CARE
Caregiver Adolescent Relationship Enhancement

A Group Program for Caregivers of Youth with Depression

camh | Cundill Centre for Child and Youth Depression

caribou by camh

CONTRIBUTORS

Madison Aitken, Ph.D., C.Psych.
Ameeta Sagar, MSW, RSW
Jacqueline Relihan
Gray Liddell
Daniel Navarro DeGiorgio
Martine Jean-Louis
Darren Courtney, MD
Stephanie Ameis, MD

ACKNOWLEDGMENT

We are grateful to all the caregivers who participated in the development phase of this program. Their feedback helped shape the program content, and we thank them being part of the program and for sharing their insights with us.

This manual is a modification of the Adolescent Coping With Depression Course (CWD-A) parent group program with permission from Gregory Clarke, PhD.

FUNDING SUPPORT

This program was developed with the support of the Cundill Centre for Child and Youth Depression at the Centre for Addiction and Mental Health (CAMH).

SUGGESTED CITATION

Aitken, M., Sagar, A., Relihan, J., Liddell, G., Navarro DeGiorgio, D., Jean-Louis, M., Courtney, D. & Ameis, S. (2026). *Caregiver Adolescent Relationship Enhancement (CARE): A Group Program for Caregivers of Youth with Depression.* Toronto, ON: Centre for Addiction and Mental Health.

Copyright © 2026 Centre for Addiction and Mental Health

All rights reserved. No part of this work may be reproduced or transmitted in any form or by any means electronic or mechanical, including photocopying and recording, or by any information storage and retrieval system without written permission from the publisher—except for a brief quotation (not to exceed 200 words) in a review or professional work. Please address permission requests to publications@camh.ca.

This publication may be available in other formats. For information about alternative formats or other CAMH publications, or to place an order, please contact CAMH Publications:

Toll-free: 1 800 661-1111
Toronto: 416 595-6059
Email: publications@camh.ca
Online store: store.camh.ca
Website: www.camh.ca

Contents

Introductory Information for Clinicians

INTRODUCTORY INFORMATION

Depression is one of the most common mental health concerns in youth, affecting approximately 1 in 10 young people (Avenevoli et al., 2015). Many youth do not respond to evidence-based treatments for depression or experience a recurrence of depression after treatment (Curry et al., 2011; Davies et al., 2020; Weersing et al., 2017). Caregiver-youth relationship problems have been identified as a major factor that predicts poor depression treatment outcomes (Brent et al., 2009; Courtney et al., 2022; Maalouf et al., 2012; Rengasamy et al., 2013; Wilkinson et al., 2011). The Caregiver Adolescent Relationship Enhancement (CARE) program was developed to address caregiver-youth relationship issues related to youth depression. It was designed to complement other components of evidence-based treatment for youth depression, including psychotherapy and/or medication (Courtney et al., 2019). The CARE program includes elements of psychoeducation, cognitive-behavioural therapy (CBT), problem solving, and parent management training.

PROGRAM DELIVERY

The CARE program was designed to be delivered in eight weekly, 1.5 hour group sessions with caregivers of youth ages 13–18 with a depressive disorder. The program works well with between six and 12 caregivers. One or more caregivers from the same family can attend, though facilitators may consider accommodating separated or divorced caregivers in separate groups. Two facilitators are recommended, and ideally facilitators will have experience with parent interventions, group therapy, and working with adolescents who are experiencing depression. The program can be offered concurrently with youth treatment, or before or slightly after youth have completed their own therapy for depression. Though originally developed for in-person delivery, we have also run the program successfully via secure videoconference.

THEORETICAL MODEL INFORMING THE PROGRAM

Evidence from longitudinal studies consistently supports a bidirectional association between youth depression and caregiver-youth relationship problems; that is, caregiver-youth relationship problems and youth depression contribute to each other (Hale et al., 2016). Caregiver-youth relationship problems may increase the risk of youth developing depression by making it more likely that the youth will have negative thoughts about themselves or decreased self-esteem (Garber & Flynn, 2001). Maladaptive communication patterns between caregivers and youth can reinforce negative affect or emotion dysregulation among youth, leading to an increased risk of their developing depression and other mental health challenges (Beauchaine, 2015).

At the same time, youth depression creates many potential challenges that can increase the likelihood of caregiver-youth conflict. For example, youth may stop attending school or attend inconsistently, leading to conflict as caregivers try to assert family rules. In addition, some of the features of depression, such as tending to make negative attributions for others' behaviour, or being irritable, can lead to communication breakdowns and difficult interactions that, over time, strain caregiver-youth relationships.

The CARE program aims to interrupt the bidirectional association between youth depression and caregiver-youth relationship problems by supporting caregivers to use communication strategies that decrease conflict and increase positive interactions with their child.

DEVELOPMENT PROCESS

This program was developed for delivery as part of an integrated care pathway for youth depression based on established guidelines for the treatment of youth depression (Courtney et al., 2019; NICE, 2019). Other components of the pathway include assessment, psychoeducational sessions (held separately for caregivers and youth), measurement-based care, team reviews, as well as optional youth psychotherapy (group CBT or other psychotherapy) and/or medication.

We began running the program with a basic structure that included components from the Coping with Depression Adolescent Program Parent Group (Lewinsohn et al., 1991) and the Care for Adolescents who Receive Information 'Bout OUtcomes (CARIBOU) Group Cognitive-Behavioural Therapy Program (Courtney et al., 2019). Over the course of six rounds of the program, we gathered oral and anonymous written feedback from caregiver participants, which we used to further shape the program by adding and removing various components. In addition, we integrated components targeting aspects of the caregiver-youth relationship that have been consistently associated with youth depression outcomes, including: 1) caregiver criticism directed at the youth; 2) maladaptive response to youth emotions (including invalidation and dampening positive affect); and 3) caregiver-youth conflict.

We then carried out a thorough review process with two caregivers who had participated in the program and two youth with lived experience of depression (supported by an experienced Youth Engagement Facilitator). Caregiver and youth advisors reviewed all session outlines and handouts and provided feedback in writing and through a series of consultation meetings. Lastly, an expert review was provided by a psychiatrist from the Cundill Centre for Child and Youth Depression at CAMH. More detailed information about the development of the program can be found in Aitken and colleagues' (2023) *Development and Preliminary Effectiveness of a Group Intervention to Improve Caregiver-Adolescent Relationships in the Context of Adolescent Depression.*

EVIDENCE

Our initial single-arm trial with 53 caregivers (of 94 who were eligible and invited to the program) supported the acceptability of the CARE program to caregivers. Fifty-six per cent of caregivers who were invited agreed to participate. The most common reason caregivers cited for not participating was a schedule conflict (44% of those who did not participate). Caregivers attended on average 65% of sessions (five out of eight), dropout was low (25%), and caregiver ratings of their satisfaction with the program on an anonymous survey were high (92%). We also examined change in family functioning from pre- to post-treatment among caregivers with data available at both time points (n = 22). Caregivers' ratings on the McMaster Family Assessment Device General Functioning Scale decreased significantly by the end of the program, indicating a decrease in family functioning problems (Aitken et al., 2023). Further research is underway to compare improvement in caregiver-youth relationships, following the CARE program, relative to usual ways caregivers are involved in their child's depression treatment.

LANGUAGE

It is important that facilitators use destigmatizing language that matches the preferences of caregivers and youth in the setting in which they are working.

We use the terms “caregiver” and “caregiving” throughout, rather than “parent” and “parenting” so as to be inclusive to adults caring for a youth with depression who are not biological parents (e.g., grandparent, foster parent, adult sibling). Facilitators may prefer to use the term “parent” if this matches the preferences of the caregivers with whom they are working.

We refer to the young person as “your child” in talking to caregivers based on input from our youth advisors, who preferred this term over other options such as “teen” or “adolescent;” however, if another term is more acceptable to the caregivers you work with, feel free to adjust the language.

Lastly, we use person-first language throughout (e.g., youth with depression, instead of depressed youth) as our youth advisors identified this terminology as less stigmatizing.

ENVIRONMENT

We encourage facilitators running the program in person to choose a comfortable environment in which to hold the sessions. Caregivers who participated in the program during the development phase noted that they preferred environments that felt less sterile or classroom-like (e.g., a smaller room with cushioned chairs where we could sit around a table was preferred to a bigger classroom with plastic chairs), where possible. In addition, caregivers requested that facial tissue be made available as some of the discussions can be emotional.

