to set you up with a blind date, but you are definitely not interested.
6. A neighbor borrowed an album and returned it scratched.

WEEK 6–DAY 2

THREE GREATEST DECISIONS

Break the group into small groups. Have the adolescents discuss and write down what the three greatest decisions in their lives will be. Next ask them to discuss the possible consequences of their decisions. Have the group share some important decisions. The following activity will present the steps of the problem-solving method that many people find useful for both important and not important decisions.

Problem-Solving Bookmark

THE PROBLEM-SOLVING METHOD	THE PROBLEM-SOLVING METHOD
STEP 1 State the problem STEP 2 Identify needs STEP 3 Brainstorm STEP 4 List pros and cons STEP 5 Try a solution STEP 6 Evaluate the outcome	STEP 1 What is the problem? Write it down. STEP 2 What are your needs? What needs of others are involved? STEP 3 Write down as many alternatives as you can think of. Be creative! STEP 4 Consider the likely outcome of each alternative. STEP 5 Pick the alternative that seems the most promising, then carry it out. STEP 6 Did it work? If not, try another.

Strategy for Problem Solving

Pass out copies of the *Problem-Solving Bookmark* and have adolescents cut, fold, paste, and personalize the bookmarks. Then have the group discuss each step of the problem-solving method. Point out that both sides of the bookmark present the same method, but one side gives more details. Be sure the adolescents understand that Step Three calls for listing all possible solutions without judgment, even those that seem ridiculous. Ask why this is important. Stress that if one solution does not seem to be working, another can be tried.

Ask the adolescents whether they think the method will or will not be useful in making their three greatest decisions and others. Why or why not?

Instruct the adolescents to bring their bookmarks for tomorrow's session where the problem-solving method will be put into practice.

The preceding material was adapted from Wodarski's (1986) *Depression and Suicide Prevention by the Teams-Games-Tournament Method.*

WEEK 6–DAY 3

PROBLEM-SOLVING ACTIVITY

Break the group into small groups. Using the *Sample Problem Situations* provided, have the groups practice using the problem-solving method. Be sure to emphasize that brainstorming is a freewheeling process. All possible solutions should be listed without criticism. Sometimes it is the alternative that seems "off the wall" that ends up being the one chosen, perhaps in modified form. Stress that there is no one "right" answer for any of the problem situations. For any problem, there are many possible solutions, some of which may be better than others, but none of which is perfect. This is, of course, true in real life problem situations also.

After the groups have completed the task, have them present their solutions to the group and open the floor for discussion. Ask again whether the adolescents think the problem-solving method will or will not be useful in real problem situations. Why or why not?

The preceding material was adapted from Wodarski's (1986) *Depression and Suicide Prevention by the Teams-Games-Tournament Method.*

Sample Problem Situations

1. You are a high school junior and hope to attend college. You enjoy sports and play on several school teams. You also are a member of the Drama Club and like acting in their productions. You have been working two evenings a week and Saturdays to earn enough for a car. Lately your grades are dropping because you don't have time to study and you find you don't have much time to hang around with your friends either. You realize you must change something. What do you do?
2. A 15-year-old girl is not yet allowed to date. She has not shown irresponsible behavior, but her parents won't budge on the matter. She is an only child. What should she do?
3. The big issue in your family is use of the car. You and your sister argue frequently over who needs it most at different times, and your parents need it for their activities too. The family can't afford another car and neither you nor your sister has any money saved. What can be done?
4. You moved to a new town three months ago and don't have any friends yet, though you had lots of friends where you used to live. You feel different from the others at school, and this makes you self-conscious, but you don't want to be a loner. What can you do?
5. It seems like your dad is on your back every second about something. He doesn't like your friends, so he won't let you hang around with them. Yet he told you he wouldn't choose your friends. What can you do?
6. Nick and Sue have been going together for six months. Sue says she's going to call, but rarely does. Nick feels he has to do all the calling, or he would never hear from her at all. This seems one-sided to him, but he's afraid he'll lose her if he complains. What can he do?
7. Your 14-year-old brother has confided in you that he has been experimenting with drugs. You know that lately he has skipped school a lot and sneaks out his window at night. What can you do?

WEEK 6–DAY 4

PROBLEM-SOLVING AND ASSERTIVENESS WORKSHEET

Instructor: Pass out the Problem Solving and Assertiveness Worksheet. *Have the adolescents complete the worksheet and then discuss the answers found below.*

PROBLEM SOLVING AND ASSERTIVENESS WORKSHEET

1. The first step in the problem solving method is to _____.
2. Unscramble this word: TIMARSBONR
3. True/False: Once you have chosen a solution, you should stick with it.
4. Name three situations in which problem solving might be helpful.
5. True/False: For any problem, there is only one right solution.
6. After stating the problem, it is important to _____ _____ _____ of all who are involved.
7. When brainstorming with a group, it is important not to _____ any of the possible solutions that are offered.
8. Name all six steps of the problem solving method in order.
9. True/False: Problem solving usually doesn't work with really big problems.
10. If the solution you pick doesn't work, what should you do?
11. How many alternative solutions should you write down in problem solving?
12. True/False: Problem solving could be used by a family to decide who gets to use the car at what times.
13. Unscramble this word: STERSANVISEES
14. Name one negative consequence of responding passively to problems.
15. Give an example of a self-statement that a person who can't say "no" might have.
16. What are the alternatives to a passive approach?
17. True/False: An assertive approach guarantees a happy ending.
18. An aggressive approach involves a _____-_____ of someone.
19. True/False: An aggressive approach is often best in many situations.
20. How could you respond assertively to the following scenario: A friend asks you to a party but you really don't want to go.
21. What is the difference between assertiveness and aggressiveness?
22. Give examples of passive, aggressive, and assertive responses to

the following scenario and identify the possible consequences of each approach: You notice a stranger parking a car where it will obstruct your driveway.

