Chapter 3

Introduction to CERT for Children

Contextual emotion regulation therapy (CERT) emphasizes the adaptive self-regulation of dysphoria as the primary road to recovery for children with clinical depression. Informed by the empirical literature on typical development, CERT is directive- and skill-focused. But it is also a flexible intervention that accommodates individual differences among young patients with respect to their mood repair response repertoires, related basic skills, and social contexts. This chapter provides an overview of CERT's distinguishing features, its central goals and intervention strategies, and guidelines for treatment duration.

Three Distinguishing Features of CERT

Three features of CERT distinguish it from other interventions for pediatric depression: (1) its *explanatory framework,* which identifies poorly regulated dysphoria (usually in the context of stress) as the central problem in depression and therefore accords a key role to adaptive mood repair in recovery; (2) the *active engagement of parent(s) in the depressed child's treatment by using a "coaching" model;* and (3) a *developmentally informed and individually tailored approach* to young patients.

The Explanatory Framework

An explanatory framework in psychotherapy is a way of explaining why the patient is suffering from the disorder and what ought to be done to help the patient recover from it. CERT's explanatory framework integrates information about the relationship between stress, coping, and depression with developmental research on emotion regulation and mood repair. It posits that recovery from depression and the ability to stay depression-free depend on the young patient's ability to keep sad and dysphoric affect at bay so that those affects do not take over, a process called *adaptive mood repair* throughout this book.

The Mood Repair Formulation of Depression

CERT identifies *mood repair failure* (or *maladaptive mood repair*) as the mechanism responsible for the child's depression. Mood repair failure contributes to clinical depression in two ways. First, it accounts for how dysphoric emotion leads to a depressive disorder. Second, maladaptive mood repair then maintains the depressive episode by contributing to persistent sadness, distress, or irritability that are central to clinical depression.

According to CERT's explanatory framework, the child's depression has come about because she has been unable to modulate the initial sadness and dysphoria that had been triggered by a negative event or process (stressor). Once the dysphoric emotion becomes persistent and segues into dysphoric mood, it is followed by a cascade of other depressive symptoms, some of which (e.g., sleep problems, concentration difficulties) further exacerbate dysphoria and distress. The end result is an episode of a depressive disorder. The depressive disorder is maintained by the child's maladaptive mood repair responses to everyday perturbations in emotions, which are brought on by the inevitable hassles of life.

While clearly acknowledging the full range of a child's depressive symptoms, this formulation focuses the therapist's attention on the young patient's affective complaints and the regulatory responses that maintain them. Because adaptive mood repair responding unfolds as a part of normative development (as reviewed in Chapter 2), persistent mood repair failure can implicate atypical development that should be identified and remediated, whenever possible. But, persistent mood repair failure also can reflect the malignant effects of more recent contextual stress processes.

The mood repair formulation of depression has several practical implications for the delivery of CERT. One implication is that right from the start, the therapist has to share this particular view of depression with the young patient and parent. Being able to think about depression as a problem in mood repair provides them with a new perspective on their difficulties and points to new directions for recovery.

Another implication is that the therapist has to frame the presenting problem (the concern that prompted the family to seek help), and the specific issues brought into each session, as *reflections of the child's mood repair problems*. Such a framing is easy if mood symptoms are the main problems. It is more of a challenge if the parents identify behavioral issues as most pressing, such as noncompliant and disrespectful behavior, declining school performance, or sibling rivalry. In these instances, the therapist has to explain that it is the dysregulated mood that gives rise to and fuels such maladaptive behaviors and most other depressive complaints.

As soon as possible the therapist has to take rapid corrective action to replace the maladaptive mood repair response(s) that maintain or exacerbate the child's despondent, dysphoric affect and introduce the parent–child pair to alternative

and adaptive ways to respond to dysphoria. Keep in mind, however, that much of mood repair is *automatic* (see Chapter 2). Thus, in the beginning of treatment, neither parent nor child may be fully cognizant of how the child's own responses to dysphoria or distress maintain it.

Viewing mood symptoms and problem behaviors as mirroring the child's mood repair difficulties, and then identifying how best to replace maladaptive responses that perpetuate the child's distress, are the initial steps for arriving at a *mood repair–based case formulation*. The case formulation goes beyond the observed mood repair problems and ways of correcting them and seeks to identify the contextual or developmental features of the child's life that may have contributed to the child's mood repair problems. It generally takes several sessions before the therapist has sufficient information to attempt an initial case formulation, which is likely to be revised as new data emerge.

Stress, Coping, and Dysphoria

The contexts of children's lives play important roles in the onset, course, and outcome of depression. Contextual elements that have been implicated in depression include acute or chronic stressors that impinge directly on children themselves (e.g., loss of a friend) or affect the entire family (e.g., parental unemployment), dysfunctional parental characteristics or family environment (e.g., mental illness, poor parenting style), limited availability of social and material resources, and stress-generating aspects of the community (e.g., Hammen et al., 1999; LeMoult et al., 2020). Recent research has also established early life maltreatment as a risk factor for depression and has started to identify some mechanisms (Hammen, 2015; Heim & Binder, 2012; LeMoult, 2020; Park et al., 2019). Notably, physical abuse is more strongly related to pediatric depression than sexual abuse (LeMoult et al., 2020).