When running the group via secure videoconference, the facilitator should set group norms with caregivers in the initial session: this includes ensuring that participants are in a private space during the group, and asking that they not engage in other activities (e.g., making dinner) during the program.

NOTES FOR FACILITATORS

We have compiled some notes below that facilitators may find helpful in planning to lead the group, many of which are based on feedback from caregivers and youth:

1. **Being sensitive to caregivers’ feelings of blame.** Many caregivers of youth with depression feel that they are somehow to blame for their child’s difficulties (Stapley et al., 2016). It is therefore important that facilitators present content in a way that does not unintentionally imply blame. As noted above, research has consistently found that the association between youth depression and caregiver-youth relationship problems is bidirectional, rather than caregivers causing youth depression. Providing psychoeducation about the numerous possible causes of depression can be helpful, along with stating directly that caregivers are not to blame for their youth’s depression. Framing the program as a way to support youth recovery from depression can also be helpful, as opposed to being about “correcting” things caregivers are doing wrong.
2. **Addressing potentially unhelpful suggestions.** The program involves soliciting a lot of input from caregivers and creating opportunities for caregivers to support one another in navigating challenges. From time to time during these discussions, caregivers may suggest ideas that are likely unhelpful. In these instances, we often ask caregivers about their experience using the particular approach and what the outcome has been. We may then ask other group members their perspectives on the approach. Of course, any serious child protection issues must be handled promptly, consistent with relevant codes of practice and legislation.

3 **Caregiver goal setting.** Participants are encouraged to identify goals in the first session that are specific to their role as a caregiver (e.g., to remain calm in the morning before school). This is in contrast to child-focused goals (e.g., for my child to no longer have depression). Caregivers should be encouraged to identify goals that are within their control and that are reasonable and likely to be within their child's boundaries. For example, spending a lot of time with their child may not be a goal welcomed by the child, even if the caregiver-youth relationship improves.

4 **Attending to caregiver stress and mental health.** Being the caregiver of a youth with depression brings a range of challenges that can affect caregivers' own mental health (Stapley et al., 2016). Because depression is familial, many caregivers may also experience depression or anxiety themselves (Lahey et al., 2011). Depending on the needs of the group, facilitators may wish to open weekly sessions with a brief relaxation exercise. Supporting caregivers in accessing their own mental health support may also be indicated for caregivers experiencing their own depression or anxiety.

5 **Adapting to the priorities of caregivers.** Caregivers consistently told us that they wanted opportunities to talk about the topics that were a priority to them. This may vary from group to group, and it is important to balance meeting the needs of individual caregivers with the interests of the other caregivers in the program. We have often found it helpful to vary the examples used in the program to match situations described by caregivers in the group. For example, if caregivers share challenges related to adolescent substance use, technology use, anxiety or attending mental health appointments, these and other topics can be incorporated into the examples used throughout the group.

6 **Creating opportunities for discussion and support.** Caregivers' most consistent feedback about the program has been that they valued, and wanted more, chances to talk with other caregivers in similar situations. We have therefore built opportunities throughout the program for caregivers to share their challenges and receive support from both facilitators and other caregivers. In doing so, it is important that facilitators ensure that all caregivers have equal opportunities to share, and that the discussion is not consistently centred around any one caregiver or family.

Session 1
Introduction and Psychoeducation about Depression

Materials Needed

- For in-person delivery:
  - White board / flipchart and markers
  - Session handouts: Understanding Depression; SMART Goals Worksheet; Mood Foundations Depression Fact Sheet
- For virtual delivery:
  - Visuals: CBT Model; Upward & Downward Spirals
  - PDFs of session handouts: Mood Foundations Depression Fact Sheet; SMART Goal Sheet

Agenda

- Introductions
- Overview of program and group guidelines
- Depression in young people
- Behaviour activation
- Setting caregiver goals
- Review and home practice assignment

PART 1: ORIENTATION

Welcome & Introduction

- Welcome caregivers to the group. Explain how their being here today and their active involvement in their child's care is a sign of their commitment to their child's well-being.
- Facilitators introduce themselves, including their names, roles, training/credentials, and contact information.
- Engage caregivers in a light icebreaker: Ask each member to share their first name, their pronouns (if comfortable), and their favourite chips / food / TV show / snack / animal etc.
- Encourage caregivers to ask questions about the group.

Overview of Group

- For caregivers of adolescents with depression, eight weekly 1.5-hour sessions
- Provide an overview of the group program, similar to the following: Being the caregiver of a young person with depression is difficult in many ways. Caregivers often feel stuck as to how to best support their child and may feel quite alone in the process. This program is designed to help address many of the common challenges caregivers encounter, with a focus on improving communication with your child, reducing stress at home, increasing positive interactions, and reducing conflict. Each of you brings your own perspectives and experiences. We will provide information each session, and we also want to hear from you and to learn from you.
- Sessions will include:
  - learning about depression in young people
  - learning and practising communication and problem-solving skills
  - assigning home practice activities to try out strategies from the group and discussing their experience using the home practice assigned in the previous session
- Ask caregivers what they have told their child about why they are participating in the caregiver group.
  - Encourage them to let their child know they're in the group to learn how they can support them and that they will be trying out new ways to communicate.

Introduction to Session Format

- Sessions will follow the same general format:
  - Review agenda.
  - Review last session content & home practice.
  - Discuss and practise a new topic, skill or strategy.
  - Assign a home practice.
- Provide an overview of today's agenda.

Housekeeping Items & Attendance

- Emphasize the importance of weekly attendance, addressing the following points:
  - Sessions build on each other, so it is important to attend as much as possible.
  - Please avoid missing more than one or two sessions maximum, and call or e-mail facilitators if you are going to be absent.

Establish Group Rules

- Solicit guidelines from the caregivers that will help the group function well together. If the session is virtual, use the shared whiteboard function or share screen in Word to write down their suggestions. If you are in person, use a white board or flipchart.

- Ensure the list includes each point below (add on as necessary):
  - **Confidentiality:** What is shared in group must not be shared with others outside of group. Note that here, facilitators should also:
    - Explain the limits of confidentiality, as appropriate in their setting or jurisdiction
    - For virtual groups, discuss the need for caregivers to be in a private space for the duration of the group session and emphasize that sessions cannot be recorded.
  - **Respect others:** Be polite and respectful of others' opinions, and ensure that only one person speaks at a time.
  - **Timing:** Group facilitators will keep an eye on the time and move discussion along to ensure we have enough time to cover all of the material and that everyone has a chance to contribute to discussions.
  - **Supportive, inclusive environment:** Stress the need to work as a team and be supportive of other group members.
  - **Minimize distractions:** Turn down background TV, avoid other online or offline activities, and put cell phones on vibrate or silent. For virtual groups, consider asking caregivers to mute their microphone if there is a lot of background noise.
- Ask caregivers what other guidelines would help them feel comfortable participating in the group.

PART 2: GETTING TO KNOW ONE ANOTHER

- Ask caregivers to take turns sharing:
  - their child's age
  - the best thing about their child
  - what they are hoping to learn by participating in the group.

PART 3: PSYCHOEDUCATION ABOUT DEPRESSION

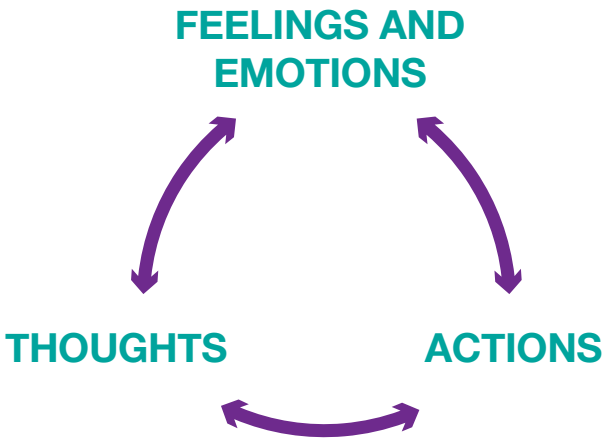
Depression in Young People

- Ask caregivers what comes to mind when they think about what depression looks like. Write down notes / key words on white board / flipchart.
- Throughout the discussion below, check in with caregivers about whether the ideas match what they have observed their child struggling with.
- Provide an overview of depression based on the Mood Foundations Depression Fact Sheet, including the following points (paraphrase as needed):
  - Core symptoms of depression include sadness that lasts for several days at a time, making it difficult to get through the day, and losing interest or enjoyment in activities. Sometimes this sadness feels like emptiness, severe boredom or like "everything is grey."
  - While intense and lasting sadness is what most people think of when they think of depression, irritability is another way that low mood can look, especially in young people with depression. Irritability means being touchy or easily annoyed and can include angry reactions. The irritability associated with depression lasts longer and is more intense than everyday irritability young people might experience as part of adolescence.