Passive response:	Possible consequence:
Aggressive response:	Possible consequence:
Assertive response:	Possible consequence:

Material for this session was adapted from Wodarski's (1986) *Depression and Suicide Prevention by the Teams-Games-Tournament Method.*

Answers to Problem-Solving and Assertiveness Worksheet

1. State the problem
2. Brainstorm
3. False
4. No right or wrong answer
5. False
6. Identify the needs
7. Criticize
8. (1) state the problem, (2) identify needs, (3) brainstorm, (4) list pros and cons, (5) try a solution, (6) evaluate the outcome
9. False
10. Try another solution
11. As many as you can
12. True
13. Assertiveness
14. Examples: you might feel angry and take it out on others, you might feel taken advantage of, you might not get something important to you
15. Examples: I must please others, I must be agreeable, other people know more than I.
16. Assertiveness, aggression
17. False
18. Put-down
19. False
20. Various answers
21. Aggression puts the other person down
22. Various answers

WEEK 6–DAY 5

PROBLEM SOLVING AND ASSERTIVENESS

Instructor: Pass out quiz and have adolescents complete. Discuss answers (see below). Allow time or questions regarding this week's sessions.

Material for this session was adapted from Wodarski's (1986) *Depression and Suicide Prevention by the Teams-Games-Tournament Method.*

Problem Solving and Assertiveness Quiz

1. The step of problem solving where you write down all possible alternatives is called _____.
2. An important step in problem solving is to identify your _____ and the _____ of others.
3. What is the first step of the problem-solving method?
4. In problem-solving, after you brainstorm, list the _____ and _____ of each alternative.
5. True/False: In problem solving you should list no more than six possible alternatives.
6. What is step six of the problem-solving method?
7. True/False: There is no "perfect" solution for any problem.
8. True/False: In the problem-solving method, if your solution doesn't work, you should get professional counseling next.
9. True/False: In brainstorming, you should limit your possible solutions to those that seem most reasonable.
10. How many steps are there in the problem-solving method we learned?
11. Could the problem-solving method be used in making your three greatest decisions?
12. True/False: Problem solving works better for business or school problems than for personal ones.
13. True/False: It's not important to write down the alternative solutions when you're brainstorming if you think there won't be many.
14. True/False: Problem solving is more effective for groups than for individuals to use.
15. True/False: In brainstorming, you should consider "silly" ideas as well as serious ones.
16. A person with a self-statement of "I must please everyone" might have trouble saying _____.
17. True/False: An assertive approach may not guarantee good results, but it makes a good result more likely.

18. True/False: If you respond passively to a problem, you might end up feeling angry and guilty.
19. If you put the other person down, you are using an _____ approach.
20. How could you respond assertively if someone dents your car?
21. True/False: If the other person is using an aggressive approach, you must respond aggressively.
22. Bill borrowed Sam's bike, then returned it with a flat tire. Sam told Bill he expected him to fix it by the weekend. What approach was Sam using?
23. What is the main problem with using an aggressive approach to resolve difficulties?
24. True/False: You shouldn't be assertive with people who are older than you.
25. Which approach to problems allows honest relationships to develop: passive, aggressive or assertive?
26. A person who has a hard time saying "no" probably has some negative _____-_____.
27. We talked about three ways to respond to problems. Name them.
28. How could you respond assertively to someone who frequently borrows pencils without returning them?
29. True/False: A passive approach to problems is often best.

Answers to Problem Solving and Assertiveness Quiz

1. Brainstorming
2. Needs, needs
3. State the problem
4. Pros, cons
5. False
6. Evaluate the outcome
7. True
8. False
9. False
10. Six
11. Yes
12. False
13. False
14. False
15. True
16. No

17. True
18. True
19. Aggressive
20. Answers approved by class are acceptable
21. False
22. Assertive
23. It leads to hostility and conflict
24. False
25. Assertive
26. Self-statements
27. Passive, aggressive, assertive
28. Example: tell the person you will not lend any more until the others have been returned
29. False

CONCLUSION

Intervention techniques have included cognitive self-management of depression, expression of feelings, dealing with anger and conflict, information relating to adolescent depression and possible subsequent suicide, relaxation, peer communication, assertiveness, and problem solving. The intervention is an attempt to alter what the adolescent thinks to effect a change in behavior.

The education, skills training, and practice applying skills in a peer group experience will enhance learning and behavior change. Ultimate beneficiaries of this treatment intervention are adolescents in crisis and society as a whole as the critical social problem of adolescent depression and subsequent suicide is addressed.

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Chapter 5

FAMILY INTERVENTION

INTRODUCTION

A significant percent of today's teenagers are maturing in a state of relative fear. Primary emphasis can be placed on the inability of teenagers to form close interpersonal relationships with adults at home and outside the family structure. The alienation experienced by the adolescent has long-term effects on the individual's outlook on both moral and social issues. Alienation itself breeds a lack of trust within the child (Arnold 1983; Coles 1983). Modern day society tends to relegate children to children's activities and adults to adult activities in social settings. Felt rejection in the adolescent results in part from this lack of intergenerational interaction (Kaplan, Robbins & Martin, 1983).

Suicidal behavior is the result of dysfunctional adjustment by the teenager to psychological and environmental circumstances. Aspects of depression and stress have been cited in research studies as prodromal clues in attempted and completed suicides (Davis, 1983). Evaluation of the role of the family and peer involvement have been examined in the same contexts. This intervention program addresses these factors and is targeted to provide essential knowledge to the parents of adolescents about depression management and suicide prevention.

Parents have expressed need and interest in receiving training in intervention to alter adolescent depression and possible suicide. This intervention program represents a new concept in depression management and suicide prevention for adolescents, using family involvement to support the adolescent's learning.

The initial two sessions focus on the dynamics of depression and suicide prevention. The third session presents information on the use of positive and negative control with adolescents. The focus within this material is on increasing use of positive reinforcement for appropriate behavior rather than often-used coercive processes such as negative reinforcement and punishment (Forehand & McMahon, 1981; Patterson, 1981).

Session 4 is devoted to teaching communication skills and problem-solving skills for conflict resolution. Session 5 teaches the use of assertiveness training and progressive relaxation. The development of assertive behavior can decrease stress that may be produced by inadequately met social needs. Progressive relaxation training can reduce the effects of stress.

In the last session, the use of communication training, problem solving, assertiveness training, and progressive relaxation are integrated and applied to depression and suicide prevention. Role plays of how to use the procedures are implemented. The material covers a six-week program in which the parents meet in groups (both parents, if possible) two hours each week.