CERT focuses on stressful life events as triggers in pediatric depression (see Chapter 1 for the supporting literature). It has long been established that stressful events that signify important real or symbolic losses appear to be specific provoking agents for depression (Beck, 1967; Brown et al., 1994), and this applies to youngsters as well (LeMoult et al., 2020). And, as already noted, there is evidence that psychosocial stressors may play a greater role in triggering the first episode of affective disorder than later episodes, possibly suggesting that the first episode sensitizes individuals to stress.

How does stress in a youngster's life lead to depression? The psychological construct of *coping* points to one pathway through which stressful events and depression are linked. Stress leads to depression only if the child has not been able to cope. According to a classical and enduring definition of coping, the word reflects the ongoing "cognitive and behavioral efforts to manage [those] specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 141; 1991). *Emotion-focused*

coping refers to efforts directed at managing the emotions and distress provoked by (or secondary to) the problem, whereas *problem-focused coping* refers to efforts directed at managing or altering the problem that caused the distress (Lazarus & Folkman, 1984, 1991). Emotion-focused and problem-solving coping are evident among children and adolescents as well (e.g., Compas, 1987; Compas et al., 1993). Although a third response type has also been proposed (Endler & Parker, 1990a, 1990b), the first two coping styles have received the most attention and researchers have consistently emphasized active problem solving as the best way to cope with stress.

Coping and emotion regulation clearly are overlapping constructs (e.g., Bonanno & Burton, 2013). This has been confirmed by an extensive meta-analysis of coping and emotion regulation in childhood and adolescence (Compas et al., 2017). And, as noted in Chapter 2, the study of coping has been one important antecedent of contemporary research on emotions (see also Gross, 1998, 1999; Tugade & Fredrickson, 2004). Having established the importance of coping with stress, research has segued into new directions, including the role of coping flexibility in depression (Bonanno & Burton, 2013; Kato, 2015).

In CERT, coping is regarded as the *broad area of stress management;* specifically, the responses to and management of adverse events and their impact on one's daily functioning and well-being. CERT's explanatory paradigm of depression, however, highlights the affective consequences of stress and underscores that coping requires the adaptive regulation of dysphoria provoked by stress. Furthermore, because many (if not most) stressful events in children's lives are outside their control and not amenable to problem solving (as would be recommended by traditional coping paradigms), children's ability to manage their emotional reactions to stressors is a crucial component of coping. Therefore, in CERT, the construct of emotion regulation, which includes mood repair, is super-ordinate to the construct of coping. Good affect regulation skills are essential for many areas of functioning and need to be deployed in the service of coping with stressful events.

Pathways from Dysphoria to Depressed Mood to Depressive Disorder

John Teasdale (1988) has noted that people who tend to get clinically depressed and those who are able to recover from an episode of sadness do not differ in the trigger events or the initial experience of dysphoria. Instead, they differ in how they respond to that affect: Depression-prone people are likely to respond in ways that impede "natural recovery." In other words, once a dysphoric emotion has been provoked, the normative and typically automatic response is to somehow lessen, diminish, or attenuate the dysphoria. But children who are prone to depression often fail to accomplish this goal. This opens the gateway to further depressive symptoms and undermines coping efforts.

Depressed mood may lead to clinical disorder via various pathways (e.g., Lyubomirsky et al., 2003; Lyubomirsky & Nolen-Hoeksema, 1993; Pomerantz &

Rudolph, 2003). For example, depressed mood elicits negative social responses, which range from being ignored to outright rejection (e.g., Joiner & Metalsky, 1995). Negative social responses, in turn, can have adverse effects on self-esteem, trigger ruminations, and thereby contribute to the downward spiral of clinical depression (e.g., Duggal et al., 2001; Feinstein et al., 2013; Joiner & Metalsky, 1995; Morrow & Nolen-Hoeksema, 1990). Protracted dysphoria also may adversely affect neurovegetative functions, most particularly, sleep. Sleep disturbance (e.g., Franzen & Buysse, 2008) can then contribute to fatigue (another symptom of clinical depression) and undermine the ability to concentrate (a further symptom), all of which then exacerbate negative mood and enable further depressive symptoms (e.g., Dahl, 1996). Self-regulatory responses, which may temporarily relieve dysphoria but engender other problems (e.g., the use of alcohol or other substances), also can pave the way to clinical depression (e.g., Cooper et al., 1995; Stapinski et al., 2016).

In general, pathways from dysregulated, dysphoric emotion to dysphoric mood and then to a depressive disorder probably are influenced by the affected individual's age and context. For example, negative family environment and parents who are emotionally unavailable or unsupportive are likely to contribute to the unfolding of depression in childhood (e.g., Cicchetti & Toth, 1998; Duggal et al., 2001), while contextual constraints, external pressures, or lack of material resources may be more decisive from adolescence onward. Regardless of the pathways whereby a depressed youngster's sad mood segued into a depressive disorder, CERT focuses on the youngster's mood repair response repertoire.

Engaging the Parent by Using a "Coaching" Model

According to a meta-analysis of clinical trials, the inclusion of parents in their children's treatment led to better outcomes than did treatments that only involved the young patients (Dowell & Ogles, 2010). However, most of the early (typically CBT) trials of depressed children and adolescents (usually conducted in school settings) did not include the parents, or only involved them in separate "parent groups" (for an overview, see Kovacs & Sherrill, 2001). In contrast, parental participation, which is consistent and active, is a critical component of CERT.