- Other symptoms that adolescents with depression might experience include disrupted sleep (like sleeping more than before, or having trouble falling or staying asleep), appetite changes (having little appetite and eating less than usual, or eating more than usual), changes to physical activity levels (like having low energy, feeling tired or fatigued, and moving more slowly than usual, although some young people can also feel unsettled or restless), trouble concentrating or making decisions, repeated negative thoughts (like feeling overly guilty about things that have happened or feelings worthless), and thoughts of death or suicide.
- There are many causes of depression. Biological causes include genetics (having a family history of depression), imbalances in brain chemistry or the stress hormone system, and substance use. Cognitive causes include negative thinking patterns about oneself, others and the future. And difficult experiences can also contribute to risk for depression, like being exposed to negative or stressful events such as bullying, relationship breakups or the death of a loved one. Depression is often the result of several risk factors working together, rather than a single cause.
- Depression also affects young people's quality of life, and makes it difficult for them to engage in everyday activities, like seeing friends, participating in family life, and going to school.

Thoughts, Feelings, Actions Triangle & Downward/Upward Spirals

- Several approaches are effective for treating depression. In our program, we use a cognitive-behavioural approach to treating youth depression.
- Ask caregivers whether they have heard of cognitive-behavioural therapy or CBT before. If so, ask what they already know about CBT.
- Provide information on cognitive-behavioural therapy (CBT), such as:
  - CBT is an approach to therapy that has been shown to help people problem solve and manage challenges that come up in everyday life. It involves a combination of cognitive strategies (learning to think flexibly, look for evidence, and challenge your own negative thoughts) and behavioural strategies (improving sleep, increasing social and physical activity), as well as problem solving to help manage challenges that come up in everyday life.
  - Use the CBT triangle diagram to explain the CBT model as a three-part system where each part affects the others *[draw or show the diagram below]*. The CBT model is a three-part system where each part (Thoughts, Feelings and Emotions, Behaviour) affects the others.



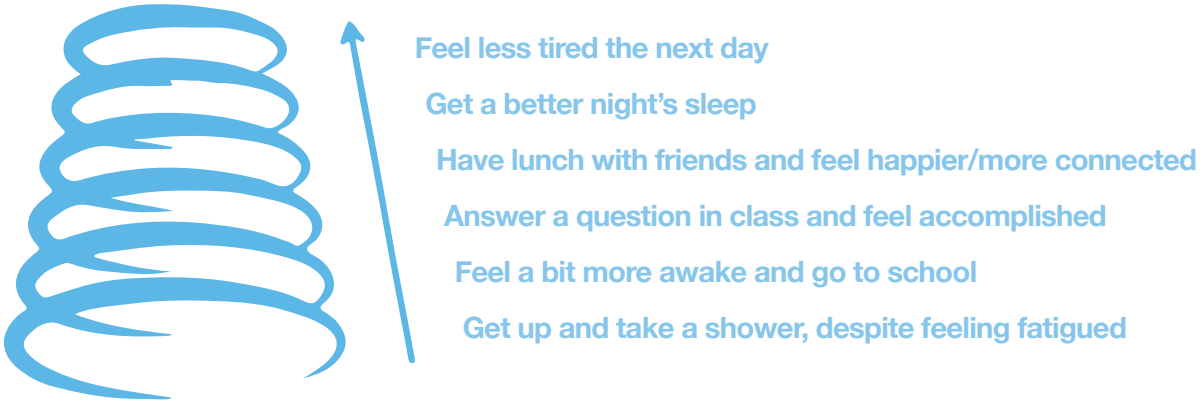
- Ask which of the three (thoughts, feelings and emotions, actions) is easiest to control or change.
  - Engage caregivers in a discussion about this, including some of the following points, as appropriate based on their response:
    - Most people try to "change" their emotions, but this is difficult to do. Give an example that may resonate with the caregivers in your group (e.g., if you were very angry about something a coworker did, how easy would it be for you to change how you were feeling?)
    - Thoughts and actions are easier to change, although it takes practice to get better at these skills.
    - As part of CBT, adolescents learn strategies to help change thinking and actions.
    - We will also talk about how this model applies to interactions with your child.
- Ask how people's THOUGHTS change when they are experiencing depression.
- Ask how people's ACTIONS change when they are experiencing depression?"
  - Engage caregivers in a discussion about how each of the parts affects the other two.
  - Feeling down = less likely to do the things we enjoy, have more doubts about our ability to be successful in doing those things (e.g., maintaining hobbies), feel more hopeless and discouraged. This can lead to a **downward spiral** of mood worsening over time. *[Draw spiral or show on screen.]*

The Downward Spiral

- Ask for examples of some things might start a downward spiral.
  - Some possible answers include: Participating in few activities, feeling depressed, doing less, withdrawing from family, thinking self-deprecating or hopeless thoughts like "Why bother trying?" or "No one likes me.".

- When we are successful, we feel proud, energized, and happy, gain self-confidence, and think we can do things well = more likely to do more things in the future. This is an example of an **upward spiral**. *[Draw spiral or show on screen.]*

The Upward Spiral



  - Ask for examples of some things might start an upward spiral.
  - Some possible answers of things that can start an upward spiral / get you "on a roll" / break or reverse a downward spiral: being successful at something (even taking a small step); accomplishing something; taking care of personal hygiene; having someone who cares about you reaching out to you; receiving support from friends, family or care team.

- Preventing or interrupting downward spirals before they become serious is the best approach.
  - As part of our CBT program, adolescents learn skills to help ward off this downward spiral, like changing thoughts and actions.
  - **Behaviour activation** is one strategy that may help to start an upward spiral. Behaviour activation involves increasing daily activities, with a specific focus on four kinds of activities that are especially helpful for improving mood:
    - **Sense of connection:** Does it make you feel closer to others?
    - **Success:** Does it give you a sense of achievement?
    - **Enjoyment:** Do you like doing it?
    - **Personal values:** Does it fit with what's important to you?

PART 4: SETTING GOALS

- Introduce the rationale for setting goals so caregivers can determine if the group has been helpful and decide how to direct their efforts.
- Ask caregivers if they have heard of SMART goals before. If they have, ask group members to share what they know about them.
- Explain that SMART goals stand for:
  - **Specific:** Goals are often general, or too vague for us to know if they've been met. For example, "Have a better relationship with my child" is general, but "Stay calm when we disagree" is more specific.
  - **Measurable**: It's easier to tell if your goal has been met if there is a way to measure or quantify it. For example, "Spend more time with my child" isn't measurable, but "Do something with my child once a week" is.
  - **Attainable**: Set goals that are realistic and that focus on things you can control. Also consider where things are currently, and what changes might be possible over the next two months of us working together. It's OK to start small. New goals can always be added later on!
  - **Relevant**: Having a goal that feels important to you is more motivating. It's easier to make changes when it feels like you're working toward something that will make a difference in your situation.
  - **Time based:** Setting a time frame can help you to stay on track and give you an opportunity to check in about whether your goals have been met. Encourage caregivers to think about a goal they will accomplish by the end of the eight-week group. Tell caregivers that for home practice, you would like them each to identify two or three goals for themselves as caregiver. Encourage them to think about the SMART goals framework when developing their goals.
- Emphasize that the goals should not be about their child alone. For example, reducing their child's depression or having their child get less angry at them are about their child's behaviour. Encourage caregivers to identify goals related to things within their control (e.g., their own behaviour or responses).

PART 5: WRAP-UP & HOME PRACTICE

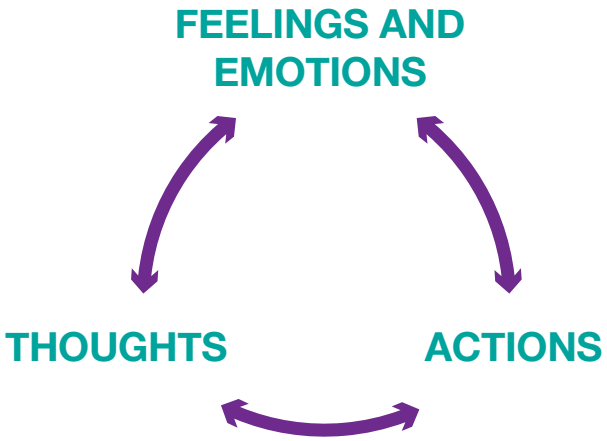
- Ask caregivers what they found the most helpful from today's group.