SESSION 1

Introduction and Presentation of Dynamics of Depression and Suicide Prevention

Opening Procedures

1. As participants arrive, greet them and introduce them to other participants.
2. After all participants are present, explain that they all share a common bond in that they all are parents of a depressed adolescent.
3. Explain the format and subject matter of the sessions to be conducted.
   a. Stress the importance of confidentiality.
   b. Explain the importance of beginning sessions on time and regular attendance. Qualify that sessions will be for two hours a week for six weeks.
   c. Discuss material that will be presented in each section. Dynamics of depression and suicide prevention are presented initially. The social learning theory aspects of depression and

parents' roles in altering and maintaining adolescents' behavior are reviewed. Parents will learn how to use stimulus control techniques to influence rates of behavior and to provide appropriate consequences for desired behavior. Parents will be taught to identify motivators to facilitate the acquisition and maintenance of appropriate behaviors, how to use contingency contracting, how to change their own behavior, etc. Stress the importance of parents' roles in applying these behavioral procedures consistently.

4. Begin discussion of dynamics of depression and suicide. Include the following content. Mood is related to activity. Certain activities are associated with reward, satisfaction or pleasure. The "positive activities" produce a positive or good mood. Other activities are associated with punishment, frustration or displeasure. These "negative activities" produce a negative or bad mood. Studies have shown that mood on a day-to-day basis is related to the number of positive and negative activities each day. While not always obvious, these associations become clearer when carefully recorded. In order to overcome depression it is important to recognize the relationship between activity and mood. Explain to parents that their adolescent will be taught to recognize this relationship between activity and mood. Stress the importance of the parents learning to recognize this relationship also. Pass out copy of Self-Monitoring Log (see p. 42, week 1, day 2) adolescents will use and discuss with parents.

   Explain that people who are depressed tend to fail to attend to positive activities. People who are depressed tend to focus on negative activities. Attention is turned toward the unpleasant events which occur from day to day and how to avoid or minimize them. Positive activities do occur but they tend to be overlooked or ignored. Positive activities may seem trivial but are clues to producing positive mood if they are recognized and attended to. Stress the parents' role in helping their adolescent attend accurately to positive activities. Ask for questions and lead discussion of above facts.

   People who are depressed tend to focus on immediate versus long-term effects of their activities. Any activity may have both immediate and long-term effects. For instance, an unpleasant job in the present may produce pleasure later on. People who are depressed may wish for future pleasant rewards but they don't attend to the here and now opportunities which may lead to these

delayed rewards. In order to overcome depression, it is important to recognize the delayed effects of behavior (especially delayed rewards) as well as the immediate effects. Stress importance of the parents' role in helping their adolescent examine the delayed effects of behavior. Lead discussion of above facts and ask for questions.

Gaining control over one's own behavior or the events in one's life will allow one to overcome depression. People who are depressed typically believe that they cannot change. The control of their own behavior or many of the events in their lives seems out of their hands. At times they may see how changing their own behavior might improve things, but the amount of effort required seems beyond their resources. Gaining control requires three critical ingredients: (1) the belief that one can change and influence one's own behavior, (2) the recognition that self-change is a skill that is gradually mastered and learned from experience, and (3) the development of a systematic action plan. By learning to look at depression as related to activities and thoughts, instead of an uncontrollable force, one gains a measure of control over it. One can " get a handle" on what brings one's mood up or down and learn to control it.

Explain to parents that understanding the above is essential. Stress the importance of their cooperation with their adolescents as the adolescents strive to learn new skills which allows them to have a sense of control over their lives. Stress the importance of parents allowing adolescents to make their own choices and learn by experience. Explain that adolescents will be educated in problem solving and communication skills and that parents' cooperation and empathetic listening are essential for this. Ask for questions and discuss.

5. Pass out Self-Monitoring Logs and Homework Assignment (see p. 42–44, week 1, day 2) for adolescents that parents are to take home and read before the next session. Explain that these will be discussed and additional facts about adolescent suicide will be presented at the next session. Ask for feedback from parents as to how they felt this session was or was not beneficial.

SESSION 2

Additional Facts About Depression and Suicide

Open session with discussion of self-monitoring material passed out last session. Answer questions parents have about their adolescent's assignment and probe for feedback on how their adolescents acquiring these skills will affect the parents.

Explain self-attribution. Rationale: People who are depressed tend to make inaccurate evaluations of their successes and failures. In working toward any goal, all people encounter obstacles and meet with varying degrees of success and failure in each step toward the goal. People who are depressed tend to conclude or believe that any successes they have are, (1) due to external forces (chance, luck, someone else's help), (2) one-time occurrences unlikely to be repeated, and (3) specific, small victories not indicative of a general trend. Any failures, on the other hand, are often assumed to be, (1) due to internal forces (lack of skill or ability), (2) examples of stable trends, and (3) indications of global failure. In order to overcome depression, it is important to make more realistic interpretations of one's successes and failures. It is important to recognize one's actual contributions to one's successes due to one's efforts and skills.

Discuss above facts with parents. Allow for questions. Pass out *Attribution of Responsibility* exercise and discuss. This material, as well as material for the first session was adapted from the *Cognitive-Behavioral Therapy Manual* (Coats & Reynolds, 1982).

Discuss *Depression and Suicide Prevention Information Sheet.*

Discuss the adolescent *ABC's of Feelings.*

Discuss adolescent *Suicide Myths and Facts Questionnaire.*

Discuss this session and ask for feedback from parents. Explain that their adolescents are learning the same material they are.

Discuss plans for the next four sessions. Third session: Teaches the use of positive and negative control with adolescents. Focus will be on increasing the use of positive reinforcement for appropriate behavior rather than coercive processes such as negative reinforcement and punishment. Fourth session: Parents will be taught communication skills and problem-solving skills. Fifth session: Parents will be taught progressive relaxation techniques and assertiveness training. These will hopefully allow them to encourage their adolescents to use these skills to better cope with problems. Sixth session: Reviews and integrates information as it applies to adolescent depression and suicide prevention.

Attribution of Responsibility Exercise

Instructor: The purpose of the exercise is to look closely at assumptions people make in assigning credit, blame, or responsibility for events. The assumption is that people who tend to be depressed often make faulty assumptions about responsibility.

1. Have parents begin with item 1 on their attribution and responsibility exercises. Parents are to list two fairly important events from their positive activity logs for the last two weeks. "Fairly important" must necessarily be subjective but should refer to the most significant items of the last couple of weeks especially with regard to their effect on mood. Ask for problems or questions in filling in these two items.
2. Next instruction to parents is: "In what ways were other people, chance, or luck responsible for these events?" The intent is to have parents fill in one or two reasons for each event (a & b). For example, "receiving a compliment from John" might be due to "his wanting to make me feel good," or "finding a $5 bill on the street" might be due to "pure luck." Ask for questions and discussion.
3. "In what ways were you (your efforts, skills, abilities, etc.) responsible for these events?" For example, "receiving a compliment from John" might be due to "my special effort to look nice that evening," or "winning a prize at a weekly swim meet" might be due to "my swimming ability." Ask for questions and discussion.
4. "What percent of the responsibility for these events was attributable to you?" What is called for here is a comparison between items 2 and 3. For example, "receiving a compliment from John," might be 80 percent attributable to you (and 20 percent to him). Ask for questions and discussion.