The Basis for Involving Parents in CERT

CERT's requirement of parental participation reflects practical as well as conceptual considerations. When parents are active participants in their child's treatment, they are more likely to feel involved in the therapeutic process and more likely to cooperate with the treatment regimen. Active parental participation also reinforces the important social and educational roles parents play in their children's lives.

But parents are involved in CERT primarily because of developmental

considerations. As described in Chapter 2, emotion regulatory responding is learned in a social context and children's acquisition of mood repair responses is initially facilitated primarily by parents. Across infancy and childhood, parents act as regulatory models, as "teachers" who selectively reinforce some responses (but not others), and as key interpersonal regulatory agents for the child. Parents remain the most important interpersonal regulators of a child's distress, at least up to the years of mid-adolescence, which further underscores the need for their active involvement in their offspring's treatment.

Another important reason for active parental involvement in CERT concerns the importance of reestablishing reasonable parent–child interactions. As any parent can testify, part of the glue of the parent–child relationship is the ability of the child to respond positively to caregiving and nurturing parental behavior. However, a depressed child often is unaffectionate and unresponsive (Kovacs & Bastiaens, 1995), denies parents the satisfactions for which they strive (Coyne et al., 1992), and prompts negative parental responses. Such interactions can become recursive, disrupt the parent–child relationship, and undermine the attachment bond. Indeed, depressed children have troubled relationships with their parents, and even subclinical depression can adversely affect interactions with parents and siblings (e.g., Dietz et al., 2008; Messer & Gross, 1995; Puig-Antich et al., 1985a, 1985b). Indeed, it is not unusual that, by the time a family presents for help, the original psychosocial stress that instigated the child's depression is no longer salient. Rather, the child's depressive symptoms and behaviors, which triggered negative parent–child interactions, has become the major source of stress and the stimulus for seeking help. The active involvement of the parent affords the therapist the opportunity to fulfill one important (although implicit) goal of CERT, the *normalization of parent–child interactions,* particularly around affect-related topics.

The "Coaching" Model

In CERT, the therapist views the parent as an active partner, not as a "co-patient." The parent becomes involved in the child's treatment in several ways. The parent: (1) actively works with the therapist as the therapist selects treatment targets, (2) acts as information gatherer, facilitator, and observer by carrying out the agreed on plan or strategy with the child and reporting on its success or failure, and (3) provides both feedback and reinforcement to the child. To facilitate their involvement, parents are given a parent manual at the start of treatment that explains depression and the parent's role within the context of CERT, and also provides other key information. A reproducible copy is included in Appendix D.

The parental role as a helpful agent or collaborator establishes a particular bond between therapist and parent. A sports analogy then provides a framework for how the parent is expected to help and how the child is expected to contribute: The therapist is the "coach," the parent is the "assistant coach," while the child

takes on the role of the special "player." The coach and assistant coach roles make it explicit that these two adults share the common goal of helping the child *and* that the focus of their interactions is the **child.** One consequence of this formulation is that, as assistant coach, the parent is expected to make objective observations of the child's behavior and thus becomes an information source for the therapist.

By defining the roles of the assistant coach and player and their implications in the presence of the young patient, the sports analogy also serves as a vehicle for **transparency:** The child now knows that the parent will have to report observations (and thus information is not being conveyed behind the child's back). Furthermore, the parental role as an assistant coach underscores that the young patient (not the parent) is the treatment focus. It is important to note, however, that while the parent plays a key role in CERT, the therapist has the final responsibility for the conduct, content, and format of treatment.

During each CERT session, the therapist takes every opportunity to get the parent involved as assistant coach in verbal exchanges: This can be introduced to the parent along the lines of "Can you now put on your coaching hat?" Furthermore, it is by identifying *coaching opportunities* for the parent that CERT provides the parent–child pair with the framework for new ways of interacting. Coaching opportunities can be structured as specific homework assignments or can be linked to the child's displays of adaptive (or maladaptive) mood repair responding.

Coaching interactions between parent and child (as well as between the therapist and the parent–child pair) *are guided by rules.* There are six rules for coaches and six rules for the child player. These are introduced in the first CERT session and are prominently displayed as posters in the treatment room. (See Posters 1 and 2 in Appendix B.) The rules are also included in the parent manual for CERT. (See Appendix D.)

Viewing the parent as a helping agent may not always be easy. For example, the parent could evidence behaviors or symptoms that may seem to be causally related to or reinforce the child's depression. The parent may appear to sabotage aspects of the child's treatment and/or divert the treatment focus from the child. However, focusing on the negative aspects of parental behavior is not likely to help the child. Instead (according to The Rules of Coaching), the therapist needs to focus on the strengths and assets of the parent to harvest them in the service of the child's treatment.

A Developmentally Informed and Individually Tailored Approach

The fact that CERT is developmentally informed is evident in several ways. As I discuss in Chapter 4, there is considerable emphasis on the therapist's use of age-appropriate language and oral communication. Furthermore, key elements of CERT are concretized for young patients by displaying illustrated posters in

the treatment room. Foremost among these is the poster The House of Emotion Regulation. (See Appendix B, Poster 3.) This poster depicts the three functional domains of regulatory responding as "rooms" that contain corresponding "tools" (mood repair responses).

On a conceptual level, CERT acknowledges that there are developmentally mediated differences in the extent to which the various mood repair responses can be used effectively even among children of similar ages. For example, one depressed 11-year-old may successfully use cognitive reappraisal to minimize the effects of a depressogenic trigger, whereas another 11-year-old's cognitive mood repair repertoire may only extend to the use of attention refocusing. Furthermore, responses also can be deployed in a developmentally inappropriate manner. Consider, for instance, a 10-year-old girl whose mood repair responses rely on interpersonal regulators. If, under circumstances of distress, this child starts crying and typically waits for the parent to initiate mood repair, her method of trying to recruit the parent is characteristic of a much younger child.