Home Practice

- Identify one caregiving goal for the group using the SMART goal sheet.

Session 1 - Handout:
Understanding Depression

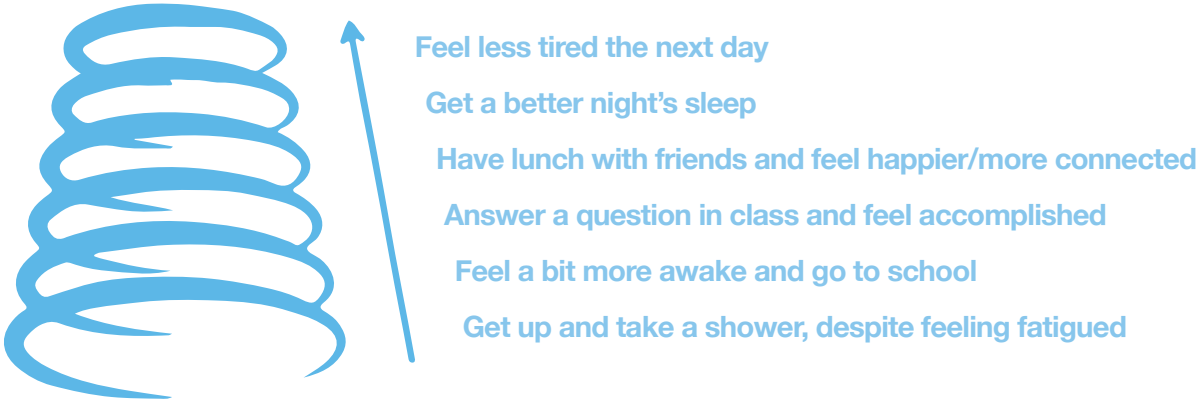
A Three-Part System



The Downward Spiral

- Feel unhappy
- Spend more time alone
- Feel sad or down
- Become less active
- Feel more depressed
- Do even less

The Upward Spiral



- Feel less tired the next day
- Get a better night's sleep
- Have lunch with friends and feel happier/more connected
- Answer a question in class and feel accomplished
- Feel a bit more awake and go to school
- Get up and take a shower, despite feeling fatigued

SMART GOALS

S PECIFIC

What outcome would you like?

M EASUREABLE

How will you know when you have reached your goal?

A TTAINABLE

On a scale of 1-10, how confident do you feel that you will do it?

R ELEVANT

How meaningful is this goal to you on a scale of 1-10?

T IMED

When do you intend to reach your chosen end point?

camh

MOOD FOUNDATIONS

Depression and Anxiety Facts

What are depression and anxiety?

Depression is when feelings of sadness, emptiness and irritability (crankiness) last longer than two weeks, affect most parts of a person's daily life, and stop them from doing things that they used to enjoy. Excessive anxiety can include worries that are difficult to control as well as physical discomfort (e.g., muscle tension, sweating, fast heart rate, stomach upset, restlessness).

Core symptoms

Depression is when sadness goes on too long and makes it difficult to get through the day.

Anhedonia is the inability to experience pleasure. It can be described as an emptiness, severe boredom or an "everything is grey" feeling.

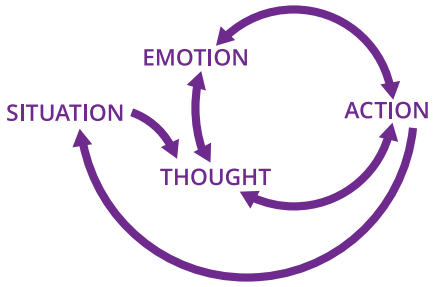
Irritability is a symptom of depression when it is disproportional or too much for the situation.

Worries are concerns about something bad happening in the future, or about what other people are thinking about you.

Associated symptoms

You might experience some or all of these symptoms:

- disrupted sleep
- disrupted appetite
- disrupted physical activity levels
- poor concentration
- muscle tension
- excessive feelings of worthlessness or guilt
- repeated thoughts of death.



COGNITIVE-BEHAVIOURAL MODEL OF EMOTIONS

What causes depression and anxiety?

Biological: genetics or family history of depression/anxiety, imbalances in brain chemistry and in the stress hormone system, substance use.

Psychological: negative views of the world, negative view of oneself, negative view of the future.

Environmental: a major stress, trauma or change.

There are many stereotypes about what depression and anxiety look like, especially in the media. The truth is, there is no one way to have these experiences. You might have different symptoms that affect your life in different ways than someone with the same diagnosis. Learning more about mental well-being can help you (and others in your life!) better understand your emotions and how you can break the stigma that surrounds it.

Treatment can significantly improve your chances of **getting better** and **staying well**

10-2024 ©CAMH

camh | Cundill Centre for Child and Youth Depression

caribou by camh

This product was developed by the Youth Engagement Initiative.
For more information about this project, or to receive an electronic copy of this product, e-mail cundill.centre@camh.ca.

Session 2
Cognitive-Behavioural Model & Caregiving

Materials Needed

- For in-person delivery:
  - White board / flipchart and markers
  - Session handouts: Empathy in Action
- For virtual delivery:
  - Visuals: CBT Model; Empathy in Action diagram
  - PDF of session handout: Empathy in Action handout

Agenda

- Review and discuss home practice (caregiver goal setting)
- Apply the cognitive-behavioural model to caregiving
- Empathy in action model of caregiving
- Review and home practice assignment

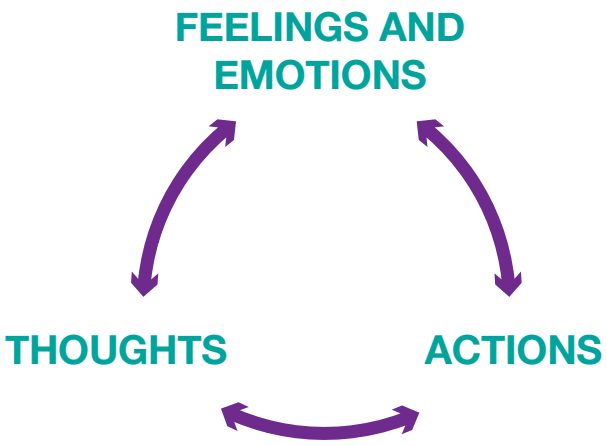
PART 1: WELCOME & HOME PRACTICE REVIEW

Welcome & Introduction

- Briefly welcome caregivers back.
- Provide an overview of today's session.
- Ask caregivers what they remember from last session. Briefly review the following key points:
  - Depression involves changes in thoughts, feelings and behaviour.
  - Thoughts, feelings and behaviour often work together to create a downward spiral, which leads to feeling worse over time.
  - One of the key components of treatment for depression is behaviour activation.
- Review home practice activity and ask caregivers to share:
  - SMART Goals: Ask each caregiver to share one of their goals for participating in the group.
- Ask caregivers whether they have had a chance to talk to their child about how they are currently part of this caregiver group.

PART 2: THE CBT MODEL

- Personality is a three-part system. *[Show the CBT model.]* Each part — Thoughts, Feelings and Behaviour — affects the others. *[Point out that arrows are bidirectional.]*



- Go through a depression-related example and discuss the three parts of the CBT triangle:
  - Example Situation: You've been in bed all day and feeling really down. Your friend texts you and invites you over.
    - *What THOUGHTS might your child have in this situation?*
    - *What are they likely to DO?*
    - *How are they likely to FEEL?*
    - Explain in relation to the downward spiral and opposite, upward spiral
- Ask caregivers to give an example of another situation that might cause someone to experience strong emotions, and go through the three components of the CBT model.