IN MOST CASES, YOU WILL PROBABLY FIND THAT YOU HAVE CONSIDERABLE RESPONSIBILITY FOR POSITIVE EVENTS IN YOUR LIFE. WHILE POSITIVE EVENTS DO SOMETIMES OCCUR PURELY BY CHANCE (WINNING AT BINGO), USUALLY POSITIVE EVENTS ARE THINGS THAT YOU HAVE WORKED FOR OR CONTRIBUTED TO. IT IS NEARLY ALWAYS WITHIN YOUR POWER TO INFLUENCE OR INCREASE THESE EVENTS. IF YOU DID NOT CONCLUDE THAT YOU HAD MORE THAN 50 PERCENT RESPONSIBILITY FOR THESE EVENTS, GO BACK TO ITEMS 2 AND 3 AND REEXAMINE THEM. PER-

HAPS YOU CAN THINK OF OTHER WAYS IN WHICH YOU WERE RESPONSIBLE FOR THE EVENTS.

5. Go over the following instructions with parents: "Look at the reasons you wrote down in items 3 above. To what extent are these reasons examples of something generally true about yourself? That is, do they represent a stable pattern or characteristic of you which you show in many situations, or do they represent an unusual or limited aspect of your behavior?"

   Have parents estimate the percentage of generality versus specificity for each of the two activities by making a vertical line on the scales.

IN MOST CASES, YOU WILL PROBABLY FIND THAT THE WAYS THAT YOU WERE RESPONSIBLE FOR YOUR POSITIVE ACTIVITIES WERE EXAMPLES OF GENERAL, STABLE CHARACTERISTICS THAT ARE TRUE OF YOU IN MANY SITUATIONS. IF YOU DID NOT CONCLUDE THAT GENERAL CHARACTERISTICS WERE INVOLVED, GO BACK AND REEXAMINE YOUR RESPONSES TO ITEM 3. PERHAPS YOU CAN THINK OF GENERAL TRAITS WHICH WERE INVOLVED.

Ask for questions and discussion.

6. "List two unpleasant or unhappy events which occurred during the last two weeks." Here subjects must rely on the recollection for two particularly unpleasant events. Ask questions and discussion.
7. "In what ways were other people, chance, or bad luck responsible for these events?" Ask for questions and discussion.
8. "In what ways were you (your efforts, skills and abilities, or lack of effort, skills and ability) responsible for these events?" Ask for questions and discussion.
9. "What percent of the responsibility for these events was attributable to you?" Ask for questions and comments.

IN MOST CASES, YOU WILL PROBABLY FIND THAT YOU ARE NOT SOLELY RESPONSIBLE FOR THE UNPLEASANT EVENTS IN YOU LIFE. IN MOST CASES, UNPLEASANT EVENTS ARE ATTRIBUTABLE TO OTHERS OR TO CHANCE. THERE IS ONE EXCEPTION TO THIS RULE. BEING PASSIVE, AND

THUS BEING BORED OR EXCESSIVELY DEPENDENT ON OTHERS, CAN BE AN UNPLEASANT EVENT FOR WHICH YOU MAY BE RESPONSIBLE. THAT IS, YOU COULD HAVE CHOSEN TO ACT MORE ASSERTIVELY. IF YOU DID NOT CONCLUDE THAT YOUR UNPLEASANT EVENTS (OTHER THAN PASSIVITY) WERE ATTRIBUTABLE TO EXTERNAL CAUSES OR TO LUCK, GO BACK OVER ITEMS 7 AND 8 AND REEXAMINE THEM. PERHAPS YOU CAN THINK OF OTHER WAYS IN WHICH OTHERS OR CHANCE WERE RESPONSIBLE FOR THESE EVENTS. IT IS IMPORTANT TO BE ABLE TO RECOGNIZE ACCURATELY THAT CERTAIN UNPLEASANT EVENTS ARE NOT UNDER YOUR CONTROL WHILE OTHERS MAY BE. ONLY BY SEPARATING THEM OUT CAN YOU CONTROL AND DIRECT YOURSELF AND YOUR MOOD.

Responsibility Exercise

The purpose of this exercise is to look closely at assumptions people make in giving credit, blame or responsibility for events. People who are depressed often make faulty assumptions about their responsibility for events.

1. List two fairly important events from your positive activity logs (self-monitoring logs) for the last two weeks.
   A:_____
   B:_____
2. In what ways were other people, chance, or luck responsible for these events?
   A:_____
   B:_____
3. In what way were you (your efforts, skills, abilities, etc) responsible for these events?
   A:_____
   B:_____
4. What percent of the responsibility for these events was due to your efforts, skills, etc.?
   Event A:_____%
   Event B:_____%

5. Look at the reasons you wrote down in item #3 above. To what extent are these reasons examples of something generally true about yourself? That is, do they represent a stable pattern or characteristic of you, that you show in many situations, or do they represent an unusual or limited aspect of your behavior?

   Event A: General, stable {----------} Unusual, specific
   Event B: General, stable {----------} Unusual, specific
6. List two (2) unpleasant or unhappy events that occurred during the last two weeks.
   C:_____
   D:_____
7. In what ways were other people, chance, or bad luck responsible for these events?
   C:_____
   D:_____
8. In what ways were you (your efforts, skills, abilities, or lack of these) responsible for these events?
   C:_____
   D:_____
9. What percent of the responsibility for these events was because of you?
   Event C:_____%
   Event D:_____%

Depression and Suicide Prevention Information Sheet

The view of adolescence as a carefree time of pizza parties and Saturday morning car washes may have reflected reality at one time, but hardly seems to fit adolescents of today. We have entered an era in which the majority of children will experience family breakups and spend at least a part of their childhood living with only one parent (Hofferth, 1984). A fundamental change in family life is underway, marked by a divestiture of traditional family functions to other institutions which are largely unprepared and reluctant to fill the void. As a result, many teenagers today face the crises that traditionally accompany the transition to adulthood without the support of a nurturing environment.