CERT also takes into account that, independent of psychopathology, children's developmental stage (which encompasses both psychosocial and physiological maturation) constrains the range and sophistication of mood repair responses. While there are no standardized or formal ways to assess a child's developmental level vis-à-vis mood repair, the key developmental trends were discussed in Chapter 2. The therapist should be fully cognizant of these trends (as well as the developmental trajectories of the skills that underpin them). This means that the therapist's expectations should reflect patients' developmental levels. For example, it would therefore be unlikely to have the same mood repair expectations of a 12-year-old and a 7-year-old.

Intrinsic to a developmental approach is the recognition of individual differences. Indeed, an individually tailored approach to depressed youngsters lies at the heart of CERT. This means that, while CERT sets the same **overall** goals for all depressed children (symptom elimination and mood repair competence), the ways in which those goals are achieved will differ across patients even of the *same age and same developmental level.* For example, CERT does *not* assume that one mood regulatory domain is better or more desirable than another; instead, it focuses on the functional domain that is "the best fit" for or preferred by the particular child. Thus, CERT easily accommodates the fact that for one child, tender hugs from the parent along with reassuring words may be a guaranteed path to feeling better; for another distressed child, the promise of some rewarding activity may work magic; yet another child may need to be engaged in some absorbing task to attenuate distress. Furthermore, for one child, the therapist might need to focus on modifying key contextual features in the home (e.g., parental affect-related behavior), while for another child, the challenge may be to assist the parent in securing material resources relevant to mood repair (e.g., access to a basketball court).

The individually tailored approach of CERT also accommodates the fact that contextual and cultural differences affect the availability and utilization of mood

repair responses. For example, it may be perfectly acceptable in one culture for teenage boys to hug each other as a way to alleviate emotional distress, whereas in another culture, such responses may cause boys unanticipated problems. Finally, an individually tailored treatment approach takes into consideration the fact that mood repair success is affected by children's temperament and existing parent–child interactions around affect displays. Thus, the CERT therapist works with the child within the framework of the child's developmental tendencies, functional strengths, and contextual reality. The flexibility inherent in CERT is captured in the following tenets:

- Youth vary in their inclinations and abilities to deploy responses from the behavioral, cognitive, and interpersonal response domains.
- Mood repair responses that "work" for some youth may not work for other youth.
- Youth vary in the extent to which their mood repair repertoires consist of adaptive versus maladaptive (and automatic vs. conscious) responses.
- Youth vary in the skills that underlie effective mood repair.
- The stage of psychosocial development (and likely neurocognitive maturation) mediates the type of mood repair responses on which a child can draw.

Goals, Pacing, and Duration of Treatment

CERT aims to reduce depressive symptoms and prevent relapse. These goals are achieved by focusing on the affective symptoms of depression, along with attending to other key symptoms as needed. A further (albeit implicit) goal is to normalize parent–child interactions particularly around topics that concern dysphoric emotions, moods, and their regulation.

CERT can be delivered across varying time periods, depending on individual need. Ideally, the duration of treatment should accommodate the temporal features of the child's depressive disorder. One possible rule of thumb is that the intervention should be about one-third (or more) of the length of the average episode of depressive disorder being targeted. That means, for example, that for psychiatrically referred (but medically well) children with major depression, CERT should be provided for *at least* 3 months, while for youngsters with dysthymic disorder, a treatment duration of about a year should be considered (see Chapter 1 for related information). However, in clinical practice, treatment duration may be constrained by financial issues, including the health insurance coverage of a family. In any case, it is highly advisable to have a *predefined treatment duration,* even if it is presented to the family as a goal that can be renegotiated at some later point in time.

Irrespective of its total duration, the intervention should include at least three phases that are distinguished in part by the "dosing" of sessions and in part by the goals of treatment. In Phases I and II, the major goals are reducing symptoms and reaching favorable emotional homeostasis. In Phase III, the goal turns to maintenance of treatment gains and prevention of depression recurrence through mood repair–related coping skills training. Thus, treatment should be delivered in a graduated fashion, with a decreasing "dosage" as follows:

Phase I: Intense intervention involving two sessions per week across an overall period of no longer than 2–4 weeks

Phase II: Regularly paced treatment, delivered on a once-a-week basis across a specified number of months

Phase III: Tapering and/or maintenance sessions separated by increasingly longer intervals, starting with 2 weeks and up to 4 or more weeks in between sessions across a specified number of months

The high frequency of contacts in the beginning helps to address the acute distress that usually accompanies initial presentation of pediatric depression. It also helps to actively engage the parent and lays the foundation for a therapeutic relationship. It was established quite a while ago that a substantial part of symptomatic improvement in adults occurs by the eighth session of psychotherapy (Howard et al., 1986); one would similarly expect an early response phase in child psychotherapy. Thereafter, weekly or less frequent sessions may be sufficient (and preferable) to achieve further symptom remission.

The therapeutic goal of Phase III in CERT is recurrence prevention, with an emphasis on the adaptive regulation of distress and a proactive approach to coping. As already noted, this phase focuses on affect-related coping skills training. The transition to Phase III takes place only after the child has few, if any, depressive symptoms. Coping skills training is most likely to be fruitful if implemented over an extended period of time with sufficiently long intervals between sessions to allow practice and consolidation of the learned information.