PART 3: CBT MODEL AND CAREGIVING

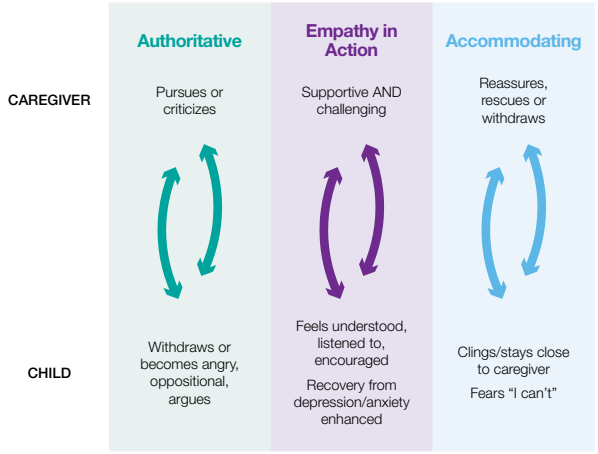
- Caregivers of children with depression often experience thoughts and feelings of their own that can affect how they approach situations with their child.
- Go through a caregiving-related example and discuss the three parts of the CBT triangle:
  - Example situation: School starts in 30 minutes and your child is still in bed, asleep. Ask caregivers if this situation is something they encounter often. If it isn't, solicit other ideas of situations when caregivers tend to experience strong emotions.
  - Ask caregivers:
    - How they would be feeling
    - What thoughts they might have
    - What they are likely to do

- Engage caregivers in a discussion about how their thoughts and feelings are related, and how they also influence actions. Encourage caregivers to share various perspectives and thoughts. For example, some caregivers may be concerned, others may feel anxious, and others may feel frustrated.
- Ask caregivers what would typically happen in this situation. Engage in a discussion about how acting when experiencing strong emotions can sometimes make a difficult situation worse, rather than waiting for those emotions to subside.

- Ask caregivers to provide another example of a caregiving situation in which they experienced strong emotions. Discuss their thoughts, feelings and behaviour in the situation, and how the three were inter-related.

PART 4: EMPATHY IN ACTION MODEL

- Ask how the way they approach caregiving has changed since their child has been experiencing depression.
- Introduce the empathy in action model of caregiving and relate it back to what caregivers have shared above. *[Show model.]*



- When children experience depression, caregivers often feel pulled in two directions.
- Very often, caregivers shift to be more "**accommodating**." This includes eliminating expectations you might have had before, offering a lot of reassurance, and stepping in to manage challenges.
- However, when caregivers take a more "**accommodating**" approach, children can end up feeling like "I can't do this on my own."
- Give the following example: Your child has been struggling a lot this week with low mood and has barely been able to get out of bed. They have a virtual appointment in 15 minutes with their psychiatrist, who they have a good relationship with. An "**accommodating**" approach might be to email the psychiatrist and ask to reschedule because your child is not feeling up to meeting.
- Sometimes caregivers also find themselves falling at the opposite end of the spectrum – what we've called "**authoritative**." This includes becoming stricter or more critical (emphasize that, in doing this, caregivers are well-intentioned).
- When caregivers take a more authoritative approach, they may find their child responding with anger, arguing or withdrawing.

- In our example above, an authoritative approach would be to go into your child's room and tell them firmly that they need to sign in to the appointment or you will take away their phone for the rest of the day.
- Ask caregivers whether they identify with either or both of these caregiving styles. Discuss examples of accommodating and authoritative caregiving from their own experience.
- In contrast, the middle road is what we've called "**empathy in action**." It involves a balance of support and encouragement. You convey your understanding of your child's current challenges and join them in working through the challenges they're facing.
- Sticking with our example above, an empathy in action approach would be to remind your child calmly about the appointment, e.g., "Hey, you have your appointment with Dr. Z soon. Can I do anything to make it easier for you to go?"
- Ask caregivers to identify a time when they were in the empathy in action zone and talk about the outcome (their child's reaction, and how they felt as caregivers in the situation).
- Encourage caregivers to identify one way they can move toward the empathy in action zone in the next week.
- Relate the empathy in action model back to the cognitive-behavioural model.
  - Caregivers' thoughts about a situation can be one factor that pulls them toward an "accommodating" or "authoritative" approach. In the example above, ask caregivers what thoughts might lead a caregiver to take the 'accommodating' approach of rescheduling the appointment. Possible responses include: Talking to their psychiatrist might be too much for them right now; or the appointment might feel too overwhelming for them.
- Ask what thoughts might lead a caregiver to take the "authoritative" approach. Possible responses include: Their depression might get worse if they don't get help; or I always have to remind them of everything.

- Ask caregivers to identify a thought that might get in the way of their Empathy in Action step this week.

PART 5: WRAP-UP & HOME PRACTICE

- Ask caregivers what they found the most helpful from today's group.

Home Practice

- Implement a step toward empathy in action caregiving. Identify a thought that might get in the way.

Session 2 – Handout
Empathy in Action

	Authoritative	Empathy in Action	Accommodating
CAREGIVER	Pursues or criticizes	Supportive AND challenging	Reassures, rescues or withdraws
			
CHILD	Withdraws or becomes angry, oppositional, argues	Feels understood, listened to, encouraged Recovery from depression/anxiety enhanced	Clings/stays close to caregiver Fears "I can't"

What was a thought you had that got in the way of you practising empathy in action caregiving this week?

Session 3
Positive Caregiving Strategies

Materials Needed

- For in-person delivery:
  - White board / flipchart and markers
  - Session handouts: Amplifying Positive Mood
- For virtual delivery:
  - PDF of session handout: Amplifying Positive Mood

Agenda

- Review and discussion of home practice (step toward empathy in action caregiving)
- Introduce positive caregiving strategies
- Discuss ways to support behaviour activation
- Additional caregiving strategies
- Review and home practice assignment

PART 1: WELCOME & HOME PRACTICE REVIEW

- Briefly welcome caregivers back.
- Provide an overview of today's session.
- Ask caregivers what they remember from last session. Briefly review the following key points:
  - The cognitive-behavioural model also affects caregiving interactions.
  - When your child is struggling with depression, it is common to feel pulled to one of two extremes: **accommodating** or **authoritative**
    - Ask what each (accommodating, authoritative) might look like when your child is struggling with depression.
  - Encourage a balanced approach called **empathy in action** caregiving, which involves being both supportive and encouraging of your child's autonomy. This means, for example, that rather than stepping in and doing things for them, or setting strict limits, you join them in working together to address challenges.

- Ask caregivers to share their experience with the home practice of implementing a step toward empathy in action caregiving.

PART 2: POSITIVE CAREGIVING STRATEGIES

- Review the concept of upward spirals from Session 1.
- Ask if they have recently noticed any examples of upward spirals happening for their child. Emphasize the importance of even small steps.
    - Caregivers can play an important role in supporting behaviour activation by:
        - **Offering instrumental support.** For example: if your child wants to try an activity, you could offer to drive them or help them sign up, get materials or equipment they need, let them know you're around if they need anything, etc.
        - **Enhancing good moods.** Look for opportunities to support and encourage signs of positive mood or happiness. Research has shown that when adolescents experience depression, over time their caregivers provide less encouragement for positive mood. Think of this like starting a fire. We aren't asking you to provide the "spark" – instead, think of yourself as the oxygen that can help to make a tiny flame grow bigger. Examples are:
            - *showing interest. If you're in the middle of something, stop what you're doing to hear more about what's important/interesting/exciting to your child. Show that you want to hear more about it.*
            - *seeming happy yourself (match your child's mood)*
            - *asking if they would like to do something together / celebrate a positive event*
        - **Avoiding bringing up things that might dampen a good mood.** For example: If your child seems happy or excited about something, avoid bringing up responsibilities around the house, acting irritated, or bringing up concerns about school. Choose neutral moments for this instead.
        - Ask caregivers for an example of something they could do that would help to enhance signs of positive mood for their child.
- Ask caregivers, *"What other ways have you found helpful in setting a positive tone in your relationship with your child?"*
    - Discuss other positive strategies, including:
        - **Genuine positivity.** This involves making positive statements about your child's actions. Focus on acknowledging and validating effort and process rather than result (e.g., "I was so proud of you for sending in your resume" rather than only congratulating them once they get the job).
        - **Paying attention.** This will look different depending on your relationship and your child. It could be spending time each week doing an activity you and your child enjoy together without teaching them anything or addressing any challenges (unless your child brings up something they want to talk to you about). The only goal is to spend time together and enjoy each other's company. It can also include remembering things your child likes or that are important to them.

- Engage caregivers in a discussion about using these other positive strategies using the questions below:
  - *How can you see these fitting in for your child?*
  - *What might make it challenging to increase positivity statements or pay attention to their child more closely?*
- Encourage each caregiver to identify one way to increase "paying attention" when with their child.