Adolescents experience a sense of alienation and loneliness both at home and outside the family, and this leads to the development of depression. In a survey of 567 high school age students, those pre-

senting with depression reported negative self-esteem, inadequate coping capacities, negative school environment and stressful life events (Steinhausen & Metzke, 2000). Olsson et al. (1999) found that depressed adolescents had more illness, conflicts and family changes than did controls. It is estimated that 5 million children and adolescents need mental health services but do not receive them. Mental disorders reportedly affect 634,000 adolescents and account for 32 percent of disability among 10- to 18- year olds (American Medical Association, 1991).

Research has established the association between suicidal behavior in adolescents and depressive symptoms. A chronic inability to cope with changing life situations has been identified as a major factor in depression and as a predictor in suicide attempts. Suicidal adolescents tend to react to emotional turmoil with feelings of helplessness and hopelessness and what Davis (1983) calls, "tunnel vision" in which the teenager fails to see other options. To a suicidal teen it may seem more difficult to deal with a problem than to swallow a bottle of pills.

Increasing numbers of adolescents do take that bottle of pills (or jump from a height, hang, stab, or shoot themselves). Between 1955 and 1980 the suicide rate for adolescents tripled, rising from 4.1 per 100,000 to 12.3 per 100,000 (Maris & Lazerwitz, 1981). Suicide is officially the third leading cause of death among teens, following accidents and homicides, but some researchers believe it is really the number one killer. Many deaths reported as accidents may in fact be suicides, especially those involving automobiles and drug and alcohol abuse. Coroners set their own standards for determining whether suicide has caused the death, and unless a suicide note is found (which studies suggest occurs in only 15 to 35 percent of cases), the official report may attribute the death to accidental causes.

There are no official tabulations of suicide attempts. Studies estimate that there are anywhere from 50 to 150 times as many attempts as there are completed suicides among young persons (Gould & Kramer, 2001; Merrick, 2001). Suicide attempts are viewed as cries for help from teens who consider their life situations hopeless. Suicidal adolescents often give clues to their intentions, but there are no reliable or valid predictors of suicide.

Most researchers support Glaser's (1987) assertion that treatment of suicidal adolescents requires using all available methods and resources separately, sequentially, and in conjunction. Primary prevention programs aimed at all teens are crucial to this approach. Such programs should offer basic training to help students identify a potential suicide

and respond effectively. Students need and want information on the causes, symptoms, and alternatives to suicide. Of 25,000 high school students surveyed in several studies, 80-90 percent wanted an opportunity to learn the facts of suicide prevention.

We need to demythologize and deromanticize suicide by discussing it in the same way we discuss other sensitive issues in the classroom, such as abortion, smoking, and AIDS. An educational program that emphasizes understanding rather than avoidance can teach self-defense against suicidal ideation and can alert adolescents to suicidal behavior in their peers. A 1980 survey revealed that high school students consistently respond that they would look to a peer for help if they were considering suicide (Ross, 1980).

Of vital importance to a primary prevention program is the teaching of skills adolescents need in order to cope with the stresses of everyday life. Numerous studies have connected suicidal behavior to depression, stress, family disruption, and poor peer relationships. An effective program should include education, training, and practice in using life skills such as problem solving, cognitive management of depression, and communication skills.

ABC'S OF FEELINGS

INSTRUCTIONS TO THE INSTRUCTOR. Explain the A, B, and C stand for (Action, Belief, Consequence) and what the ABC principle is. Ask the parents whether they think all our beliefs are conscious ones. What are certain examples of unconscious beliefs? How do we know they exist? Example: a person who keeps trying to get something right may believe "I am capable," while a person who gives up easily may believe "I am too dumb to figure things out."

Explain to the parents that these kinds of beliefs are called self-statements. They may be conscious or partly conscious, but often we are not even aware of them because they come from early childhood. Whether they are conscious or unconscious, they affect our behavior every day in ways we don't realize.

Have the parents gather into small groups and distribute the ABC scenarios provided at the end of this activity. The groups should discuss each Action, then decide on two different Consequences, based on the positive and negative self-statements (Beliefs) provided. Explain that the different outcomes should not be based on luck or magic, but should result from the self-statements. These are assumed to be unconscious.

When the groups have completed the stories, conduct a large-group discussion, having the smaller groups present and compare their versions. Would it make any difference if the self-statements were conscious? If the character is conscious of the negative self-statements, could he change them? How?

SUICIDE MYTHS AND FACTS QUESTIONNAIRE

Instructions to the Instructor. Break the group into pairs. Discuss Suicide Myths and Facts. Distribute copies of the *Suicide Questionnaire* (Chapter 4, Week 3, Day 3, p. 93). Tell the parents not to write their names on their papers. Tabulate the results on the blackboard and provide the correct answers.

Encourage group discussion, paying particular attention to those questions that were answered incorrectly by some of the subjects. Incorporate into the discussion the explanations given below and encourage the parents to fully express their opinions. Explore with the group why misconceptions about suicide are so prevalent. See if the group can identify any additional misconceptions the public may have about suicide.

SESSION 3

Positive Reinforcement

Behavior is controlled by rewards and punishments. If you want to increase, strengthen, or encourage the activity or behavior, follow it with a reward. If you want to decrease, weaken, or discourage an activity or behavior, you punish it. The important point is that the reward or punishment must be contingent (comes only after the behavior has occurred).

People may control their own behavior by giving themselves rewards and punishments. When people do something they are proud of or feel they have done well, they may treat themselves to a reward or they may "pat themselves on the back." When people do something they are not proud of or feel they have not done well, they may punish themselves. Rewards and punishments can be tangible or verbal. Self-rewards and self-punishments can be observable or private.

People who are depressed tend to punish themselves too much and reward themselves too little. People who are depressed tend to be down on themselves and are constantly punishing themselves either

by what they do or say to themselves. The same people may believe it is almost improper or immoral to do something to reward themselves or even to think something positive about themselves. The result is that they are not motivated to be more active in pursuing goals. Someone who is depressed is more likely to focus on what he or she has not accomplished rather than on what he/she has done well, and then punish him/herself for failing rather than reward him/herself for successes. Since it is important in overcoming depression for the adolescent to feel a sense of control over his/her life, it is important that he/she learn to reward him/herself.