For example, given a child with major depression, a plan can include a 22-session intervention across a 6-month period, with 4 sessions in weeks 1 and 2, followed by weekly sessions until the end of month 4, and then tapering to 1 session every 2 weeks for months 5 and 6. In a treatment study of children with dysthymic disorder (a more protected form of depression; see Chapter 1), CERT was delivered as a 30-session intervention across a 10-month period (Kovacs et al., 2006). Month 1 included 2 sessions per week, and months 2–4 included weekly sessions (up to a total of 13 sessions). Tapering was delivered in two phases: 1 session every 2 weeks in months 5–6 and then monthly sessions across months 7–10.

To accommodate individual differences in the speed of therapeutic response,

a young patient may be advanced across the various phases based on symptom criteria. For example, a predefined percent drop in initial depression severity (by self-rating or clinical evaluation) could be required to progress from Phase I to Phase II. Maintenance of gains may be required for several weeks before moving from Phase II to Phase III. In general, some combination of the just noted criteria (time, or number of sessions, along with symptom severity) may be the most useful guide to progress a patient across Phases I to III.

How CERT Accomplishes Its Goals

Overall Approach

CERT is directive. In practice, this means that the therapist explicitly sets the focus of the session and, as "head coach," makes sure that the session's actual content remains true to the goal. To accomplish this, each session starts with "setting an agenda," which is basically a session plan. Likewise, the CERT therapist is directive when she guides the family to focus on a particular symptom or complaint. The symptom-oriented chapters provide numerous examples of the directive nature of CERT.

CERT is skill-focused. This means that teaching, demonstration, and practice are important elements of each session. CERT's skill focus is one reason why homework assignments, and practicing mood repair responses and related skills, are key treatment components. The didactic aspects of CERT can take the form of psychoeducation, such as when the therapist explains to the parent–child pair CERT's approach to depression. However, CERT typically promotes an approach involving the therapist posing questions in ways that help the parent and child to connect the dots themselves.

CERT's skill focus also means that the therapist takes every opportunity to demonstrate (rather than just talk about) how mood repair works. For example, if a child experiences an upsurge in distress *within the session,* the therapist can demonstrate how to attenuate it by having the parent and child engage together in physical activity for a few minutes (like jumping jacks or vigorously throw a ball back and forth; see Chapter 6). The fact that physical activity can reduce the child's distress *in vivo* then is fodder for a discussion of "what just happened," including which aspect of the intervention (e.g., mood repair response domain) made it effective.

CERT is also a practical intervention: It recognizes that the needs of a given young patient at a given point in time may override directives in the treatment protocol. For example, although there are guidelines for topics to be covered in the first CERT session (see Chapter 6), the therapist can elect to address only some of them if the situation warrants it. Likewise, during coping skills training, practical considerations may limit the range of topics that are addressed. All in all,

the empirical and practical approaches imbedded in CERT mean that the road to recovery is not straight, but is likely to include some trial and error on the part of the therapist and the parent–child pair.

Symptom Reduction

Young patients can manifest a variety of depressive and nondepressive symptoms; parents may also identify behavioral issues, including the child not listening, having tantrums, or being disrespectful of elders. The CERT therapist prioritizes the reduction of affective symptoms of depression (see Chapter 7) but can readily intervene with nonaffective symptoms as well (see Chapter 8). However, the nature of some acute symptoms may not be clear, while other symptoms may persist or change across contexts or interactions. The template for working with target symptoms offered in the next section can help the CERT therapist decide how to approach a symptom and what to do about it.

A Template for Working with Target Symptoms

The template identifies five steps for working with a target symptom. For some symptoms, the sequence listed here may be followed exactly. However, interventions with some other symptoms may emphasize only some of the five problem-solving features of the template. In addition to the two brief examples given, the symptom-focused chapters (principally Chapters 7 and 8) contain further illustrations of how parts of this template can be applied.

The five steps for working with a target symptom are: symptom verification, contextual mapping of the symptom, symptom (re)formulation (if warranted), selecting an intervention point and strategy, and assessing the outcome of the intervention. See also Table 3.1.

1. ***Symptom verification:*** The therapist, parent, and child need to agree on what the target symptom is, that it has been present recently, and that it has been a problem. As amply illustrated in this book, it is very important to clarify what the symptom is. For example, what parents may perceive as intentional meanness on

TABLE 3.1. Steps for Working with a Target Symptom

Symptom verification
Contextual mapping of the symptom
Symptom (re)formulation (if warranted)
Selecting an intervention point and strategy
Assessing the outcome of the intervention

the part of their child often turns out to be extreme irritability. It is also important to identify and isolate the most recent example of the symptom. If agreement cannot be reached on these three points, work should not proceed on the symptom in question and an alternative target should be selected.

2. ***Contextual mapping of the symptom:*** Symptoms are embedded in particular contexts, which can have ramifications for how the therapist elects to intervene. For any symptom, it is helpful to identify at least three contextual elements: the interpersonal interactions within which the symptom became manifest, the behavioral and environmental antecedents or concomitants of the symptom, and the interpretations attached to the symptom by key actors. More specifically, a symptom is mapped by asking, "what, how, when, who, and where" it occurred. The resulting information helps the therapist to select an intervention point. For example, the therapist may focus on the parent–child interactions that typically precede a symptom for a given child in order to reduce the likelihood of its occurrence. Or, the intervention focus may be to reduce the child's tantrum that occurs concomitant with his display of acute dysphoria.