PART 3: OTHER CAREGIVING STRATEGIES

- Ask caregivers what other caregiving strategies they use currently and how helpful they are generally.
- As needed, discuss natural and logical consequences in the context of challenging situations caregivers are currently experiencing, if appropriate.
  - **Natural consequences** happen as a result of the behaviour, without you intervening or doing anything. For example, if you decide not to wear a coat, you may be cold walking home. If you leave your laundry unfolded in the basket, you will have wrinkled clothes. If you stay up too late, you will be tired the next day.
    - Ask caregivers about their experience of allowing natural consequences to happen and what the result has been.
    - Natural consequences are helpful because:
      - *They are meaningful and directly related to the behaviour.*
      - *They reduce the number of times caregivers address concerns directly, creating less conflict.*
  - **Logical consequences** are related to the behaviour in a way that makes sense, but they require someone to put the consequence in place. For example, if you don't return a library book, you will get a late fine. If your child doesn't hand in an assignment, they will lose marks for a course. If your child is caught driving the family car unsafely, they may not be allowed to drive with friends for a certain period.
    - Use discretion and consider your child's age and the situation when you decide whether or not to put consequences in place.
    - Ask what their experience has been with using logical consequences.
    - Logical consequences should be used:
      - *very sparingly*
      - *when other strategies haven't worked. Use praise, positive strategies and problem solving first.*
      - *when the problem is disrupting family life or is serious*
      - *only for a short period (e.g., a day, not a week).*
- Emphasize that building a positive relationship, using "empathy in action" caregiving, and improving communication are the main tools that research suggests are most likely to help adolescents recover from depression.

PART 4: WRAP UP & HOME PRACTICE

- Ask caregivers what they found the most helpful from today's group.

Home Practice

- Identify one opportunity to enhance or amplify positive mood or support an upward spiral. Note what you did and what the result was.
- Use the questions below to support each caregiver in planning their home practice:
  - Emphasize that this will be different for each child.
  - Ask caregiver to identify one recent situation in which their child's mood seemed slightly more up, and what may have led to this.
  - Support caregivers in identifying a way they could enhance their child's slightly more positive mood in the above situation.
  - If caregivers are stuck, suggest a few ideas. For example, if their child is smiling or laughing about something they're watching on their phone, caregivers could show interest or ask if they can enjoy it together. If they seem happy about getting a text from a friend, offer to drive them to meet up with this friend.

Session 3 – Handout
Amplifying Positive Mood

Identify an opportunity to enhance your child's positive mood this week:

What did you do?

What was the result?

Session 4
Communication, Part 1 – Receiving Skills

Materials Needed

- For in-person delivery:
  - White board / flipchart and markers
  - Session handouts: Communication Skills and Active Listening
- For virtual delivery:
  - Visuals: Validating vs. invalidating responses
  - PDF of session handout: Communication Skills & Active Listening

Agenda

- Review and discussion of home practice (supporting upward spirals)
- Depression and communication
- Active listening and validation
- Review and assignment of home practice

PART 1: WELCOME & HOME PRACTICE REVIEW

- Briefly welcome caregivers back
- Provide an overview of today's session.
- Ask caregivers what they remember from last session. Briefly review the following key points:
  - Behaviour activation (increasing fulfilling/enjoyable/physical activities) is an important component of depression treatment.
  - Caregivers can support the upward spirals of behaviour activation by offering instrumental support, enhancing positive moods, and avoiding bringing up things that dampen a good mood.
  - Positive caregiving strategies like praise and quality time can also help strengthen the caregiver-child relationship.
- Ask caregivers to share their experience with the home practice of enhancing or amplifying positive mood or supporting an upward spiral.
  - *What did they do?*
  - *What was the result?*

PART 2: DEPRESSION AND COMMUNICATION

- Caregiver-child communication changes over time.
- Ask caregivers how they think communication has changed between them and their child as their child has gotten older.
- Briefly discuss adolescence as a developmental stage and how the caregiver-child relationship changes (i.e., adolescence as a time of creating their identity, increased capacity for thinking about goals and the future, and being more influenced by peers), but caregivers remain an important influence.
    - Ask caregivers if they remember how much more their child relied on them when they were very little.
    - Ask if they recall when their child started to become more independent and less reliant on them. This moving away from caregivers is called individuating and separating, and is a normal and healthy part of development because children learn to be their own people.
    - When children reach adolescence, their peers become more important to them than parents/caregivers. Ask caregivers if they remember their child saying things like, "You just don't get it" or "You won't understand."
    - Because parents/caregivers are the experts when their children are younger, it can be difficult for them when their children start spending more time with their peers. Sometimes children being more independent can be hurtful for caregivers, or cause them to pull away.
- Adolescents with depression can be more withdrawn and struggle to communicate with others. Discuss how the downward spiral contributes to this and how it becomes a habit over time.
    - Ask caregivers what they have noticed about the way their child communicates with their friends or family. How does their behaviour affect how others respond?
    - When people are experiencing depression, social interactions may be affected (the person may be more withdrawn, less active, and have less fun).
    - Healthy social functioning is important because:
        - Poor social skills ➔ Troubled relationships ➔ Isolation, loneliness, possible depression
    - Communication challenges associated with depression can make it easier for miscommunications to happen.

PART 3: COMMUNICATION AS A SKILL

- Ask caregivers what they notice about situations in which there is good communication versus situations when communication is poor.
  - Good communication = feel understood, in control, cared for; builds good relationships
  - Poor communication = feel misunderstood, isolated, powerless; disrupts relationships
- Share the following points about communication with caregivers:
  - Good communication is a skill that can be learned. Understanding the process and practising specific techniques can help.
    - These techniques can help to enhance what you're already doing. We are not suggesting that you've been doing things wrong.
    - Depression is complex, and adolescence can be a challenging time. These strategies are meant to improve communication if it's gotten off track. Some strategies may be helpful for you and others may not.
  - Communication involves a sender (speaker) and receiver (listener) who usually switch back and forth.
    - We will start by focusing on receiving or listening, and then move on to sending.
  - Communication takes place in a social context, and each context has its own rules (e.g., talking to your boss vs. talking to a friend).
    - Communication also takes place in the context of a relationship and a family's cultural background.
    - Patterns of communicating develop over time, so changing them can also take time and be gradual.
    - This is especially true if there has been a lot of tension or conflict in the relationship: it can take time to rebuild trust and develop new ways of communicating.
  - When good communication rules are not well defined, problems can arise.
    - For example, this can happen when caregiver and child have different opinions about the rules.
    - Rules may change if the relationship changes (e.g., as your child gets older).
  - Nonverbal communication plays and important role in how a message is received.
    - Encourage caregivers to think about how non-verbal communication has affected their communication with someone like a boss/coworker/friend/spouse (either positively or negatively).
    - Discuss the aspects of non-verbal communication below:
      - *facial expression (e.g., You walk into your boss's office for a meeting and she is frowning. What might you think?)*
      - *tone of voice (e.g., "I had a really great time at the party," said in a sarcastic way)*
      - *body language (e.g., saying "I feel fine" while sitting slumped in a chair and not making eye contact).*

- Now take somebody who is experiencing depression and ask what their nonverbal communication might look like. Discuss how nonverbal communication associated with depression might affect how caregivers interpret their child's communication and respond to them.
- Ask caregivers to share what their non-verbal communication looks like when they are upset, sad or angry. Discuss how this can affect how their message is received.

- Communication can be a delicate process:
  - Communication breakdown = listener receives a message that isn't what the speaker meant to communicate.
  - Different perspectives or priorities, language and generational differences are all things that can contribute to a breakdown in communication.
  - Thinking patterns associated with depression can make negative interpretations more likely. This can include all-or-nothing thinking, in which things are either good or bad; and a tendency to make negative attributions about oneself and others, such as thinking things are your fault when that isn't the case, or thinking that others think negative things about you when that isn't the case.
  - An example: Father: "I'm not buying you that shirt" – child hears "Dad doesn't care about me. He could buy it for me if he really wanted to."