Pass out *Self-reward Assignment/Exercise* (Chapter 4, Week 1, Day 2, p. 49) and discuss. Stress with parents the importance of using positive reinforcement rather than coercion with their depressed adolescent. Explain that coercion only leads to a feeling of powerlessness in the adolescent which in turn leads to further depression. This material was adapted from the *Cognitive-Behavior Therapy Manual* (Coats & Reynolds, 1982).

Parent Effectiveness Training (P.E.T.) skills. P.E.T. employs a "no-lose" method of resolving conflicts. It is a no-power method; conflicts are resolved with no one winning and no one losing. Both win because the solution must be acceptable to both. Parents and adolescents encounter a conflict-of-needs situation. The parent asks the adolescent to participate with him/her in a joint search for some solution acceptable to both. One or both may offer possible solutions. They critically evaluate them and eventually make a decision on a final solution acceptable to both. No selling of the other is required after the solution has been selected because both have already accepted it. No power is required to force compliance because neither is resisting the decision.

Give out handout *Parent Effectiveness Training Scenarios* providing two examples of conflict resolution involving this method. Discuss. Ask for role playing, letting a parent make up a problem and another parent use this method to solve the problem. Discuss after role playing.

Explain that this is a good method to use for conflicts between two or more individuals. Explain that in the next session problem solving will be explored which will give the adolescents a good method of solving problems and making decisions on their own.

Information on P.E.T. was adapted from *Parent Effectiveness Training* written by Dr. Thomas Gordon in 1970.

Parent Effectiveness Training Scenarios

Scenario I

Jane: Bye, I'm off to school.
Parent: Honey, it's raining outside and you don't have your raincoat on.
Jane: I don't need it.
Parent: I think it's raining quite hard and I'm concerned that you'll ruin your clothes or get a cold, and that will affect us.
Jane: Well, I sure don't want to wear my raincoat.
Parent: You sure sound like you definitely don't want to wear that raincoat.
Jane: That's right, I hate it.
Parent: You really hate your raincoat.
Jane: Yeah, it's plaid.
Parent: Something about plaid raincoats you hate, huh?
Jane: Yes, nobody at school wears plaid raincoats.
Parent: You don't want to be the only one wearing something different.
Jane: I sure don't. Everybody wears plain-colored raincoats–either white or blue or green.
Parent: I see. Well, we really have a conflict here. You don't want to wear your raincoat cause it's plaid, but I sure don't want to pay a cleaning bill, and I will not feel comfortable with you getting a cold. Can you think of a solution that we both could accept? How could we solve this so we're both happy?
Jane: (Pause) Maybe I could borrow Mom's car coat today.
Parent: What does that look like? Is it plain-colored?
Jane: Yeah, it's white.
Parent: Think she'll let you wear it today?
Jane: I'll ask her. (Comes back in a few minutes with the car coat on; sleeves are too long, but she rolls them back). It's OK by Mom.
Parent: You're happy with that thing?
Jane: Sure, it's fine.
Parent: Well, I'm convinced it will keep you dry. So if you're happy with that solution, I am too.
Jane: Well, so long.
Parent: So long. Have a good day at school.

What happened here? Obviously, Jane and her father resolved their conflict to the mutual satisfaction of both. It was resolved rather quickly, too. The father did not have to waste time being an imploring salesman, trying to sell his solution. No power was involved–either on the part of the father or of Jane. Finally, both walked away from the problem-solving feeling warmly toward each other. The father could say, "Have a good day at school" and really mean it, and Jane could go to school free of the fear of embarrassment over a plaid raincoat.

Scenario II

Mother: Cindy, I'm sick and tired of nagging you about your room, and I'm sure you're tired of my getting on your back about it. Every once in a while you clean it up, but mostly it's a mess and I'm mad. Let's try a new method I've learned in class. Let's see if we can find a solution we both will accept–one that will make us both happy. I don't want to make you clean your room and have you be unhappy with that, but I don't want to be embarrassed and uncomfortable and be mad at you either. How could we solve this problem once and for all? Will you try?

Cindy: Well, I'll try but I know I'll just end up having to keep it clean.

Mother: No. I am suggesting we find a solution that would definitely be acceptable to both, not just to me.

Cindy: Well, I've got an idea. You hate to cook but like cleaning and I hate cleaning and love to cook. And besides I want to learn more about cooking. What if I cook two dinners a week for you and Dad and me if you clean up my room once or twice a week.

Mother: Do you think that would work out–really?

Cindy: Yes, I'd really love it.

Mother: OK, then let's give it a try. Are you also offering to do the dishes?

Cindy: Sure.

Mother: OK. Maybe now your room will get cleaned according to my own standards. After all, I'll be doing it myself.

SESSION 4

Communication and Problem Solving Skills

Discussion of Effective Communication.

1. Discuss how body language affects communication. Stress importance of parents' role of listening to adolescent.
2. Discuss difference in hearing and listening. Listening means hearing the meaning as well as the words.
3. Discuss definition of active listening–when a person listens for the meaning of a message, then tries to express it in his own words.
4. Discuss importance of listening without judging or advising.

Have parents role play and have the listener repeat the message. Discuss whether body posture was congruent with message.

Discuss importance of allowing adolescent to express feelings and parents' role in listening to the expression of feelings. Anger is a natural emotion. If anger is not expressed it will turn inward and can cause depression. Relationships grow through honest expression of feelings.

Discuss importance of using "I" messages in expressing feelings instead of "you" messages. Use the *"I" Message Book* (Chapter 4, Week 2, Day 3, p. 76)and have parents role play listening to and expressing feelings.

Discuss problem solving method using *Book Mark* handout (Chapter 4, Week 6, Day 2, p. 128) and explanation (Chapter 4, Week 6, Day 2 "Three Greatest Decisions," p. 128). Explain that this method can help adolescents become more independent in their decision making and thus feel more "in control" of their lives. Explain necessity for this skill in adolescents' lives. Encourage parents to guide their adolescents in the use of this skill rather than try to solve problems for them. Have parents make up situations that might be problems. Have them role play guiding adolescents through problem-solving steps. Stress that adolescents must choose alternatives.

Ask for feedback from parents as to how they feel sessions are helping. Allow for discussions and questions.

SESSION 5

Assertiveness Training and Progressive Relaxation

Assertiveness Training

Discuss importance of assertiveness training for adolescents. How one interacts with others can be a source of stress in one's life. Assertiveness training can reduce that stress by teaching one to stand up for his/her legitimate rights without bullying others or letting them bully him/her.