3. ***Symptom (re)formulation (if warranted):*** With some families, it may be necessary or useful at times to formulate (or reformulate) what a symptom signifies in order to place it within the explanatory framework of CERT, provide parent and child with a new way of looking at that difficulty, and lessen the sense of personal blame for the patient's and family's dysfunction. One formulation of a symptom is that it is a sign of depression. For example, if the parents regard a depressed child's lack of interest in joining family functions as being oppositional, the behavior can be reformulated as mirroring the anhedonic aspect of depression. The symptom also can be reformulated as resulting from the child's problems in mood repair, rather than as evidence of willful disobedience.

4. ***Selecting an intervention point and strategy:*** Should the therapist focus on the symptom itself, its precursors, or its consequences? That is a clinical decision, which is influenced by the nature of the symptom. As noted in a prior example, if the target depressive symptom arises amid a parent–child dispute (symptom antecedent), then the therapist may wish to focus on and resolve the interpersonal interactions between parent and child and thereby reduce the child's exposure to that particular depressogenic process. Such stress reduction can be especially helpful early in treatment when the patient–therapist alliance is still being formed. But if the symptom is known to have multiple adverse effects (e.g., marked sleep disturbance), then it needs to be the treatment target. Later in this chapter, various intervention strategies are listed that the CERT therapist may use to alleviate depression symptoms.

5. ***Assessing the outcome of the intervention:*** After an intervention has been applied, the next step is to assess its outcome: Did it achieve its goal? If not, why not? Exactly when this step is implemented depends on whether the intervention

is applied in the treatment session (in which case, its effects can be immediately recognized), or if it is to be carried out by the child and parent as part of a homework assignment (in which case, the outcome can be reviewed only at the next session).

Intervention Strategies

An intervention strategy may be deployed in-session or assigned as part of homework for the parent and child to implement between sessions. The therapist can draw from a broad array of focused and goal-directed techniques that have been documented in the professional literature as feasible and effective with pediatric samples, as follows:

- **Behavioral techniques:** These techniques require the child or parent to engage in a specific action or overt behavior. It can involve assignments that the parent and child complete together, such as keeping a log of a target behavior, monitoring of symptom frequency and/or severity, "behavioral experiments," or keeping "temperature charts" of moods. It may entail the parent setting up differential reinforcement schedules for the child. Other examples include implementing various behavioral regulatory responses to dysphoria, such as assigning physical exercise to be performed by the child at preset occasions or intervals, having the parent and child engage in affect-related interpersonal interactions like long hugs twice each evening, implementing a sleep hygiene protocol, role playing within or outside the session, social skills training, or improving communication skills.

- **Cognitive techniques:** Cognitive techniques are used in CERT differently than they are in traditional cognitive therapy. In cognitive therapy, cognitive techniques are used to correct the patient's negative and biased information processing about the self and related issues; in contrast, in CERT, cognitive techniques are used to reinforce adaptive cognitive regulatory responses and deter the deployment of maladaptive cognitive responses to sadness and dysphoria.

The following cognitive techniques can help the child to interrupt sadness and/or thoughts that maintain or worsen it: visual and/or auditory imagery (e.g., a magic sign or phrase, "Pretend in your head . . . ," "Make believe you see a picture of . . . ," "Sing a song in your head"); thought interference (e.g., "Think of an opposing idea"); refocusing attention on a nonaffective problem-solving task (e.g., picture puzzle, word puzzle); thought substitution using nonaffective content ("Think about the room layout of your house," "Think about a favorite object"); or using positive affective content (recalling a fun-filled or happy event). With older youth, the therapist may try to counter cognitions that exacerbate distress with cognitions that entail alternate and neutral interpretations of the source and implications of the distress.

• **Contextual–environmental manipulation:** Changes in a child's physical environment can bring about surprising improvement in various depressive symptoms. Here are several examples: reducing negative stimulation by changing physical features of the home environment, such as where the child sleeps (see the discussion of sleep disturbance in Chapter 8) or does his homework; altering aspects of the school environment, such as changing the child's sitting arrangement in a classroom to facilitate attention; and working with community resources to provide safe exercise space to be used for behavioral mood regulatory responses.

Relapse and Recurrence Prevention

As the child achieves symptom relief, the focus of CERT turns to the maintenance of treatment gains, and the prevention of depressive relapse and recurrence. This part of CERT is called *coping skills training*, which includes emotion regulation coping goals and problem-solving coping goals. The concepts and strategies that were articulated to the child and parent in the symptom-reduction phase of the treatment become the basis of a preventative and hence a proactive (as opposed to a palliative and reactive) perspective. This shift in framework prepares the child and parent for the fact that recovery from the current episode by itself is unlikely to alter future risk of depression. However, continuous efforts at adaptive mood repair responding and willingness to strengthen one's existing mood repair response repertoire should lower the likelihood of depression recurrence.