- Ask caregivers when they notice that communication goes well with their child. Explore the following questions and topics with them:
  - *What do you do that helps the communication to go well?*
  - *What cues from your child tell you it might be a good time to talk?*
    - Emphasize the importance of being mindful of their child's cues, giving them choice about the discussions, and checking in with them about how they're feeling about the topic.
  - Recognize when to give space or take space for yourself to cool down if a conversation gets heated. You may need to come back later when you can both think more calmly and clearly and avoid saying hurtful things.
  - If your child has had thoughts of suicide, you may be an important part of their safety plan. Finding a simple way to check in with them that isn't overwhelming can be important (e.g., a hand signal check in with thumbs up = I'm OK; or thumbs down = I'm not OK when texting). Ask your child how they would like you to check in with them.

PART 4: ACTIVE LISTENING & VALIDATION

- Listening isn't passive – it takes time and energy and hard work to listen carefully.
- Listening and communication are affected by:
  - our past experiences
    - e.g., being reluctant to offer suggestions to your boss because a previous boss blew up at you when you suggested making a change at work
    - e.g., giving up trying to listen to your youngest child because it didn't seem to work with the older children in the family
  - how we feel
    - e.g., we are more likely to interpret an ambiguous message in a text or email as positive when we are happy, and we are more likely to interpret a similarly ambiguous message as negative when we are angry or sad.
- Some ways to listen generally work well; others don't work at all.
- Introduce the following three ways of responding. For each, give an example, have caregivers try this type of listening with each other, and ask caregivers if they find themselves listening in this way at times (e.g., by a show of hands). After giving caregivers a chance to try each approach with a partner, debrief by asking how the speaker and listener felt. Facilitators are encouraged to acknowledge that they sometimes use these less helpful ways of listening, too, to show that no one is perfect.
  - **Irrelevant responses**
    - The person responds by talking about an unrelated topic.
    - The person appears to have not heard what the other person is saying.
    - Example: Child says to mother, "I saw the most incredible dress in a store on Queen Street today!" Mother says "Have you cleaned up your room yet? I don't want to talk about anything until you have taken care of that mess!"
  - **Partial listening**
    - **Paying slight attention**, then politely introducing your own ideas. The person uses a small part of what the other person was saying, but takes off in a different direction.
    - This may mean listening to what the other person is saying but only for the purpose of **changing the topic** to something more interesting to you (e.g., Caregiver: "I got a raise today at work." Child: "Great, how about giving me more allowance?")
    - Example: Child: "I had the worst day at school today." Caregiver: "I had a tough day too. I dropped the car off to get the oil changed so I was late for work, and now I have to make dinner. Can you help set the table?"

- **Active listening**
  - Sender's message is the focus of the conversation.
  - Listening actively helps you understand the other person's position.
  - Three rules for active listening:
    1. Restate the sender's message in your own words. Avoid repeating it back exactly.
    2. Begin your restatement with phrases like "It sounds like you feel..." or "It sounds as if you think..." or "Let's see if I understand what you're saying...".
    3. Don't show approval or disapproval of the sender's message.
  - Example: Child: "I'm never going to find a summer job. I sent in like 20 resumés and still haven't gotten an interview. Everyone wants to hire someone with experience so there's no way they'd want me."
    - *Irrelevant listening = Caregiver: "Did you take the dog out for a walk yet?"*
    - *Partial listening = Caregiver: "You know, your cousin got a job at Starbucks last week. Maybe you just need to keep trying."*
    - *Active listening = Caregiver: "That sounds so frustrating. And it's so hard to submit all these applications."*
  - This skill is not easy, but it is very important. With time and practice, it can improve a relationship.
- Increasing active listening can help to reduce conflicts and disagreements by increasing understanding, and reducing communication breakdowns.
  - Engaging in active listening 100% of the time may not be realistic. Even small changes can be helpful in reducing miscommunication and improving relationships.
- **Next-Level Active Listening: Using Validation**
  - Another effective component of listening when someone expresses their private experiences involves providing validating responses.
  - **Validating** responses convey that a person's emotions in a situation are understandable, acceptable and legitimate, without trying to change how the person is feeling.
  - In contrast, **invalidating** responses convey that the person's emotional experience is incorrect, unacceptable or undesirable. These responses may also punish or trivialize how the person is feeling. Invalidating responses are often well-intentioned; for example, trying to cheer someone up when they are feeling bad about something.
  - For example — Child: "Alex invited everyone but me to her cottage this weekend. She posted a picture of everyone and tagged me to make sure I saw it. I feel like everyone hates me."
    - ***Invalidating response:*** *"I don't know why you let them get to you. You should just ignore them and be yourself. You've got so many good things going on."*
    - ***Validating response:*** *"That's so hurtful. I can see why you feel left out. What a mean thing to do."*

– Share research evidence on the effects of validating and invalidating responses:
  - *Invalidating responses can increase the intensity of difficult emotions in the sender and increase emotional reactivity (make emotions like anger, sadness or anxiety bigger and more intense).*
  - *Validating responses can help the sender manage difficult emotions.*
  - *Research has shown that we also respond physically to these two types of responses: When people hear validating responses after a stressful task, their heart rate decreases. However, when they hear invalidating responses, their heart rate tends to increase (Shenk & Fruzzetti, 2011).*
– Show examples of validating and invalidating responses.

Invalidating	Validating
Really? That doesn't seem like something to get upset about.	I can understand how this would make you feel.
I don't see why you would feel that way.	It seems like you were pretty angry/frustrated/hurt, etc.
I'm sure they didn't mean it that way.	I can see why that would make you angry/frustrated/hurt, etc.
There's no need to get upset.	I would feel _____ too if that happened to me.
Don't worry about it. It's not a big deal.	I think a lot of people in the same situation would feel angry/frustrated/hurt, etc.

- Have caregivers practise validating responses as a group:
  - For in-person groups, distribute cards to caregivers containing validating and invalidating responses. Include some subtly invalidating responses, as well as more obvious ones. For example, a subtly invalidating response to someone who is worried about their child's depression would be, "All kids go through a phase like this. I'm sure he'll be fine." Read out a sample statement that a young person might make. Have each caregiver read what is on their card. Decide as a group if it is validating or invalidating and why.
  - For online groups, facilitators can put up a slideshow of different statements a young person might make, or write them on the virtual whiteboard. Then offer two statements (one validating and one invalidating; include some subtly invalidating responses, as well as more obvious ones). Have caregivers vote on which statement would be validating, and which would be invalidating, and why.
- Ask caregivers to pair up and try taking turns expressing something mildly upsetting (a minor hassle) and having their partner respond with a validating response.
  - Discuss what they noticed about giving and receiving validating responses.
  - How could they see this fitting in with how they communicate with their child?

PART 5: WRAP-UP & HOME PRACTICE

- Ask caregivers what they found the most helpful from today's group.

Home Practice

- Practise active listening with validation at least once a day. Use the tracking sheet to note what happens. Try this exercise at least two or three times this week with your child.
  - Suggest that caregivers be transparent with their child that they are learning new ways to communicate. They may also want to ask if their child would be willing to help them practise their new skills.

Session 4 – Handout
Communication Skills and Active Listening

Basic Points about Communication

1. Good communication is a skill that can be learned like any other skill.
2. Communication involves a "sender" (or speaker) and a "receiver" (or listener). The sender has a message they want the listener to understand.
3. All communication takes place within a social context that involves other people. There are many different social contexts, and each one has its own "rules."
4. In many cases, the rules for communication in a specific context aren't well defined, and problems may arise when the rules aren't clear.
5. Communication usually involves words, but part of the message is also conveyed through nonverbal communication that involves facial expressions, tone of voice, and body language.
6. Sometimes the person who is listening receives a message that isn't what the sender meant to communicate. This is called a communication breakdown.

Rules for Active Listening

1. Restate the sender's message in your own words.
2. Begin your restatement with phrases like, "You feel …" or "It sounds as if you think …" or "Let's see if I understand what you're saying …."
3. Don't show approval or disapproval of the sender's message.

Next-Level Active Listening: Validation

There are two main types of responses when someone shares their personal experiences:

Invalidating

- Sends the message that the person's emotional experience is incorrect or unacceptable
- Tries to change how the person is feeling, or may punish or trivialize the person's feelings
- Often subtle or unintentional
- Tends to increase the intensity of the receiver's difficult emotions

Examples:

Really? That doesn't seem like something to get upset about.

I don't see why you would feel that way.

Yeah, you could have handled that better.

Other people don't usually feel that way.

There's no need to get upset.

Validating

- Conveys understanding, acceptance and legitimacy of the person's experience
- Does not try to change how the person is feeling
- Tends to help the receiver manage difficult emotions more effectively

Examples:

It seems like you were pretty angry/frustrated/hurt, etc.