Pass out *Mistaken Traditional Assumptions and Legitimate Rights*. Discuss these and allow for feedback and questions.

MISTAKEN TRADITIONAL ASSUMPTIONS AND LEGITIMATE RIGHTS

Mistaken Traditional Assumptions	Your Legitimate Rights
1. It is selfish to put your needs before others' needs.	You have a right to put yourself first sometimes.
2. It is shameful to make mistakes. You should have an appropriate response for every occasion.	You have a right to make mistakes.
3. If you can't convince others that your feelings are reasonable, then they must be wrong, or maybe you are going crazy.	You have a right to be the final judge of your feelings and accept them as legitimate.
4. You should respect the views of others, especially if they are in a position of authority. Keep your difference of opinion to yourself. Listen and learn.	You have a right to have your opinion and convictions.
5. You should always try to be logical and consistent.	You have a right to change your mind or decide on a different course of action.
6. You should be flexible and adjust. Others have good reasons for their actions and it's not polite to question them.	You have a right to protest treatment or criticism.

7. You should never interrupt people. Asking questions reveals your stupidity to others.	You have a right to interrupt in order to ask for clarification.
8. Things could get even worse; don't rock the boat.	You have a right to negotiate for change.
9. You shouldn't take up others' valuable time with your problems.	You have a right to ask for help or emotional support.
10. People don't want to hear that you feel bad, so keep it to yourself.	You have a right to feel and express pain.
11. When someone takes the time to give you advice, you should take it very seriously. They are often right.	You have a right to ignore the advice of others.
12. Knowing that you did something well is its own reward. People don't like show-offs. Successful people are secretly disliked and envied. Be modest with compliments.	You have a right to receive formal recognition for your work and achievements.
13. You should always try to accommodate others. If you don't, they won't be there when you need them.	You have a right to say "no."
14. Don't be antisocial. People are going to think you don't like them if you say you'd rather be alone instead of with them.	You have a right to be alone, even if others would prefer your company.
15. You should always have a good reason for what you feel and do.	You have a right not to have to justify yourself to others.
16. When someone is in trouble, you should help them.	You have a right not to take responsibility for someone else's problem.
17. You should be sensitive to the needs and wishes of others, even when they are unable to tell you what they want.	You have a right not to have to anticipate others' needs and wishes.

18. It's always a good policy to stay on people's good side.	You have a right not to always worry about the good will of others.
19. It's not nice to put people off. If questioned, give an answer.	You have a right to choose not to respond to a situation.

Discuss the three basic styles of interpersonal behavior.

1. Aggressive style–fighting, accusing, threatening and generally stepping on people without regard for their feelings.
2. Passive style–when a person lets others push one around, when one does not stand up for oneself, and when one does what one is told regardless of how one feels about it.
3. Assertive style–a person stands up for oneself, expresses one's true feelings, and does not let others take advantage of him/her. At the same time, one is considerate of others' feelings.

Read scenes 1-6 to parents and have them label person A's behavior as aggressive, passive, or assertive.

Scene 1

A: Is that a new dent I see in the car?
B: Look, I just got home, it was a wretched day and I don't want to talk about it now.
A: This is important to me, and we're going to talk about it now!
B: Have a heart.
A: Let's decide now who is going to pay to have it fixed, when and where.
B: I'll take care of it. Now leave me alone, for heaven's sake!

A is aggressive. A's initial hostile statement produces resentment and withdrawal.

Scene 2

A: You left me so long by myself at that party. . . . I really felt abandoned.
B: You were being a party pooper.
A: I didn't know anybody–the least you could have done is introduce me to some of your friends.
B: Listen, you're grown up. You can take care of yourself. I'm tired of your nagging to be taken care of all the time.
A: And I'm tired of your inconsiderateness.
B: Okay, I'll stick to you like glue next time.

A is aggressive. The tone is accusing and blaming. B is immediately placed on the defensive and no one wins.

Scene 3

A: Would you mind helping me for a minute with this file?
B: I'm busy with this report. Catch me later.
A: Well, I really hate to bother you, but it's important.
B: Look, I have a four o'clock deadline.
A: Okay, I understand. I know it's hard to be interrupted.

A is passive. A's timid opening line is followed by complete collapse. The file problem must now be dealt with alone.

Scene 4

A: I got a letter from Mom this morning. She wants to come and spend two weeks with us. I'd really like to see her.
B: Oh no, not your mother! And right on the heels of your sister. When do we get a little time to ourselves?
A: Well, I do want her to come, but I know you need to spend some time without in-laws underfoot. I'd like to invite her to come in a month, and instead of two weeks, I think one week would be enough. What do you say to that?
B: That's a big relief to me.

A is assertive. The request is specific, non-hostile, open to negotiation and successful.

Scene 5

A: Boy, you're looking great today!
B: Who do you think you're kidding? My hair is a fright and my clothes aren't fit for the Goodwill box.
A: Have it your way.
B: And I feel just as bad as I look today.
A: Right, I've got to run now.

A is passive. A allows the compliment to be rebuffed and surrenders to B's rush of negativity.

Scene 6

(While at a party, A is telling her friends how much she appreciates her boyfriend taking her out to good restaurants and to the theater. Her friends criticize her for being unliberated).

A: Not so. I don't make nearly as much as a secretary as he does as a lawyer. I couldn't afford to take us both out or pay my own way at all the nice places we go. Some traditions make sense, given the economic realities.

A is assertive. She stands up to the prevailing opinion of the group and achieves a clear, non-threatening statement of her position.

Discuss LADDER Steps to Assertive Behavior.

LADDER

The first letters of each element combine to spell "LADDER." You may find this a useful mnemonic device to recall the steps toward assertive behavior. The LADDER script can be used to rewrite your problem scenes so that you can assert what you want. Initially, LADDER scripts should be written out and practiced well in advance of the problem situation for which they are created. Writing the script forces you to clarify your needs and increases your confidence in success.

As an example of a LADDER script, let's say that Jean wants to assert her right to half an hour each day of uninterrupted peace and quiet while she does her relaxation exercises. Frank often interrupts with questions and attention-getting maneuvers. Jean's script goes like this:

Look at: It's my responsibility to make sure Frank respects my needs, and I am certainly entitled to some time to myself.

Arrange: I'll ask him if he's willing to discuss this problem when he gets home tonight. If he isn't, we'll set a time and place to talk about it in the next day or so.