Coping skills training focuses on the child's mood repair strengths (while remaining mindful of vulnerabilities) and builds in great measure on what the child and parent have learned and achieved throughout the symptom-reduction phase of CERT. It also introduces problem-solving coping as either a proactive or reactive response to impending or existing stressors, as one way to minimize their depressogenic effects. Coping skills training focuses on the following issues:

- Ongoing reinforcement of adaptive mood repair responses that have "worked" for the young patient to reduce dysphoria
- Ways to strengthen further the young patient's existing adaptive mood repair response repertoire
- Awareness of personally significant depressogenic stressors
- Use of proactive and reactive problem solving to eliminate stressors or mitigate their depressogenic effects

By the time this phase of CERT is reached, the therapist will have considerable information about the child's and parent's achievements in CERT and the child's depression history, including depressogenic stressful events (or processes). Based on such information, the therapist formulates a tentative "training plan" with

specific goals for the child and how to best achieve them, which is then implemented by the parent–child pair.

Coping skills training differs from the symptom-reduction phase of CERT in several ways. One difference is that coping skills training involves substantially more teaching (didactics) or psychoeducation. The purpose of didactics is to help the child–parent pair identify and integrate what they have learned in treatment, distill essential lessons that may be of help in the future, and provide conceptual schemata that will serve to anchor information about a preventative approach to depression. Additionally, coping skills training is future-oriented, while the symptom-reduction phase is present-oriented. Finally, because coping skills training is implemented while the frequency of patient–therapist contact is reduced (as noted earlier), this third phase of CERT also involves considerable demands for self-motivation and self-reinforcement on the part of the child and parent.

Homework: Why, How, and What

Homework assignments are an essential part of CERT and present the greatest demand for parent–child treatment adherence. In CERT, *homework* refers to a task that is assigned to the parent–child pair to complete before the next therapy session. Because homework usually involves gathering evidence or information, and changing behavior or aspects of the child's environment, it typically requires the use of one or more of the techniques noted in the prior section "Intervention Strategies." With few exceptions (usually involving adolescents), homework assignments are implemented by the parent serving as the coach to the child.

The Why of Homework

One reason for homework assignments is that the results provide the therapist with factually more accurate information than the family's narrative recall of events. The importance of getting parents and children to monitor and report on tasks in real time cannot be overemphasized because research has shown that memory is reconstructive and both negative and positive mood act to bias (to filter) the way in which memories are recalled. Consequently, the narrative information the therapist obtains in the session from child or parent is likely to be somewhat distorted as compared to the actual flow of events. For example, a frustrated mother may recall a day when her daughter was "always cranky." But a homework assignment involving the mother and child completing a mood log each morning and evening may show, for example, that the child was cranky in the evening but not during the day (see Appendix A, Forms 5–7, for examples you can photocopy and/or download). The therapist can use this information to explore the context of the irritable mood and factors that feed into it. The results of homework assignments

also provide the therapist with information on whether the therapeutic decisions were appropriate and suitable to the young patient's needs.

Another important reason for homework assignments is that many of them provide the parent–child pair with the opportunity to implement approaches, behaviors, and mood repair skills that have been addressed in the therapy sessions. Recall that CERT seeks to reduce the child's depressive symptoms and teach the parent and child to be more effective in managing the child's dysphoric affect in everyday life. These goals can only be accomplished by an iterative process that involves the parent–child pair repeatedly implementing specific symptom-reduction and mood repair tasks outside the treatment setting. Learning new skills or improving existing ones requires practice, which can be facilitated by the structured nature of homework assignments.

And finally, homework assignments in CERT provide the parent–child pair with a new paradigm for interacting with one another in daily life. This is important because, as already noted, by the time they seek treatment, the interactions between parents and their depressed children tend to be conflictual and dysfunctional. However, homework assignments involve specific roles and rules as well as a commonly agreed on goal. The parent serves as coach, the child is the team player, and the rules of coaching and of being a good player have to be followed: These features maximize the likelihood of positive outcomes. Additionally, a well-designed homework assignment gives the parent–child pair the opportunity to engage in role-appropriate interactions and thereby serves as implicit proof that the parent–child relationship can be mended.

The How: Rules for Assigning Homework

There are three rules for assigning homework:

Rule 1: The therapist must have a clear rationale for the homework, which is integrated with the goal of treatment at that point in time. A task assigned just to give the parent–child pair something to do is unlikely to be completed and unlikely to contribute to therapeutic progress.

Rule 2: The young patient and the parent both have to understand the reasons for the assignment; the reasons have to "make sense" to them.

Rule 3: The assignment has to be doable. In other words, the parent–child pair must have the internal and external resources to implement the assignment. Even if the results are negative, or not as expected, completion of homework assignments greatly furthers therapeutic progress.

To implement these rules, the homework has to be discussed and rehearsed in detail, with the following questions in mind:

Does it make sense to parent and child?

Do parent and child understand how it can help to deal with the symptom or target problem?

Do parent and child believe that they will be able to implement the assignment?

Homework assignments should be graded across CERT sessions. This means that the CERT therapist must start with relatively simple tasks, even if the child presents as unusually precocious and the parent as very eager. The first one or two homework assignments should involve monitoring no more than two important parameters, for example, the occurrence of irritable mood (yes/no) using an hourly log and the patient's location at logging. Tasks can gradually be increased in complexity by adding further parameters: For example, while monitoring irritable mood, each occurrence can be rated on a severity scale as well.

With all homework assignments, the therapist presents the strategy, explains its rationale, obtains parent–child agreement on its implementation, and reviews in detail with the family how to do it. It is especially important for the therapist to ask the parent and the child to explain, in their own words, their understanding of the homework assignment. The therapist must listen carefully for signs of any misunderstanding of the nature of the assignment, which needs to be corrected.