Define: At least once, and sometimes more often, I'm interrupted during my relaxation exercises–even though I've shut the door and asked for the time to myself. My concentration is broken and it becomes harder to achieve the relaxation.

Describe: I feel angry when my time alone is broken into, and frustrated that the exercises are then made more difficult.

Express: I would like not to be interrupted, except in dire emergency, when my door is closed. As long as it is closed, assume that I am still doing the exercises and want to be alone.

Reinforce: If I'm not interrupted, I'll come in afterward and chat with you. If I am interrupted, it will increase the time I take doing the exercises.

As another example, Harold has felt very reluctant to approach his boss to find out why he was turned down for a promotion. He's received no feedback about the reasons for the decision, and Harold is now feeling somewhat negative toward the company, and his boss in particular. Harold's script is as follows:

Look at: Resentment won't solve this. I need to assert my right to reasonable feedback from my employer.
Arrange: I'll send him a memo tomorrow morning asking for time to discuss this problem.
Define: I haven't gotten any feedback about the promotion. The position I applied for has been filled by someone else, and that's all I know.
Describe: I felt uncomfortable not knowing at all why I didn't get it and how the decision was made.
Express: So I'd like to get some feedback from you about how my performance is seen, and what went into the decision.
Reinforce: I think your feedback will help me do a better job.

These scripts are specific and detailed. The statement of the problem is clear and to the point, without blaming, accusing, or being passive. The feelings are expressed with "I messages" and are linked to specific events or behaviors, not to evaluations of Jean's husband or Harold's boss. "I messages" provide a tremendous amount of safety for the assertive individual because they usually keep the other person from getting defensive and angry. You are not accusing anyone of being a bad person, you are merely stating what you want to or feel entitled to. Successful LADDER scripts do the following:

1. When appropriate, establish a mutually agreeable time and place to assert your needs.
2. Describe behavior objectively, without judging or devaluing. Ask for changes that are reasonably possible, and small enough not to incur a lot of resistance.
3. Ask for no more than one or two very specific changes at a time.
4. Make the reinforcements explicit, offering something that is really desirable to the other person.
5. Avoid punishments that are too big to be more than idle threats.
6. Keep your mind on your rights and goals when being assertive.
7. Describe clearly, using specific references to time, place and frequency.
8. Express feelings calmly and directly.
9. Confine your feeling response to the specific problem behavior, not the whole person.

10. Avoid delivering put-downs disguised as "honest feelings."

Have parents think of an example where they would like to become assertive and role play. Have parents pretend they are adolescents and want to be assertive. Have parents role play this. Ask for feedback after role playing. Have parents express how they might feel if their adolescents become assertive with them. Stress importance of assertive behavior for adolescents. Explain that it allows for expression of feelings and prevents storing up a heavy burden of resentment and guilt. This material is adapted from *The Relaxation and Stress Reduction Workbook* (Davis, Eshelmann, & McKay, 1982).

Progressive Relaxation

Explain that deep muscle relaxation reduces tension and is incompatible with anxiety. Therefore, the habit of responding with one blocks the habit of responding with the other. Most people do not realize which of their muscles are chronically tense. Progressive relaxation provides a way of identifying particular muscles and muscle groups and distinguishing between sensations of tension and deep relaxation. Four muscle groups will be covered:

1. Hands, forearms and biceps.
2. Head, face, throat and shoulders, including concentration of forehead, cheeks, nose, eyes, jaws, lips, tongue and neck. Considerable attention is devoted to the head because, from the emotional point of view, the most important muscles in your body are situated in and around this region.
3. Chest, stomach and lower back.
4. Thighs, buttocks, calves, and feet.

Teach subjects to breathe in through their noses and out through their mouths. Have subjects get in comfortable position in a chair or on the floor and read the Basic Procedure for Relaxation (Chapter 4, Week 4, Day 1, p. 104)

After this exercise, have parents discuss how it felt. Now have parents close eyes and get in a comfortable position and listen to a progressive relaxation tape. After they have experienced the tape, lead discussion on how this affected them. Stress the importance of this skill for their adolescent. Explain that reducing anxiety helps to alleviate depression. Explain that their adolescent will be taught this skill. Ask for questions and discussion of this session. The material on relaxation was adapted from *The Relaxation and Stress Reduction Workbook* (Davis, Eshelmann, & McKay, 1982).

SESSION 6

Overview and Practice of Skills

Ask for discussion of how the past sessions have helped or hindered them as parents. Ask if they have any questions about previous sessions. Allow time for clarification of any confusing issues.

Have parents make up scenes of previous conflicts with adolescents. Have them role play how they would handle the situation now, using other parents as the adolescents. Have other parents provide feedback and suggestions. Let everyone have a turn at this. Ask parents to compare how they would have handled situation before versus now. Ask for feedback as to whether they feel more skilled at dealing with conflict situations and helping their adolescents problem solve. Also probe for feedback as to the effectiveness of support from other parents in the group. Allow time at the end of the session for closure and expression of group experience by parents.

CONCLUSION

In this family intervention component, parents and adolescents were taught the same skills for coping with depression and possible suicide.

The initial sessions focused on the dynamics of depression and suicide prevention. This information was dispensed in handouts.

The third session presented information on the use of positive and negative control with adolescents. Emphasis was on the increased use of positive reinforcement for appropriate behavior rather than coercive processes such as negative reinforcement and punishment.

Session Four was devoted to teaching communication skills and problem-solving skills for conflict resolution. The communication skills taught were effective communication, active listening, and expression of feelings. The five steps involved in problem-solving which were delineated were problem definition, generation of alternate solutions, decision making, planning solution implementation, and renegotiation. Topics were discussed in the group, and then role plays of how to use the procedures were implemented.

Session Five trained the parents in the use of assertion and progressive relaxation. These techniques aid the process of cognitive restructuring where the parent can help the adolescent to: identify cues, particularly stresses which can cue depressive behavior; develop appro-

priate communication and assertion skills; learn how to receive assertions and deal with others' anger; and practice alternate behavior such as stimulus removal in stress provoking situations.

The last session integrated the use of problem solving, communication training, positive reinforcement procedures, and assertiveness and progressive relaxation training, and applied these techniques to depression and suicide prevention. Parents role-played solving problems of adolescents of other group members.

Parents' ability to use communication skills, problem-solving skills, positive reinforcement, assertiveness, and relaxation will result in a better relationship with their adolescents (better communication, less conflict) and, therefore, will reduce the probability of adolescent depression and subsequent suicide.

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