For example, after a therapist asks a parent about her understanding of a mood-monitoring homework, it is not unusual early in the treatment for the parent to respond along the lines of "You want me to write down for you each time [the child] is cranky and upset." The therapist needs to correct such a statement by saying, "I don't think I explained this homework well" and then adding, "It is not that I want this, but that it is a good idea because it will help us to see if there is a pattern to [the child's] distress, so then we can talk about what we could do about it." The corrective statement emphasizes that the homework is a collaborative task, one which will yield information that can be used on the path to help the child feel better. The symptom-focused chapters provide examples of how homework assignments are introduced and used in CERT.

The What: Types of Homework

There are two general categories of homework assignment: tasks that involve monitoring and recording, and behavioral experiments that involve some action with the goal of changing some variable. However, the range and content of homework assignments are limited only by the imagination of the therapist and the topic.

Monitoring and Recording. Monitoring or recording of symptoms, mood, and behavior is the strategy of choice in the beginning of therapy; it is the simplest and easiest to do. This type of homework provides the therapist with real-time data regarding the ebb and flow of the young patient's emotions, symptoms, and

behaviors and the effects of context on them. The therapist also can use the successful completion of this assignment as proof of the ability of the parent and child to effectively work together to help the child get well. Thus, completed monitoring homework can provide parent and child with a sense of accomplishment early in treatment.

The easiest monitoring and recording procedure is completion of a daily log of any given behavior, activity, mood state, or context. A log can focus on how *frequently* a particular behavior or symptom occurs on a typical day (e.g., recorded as a "yes" or "no"). The recording window can be the entire day until the child goes to bed or only selected segments, such as after school or after dinner. See Appendix A, Forms 5 and 6, for reproducible daily feelings logs to track dysphoric mood.

After the child and parent have mastered simple monitoring, they can be asked to provide information about additional dimensions, such as how severe or disruptive a given symptom or complaint was (rated on a Likert-type scale). A further rating dimension can be the context at the time that the mood is logged (e.g., at school, at home) or the child's reaction to her affect (e.g., "Write down what you did or thought when you had this bad feeling"). Form 7 in Appendix A is a blank reproducible version of a daily log of affect, including severity ratings and context.

When monitoring affect intensity with younger children, line drawings of faces can be used to indicate the strength or severity of the target experience. Alternatively, colors can be used, with dark blue signifying great sadness or upset and increasingly paler blue colors signifying less and less sadness or upset. If a numeric scale is used with younger children, it should be simple, ranging, for example, from 1 (little; not strong) to 4 (a lot; very strong). Older children should be able to rate affect intensity on a more differentiated numeric scale (e.g., from 0 = not at all to 9 = very strong). To lessen response bias, try to avoid a metric with a natural midpoint. A more difficult assignment, generally suitable only for older children (and their parents), is monitoring both the affect and the young patient's response to it. An equally challenging monitoring task is to record target cognitions or thoughts that emerge in association with particular mood states. These types of assignments require trial runs in the session so that the therapist can determine whether the assignment is understood and if the child can complete it on her own.

Behavioral Experiments. Some homework assignments are defined as experiments because: (1) They involve attempts to change or explore something and (2) neither the therapist nor the parent–child pair know the outcome beforehand. The results will be learned only after the assignment has been attempted. Most behavioral experiments entail overt behavior change, including the implementation of new mood repair responses. Note that, by definition, in an experiment, both negative and positive results are equally important and informative! Chapters 7 and 8 contain examples of homework assignments focused on adaptive mood repair responses that were presented by the therapist as behavioral experiments.

Homework Compliance and Noncompliance

Because most families may not be familiar with the concept and practice of therapeutic homework assignments, do not expect perfect compliance. It is not uncommon in the beginning of CERT for many parent–child pairs to return to the next session with partially completed homework assignments or assignments that were executed incorrectly. However, families should always be praised for any effort that has been exerted on behalf of homework, even if the task was not completed or was executed incorrectly (e.g., "I am really happy to see that you gave [the task] a try! This is very important—and you can now tell me about it!"). The fact that the parent and child had tried to implement an assignment signals that both are engaged in the treatment.

If there is full noncompliance, the therapist should make every effort to determine the reasons for it. During such questioning, be sure to be supportive, which can be conveyed by statements like the following:

> *Yes, homework can be a real pain and hard to do, so why do you think you had trouble getting it done?*
>
> *I was wondering if I explained it to you correctly. Was the explanation too complicated?*

It is particularly important to find out whether noncompliance reflects solvable issues such as the parent–child pair having failed to understand or agree with the homework's rationale and/or not having the needed resources, or the homework being too taxing or cumbersome.

If task complexity was the reason for noncompliance, simplifying a homework assignment by breaking it into subcomponents (if possible) can facilitate its completion. Further explaining the homework's rationale may motivate young patients and parents, who otherwise may have failed to see any beneficial consequences of the homework. And proposing an alternate homework may be the solution if noncompliance reflects insufficient parental resources. Parents and young patients also can be asked to propose modifications to some homework. Regardless, always be willing to negotiate the scope of any homework.

In closing this chapter, I wish to reemphasize the importance of homework in CERT. In the earlier phases of treatment, homework assignments generate very important information for the therapist and provide the parent–child pair with learning experiences. And depending on the issues at hand, homework assignments can comprise significant portions of a child's coping skills training.

Guilford Publications
370 Seventh Avenue
New York, NY 10001
212-431-9800
800-365-7006
www.guilford.com