I can see why that would make you angry/frustrated/hurt, etc.

I would feel _____ too if that happened to me.

I think a lot of people in the same situation would feel angry/frustrated/hurt, etc.

Try providing validating responses with your child this week:

Emotion expressed	Validating statement	How they responded

Session 5
Communication, Part 2 – Sending Skills

Materials Needed

- For in-person delivery:
  - White board / flipchart and markers
  - Session handouts: Sharing Pleasant and Difficult Feelings
- For virtual delivery:
  - Visuals
  - PDF of session handout: Sending Skills

Agenda

- Review and discussion of home practice (active listening and validation)
- Strategies for sharing pleasant and difficult feelings
- Review and assignment of home practice

PART 1: WELCOME & HOME PRACTICE REVIEW

- Briefly welcome caregivers back.
- Provide an overview of today's session.
- Ask caregivers what they remember from last session. Briefly review the following key points:
  - Changes associated with depression, like being more withdrawn, or tending to interpret situations in a negative way, can affect communication.
  - Communication is a skill that can be learned and improved.
  - Effective communication begins with active listening.
  - Active listening = listening without judgment, and conveying back to the person that you understand or are trying to understand.
  - Validation as a "next level" of active listening = conveying that what the person is feeling is understandable and acceptable.
- Ask caregivers to share their experience with the home practice of using active listening and validation with their child.
  - Discuss as a group and problem solve if any challenges arose.

PART 2: SENDING SKILLS

- Last session we discussed RECEIVING skills. Now we will talk about SENDING skills, beginning with positive or pleasant feelings.
- Display the following rules for self-disclosure:
  - Self-disclosure involves honestly telling how you feel about a situation or about another person's behaviour.
  - Self-disclosure does not mean revealing every intimate detail of your thoughts and feelings.
  - A relationship is strengthened by disclosing your reaction to events that both you and the other person experience, or to what the other person is saying or doing.
  - Hiding your reactions (positive or negative) to another person's behaviour does not improve your relationship with that person.
  - Self-disclosure involves some risk taking.
  - If a person's behaviour upsets you, it may be helpful to tell the person how you feel about their behaviour.
  - When you are disclosing your feelings, consider the relationship you have with the other person and the situation you're in. For example, self-disclosure to your child wouldn't mean confiding about very personal topics such as marital issues or the family's finances.
  - Self-disclosure is a two-way street – both people in a relationship should participate in the process. This means that, as caregivers, you must also be open to receiving feedback from your child about things you have done that may have upset them.

PART 3: SHARING PLEASANT FEELINGS

- Ask caregivers why stating pleasant feelings might be helpful.
  - Some reasons include that it promotes communication, makes others less defensive, makes us feel understood
- When you're disclosing pleasant feelings, it's helpful to describe the feeling and then explain why you feel that way.
- A good statement of feelings has two parts:
  - Describe how you reacted (your feeling).
  - Recount what happened (the specific behaviour or event).
- This may feel awkward at first. One way to do this is to **use "feeling words."**
  - Ask caregivers to generate a list of pleasant or positive feeling words. *[Write on white board.]*
- When we make statements about our feelings, we describe the outcome ("I feel ...") and then the reason ("when you ..."), e.g., "You make me happy." It's fine to make this general statement, but being **specific** is better because it tells the other person what he or she did that made you happy (e.g., "I was so happy you watched that show with me last night. It was nice spending time with you.").

- Note that sharing pleasant feelings needs to be done thoughtfully. Encourage caregivers to think how their child will feel on the receiving end. For example, saying something like "It makes me happy to see you smile" can be taken the wrong way by a young person experiencing depression.
- How could you make the following statements more specific?
  - *"I'm proud of you."*
  - *"Everyone thinks you're a nice guy."*
- Ask each caregiver to think of something positive their child did recently. Then ask how they can acknowledge it with a positive statement.
- If caregivers aren't able to think of an example, suggest one of the following things their child may have done:
  - took the dog out for a walk.
  - got up on their own and got to school on time.
  - applied for a job.
  - handed in a project.
  - was patient with their younger sibling.

PART 4: SHARING DIFFICULT FEELINGS

- There will also be times when you need to raise problems with your child for discussion, or share difficult or negative feelings you are having.
- Ask caregivers why they think it would be important or helpful to express difficult feelings.
  - Rationale: People often unintentionally do things that upset us. If we tell other people about our difficult/negative feelings in a constructive way, they are usually willing to listen and perhaps try to change the situation.
- The best way to tell someone about something that upsets is very similar to how we discussed ways to state pleasant feelings.
- Points about sharing difficult feelings:
  - Telling someone about what is upsetting you is mainly helpful when that person is someone you care about. Otherwise, you may choose to avoid the situation (e.g., an irritable store clerk may not be worth the effort as you likely won't see them again).
  - Before telling your child how you are feeling, consider whether the timing is right (i.e., will they be able to change the behaviour that is upsetting you, and is it a priority compared to other challenges you may be supporting them with). For example, certain things may be much more difficult for your child because of their depression (e.g., keeping their room clean, getting up on time).
  - Sharing difficult feelings is not about making the person feel bad or getting even.
  - Stating difficult feelings is usually much harder than stating pleasant feelings, but both are important for building healthy relationships.

- Ask caregivers what their current experience has been raising problems for discussion with their child.
  - Normalize that caregivers often feel like they can't bring up difficult issues with their child. They may feel like they are "walking on egg shells."
  - We will discuss ways to raise issues for a discussion that may make it less likely for their child to feel defensive or react negatively.
- Guidelines for Stating Negative Feelings

  1 **Be specific.** This allows the listener to understand what they did that upset you.
    - E.g., "I'm upset that you called me names in front of my friend" is much better than "I'm mad at you."

  2 **Describe behaviours without making a judgment.** Judgments will make the other person defensive and they will stop listening – the goal is to have them understand what you're trying to say without any name calling. Avoid using "never," "always" or "should" (i.e., absolutes).
    - Provide the examples below and ask caregivers if they are effective ways to provide feedback, and why or why not.
      - *"You never help out around here."*
      - *"I always have to remind you to put away your laundry and it's still downstairs the next day."*
      - *"You should get up earlier to make sure you aren't late."*
    - Ask caregivers to think of some statements that describe behaviours without making judgments.

  3 **Express your unpleasant feelings with words.**
    - Body language lets the person know you're upset but doesn't tell them why (e.g., slamming doors, crossing arms); the person is unlikely to know what is bothering you, even if it seems clear to you.

  4 **Deliver it cold (when you feel calm).** If you are angry or frustrated, it is better to wait until you can deliver the message in a calm way.

  5 **Choose moments carefully, and avoid making a difficult situation worse when your child is already upset.** Try to express difficult feelings when your child isn't already feeling bad; e.g., It may be appropriate to let them know you are upset when they come home past their curfew but not when they have just received a bad mark on a test.

- Read the following examples and ask caregivers what is effective or ineffective about this feedback and how it could be improved.
  - *You're always on your phone.*
  - *You're mean to your younger siblings.*
  - *I feel embarrassed when you swear at me in front of my friends.*
  - *I get worried when you stay out late and don't text me where you are.*

PART 5: WRAP-UP & HOME PRACTICE

- Ask caregivers what they found the most helpful from today's group.

Home Practice

- **State one pleasant feeling each day to your child that is about them.** Record the statements on the Stating Pleasant Feelings form. Note how this felt to you, and describe your child's reaction to the pleasant-feeling statement.
- **Continue practising active listening and validating responses.**

Session 5 – Handout
Sharing Pleasant and Difficult Feelings

Rules for Self-Disclosure

1. Self-disclosure involves honestly telling how you feel about a situation or about another person's behaviour.
2. Self-disclosure does not mean revealing every intimate detail of your thoughts and feelings.
3. A relationship is strengthened by disclosing your reaction to events that both you and the other person experience, or by responding to what the other person is saying or doing.
4. Hiding your reactions to another person's behaviour does not improve your relationship with that person.
5. Self-disclosure involves some risk taking.
6. If a person's behaviour upsets you, you should tell the person how you feel about their behaviour.
7. When you are disclosing your feelings, the relationship you have with the other person and the situation you're in should be taken into account.
8. Self-disclosure is a two-way street. Both people in a relationship should participate in the process.

Sharing Pleasant Feelings

A good statement of feelings has two parts:

1. Describe how you reacted (your feeling).
2. Recount what happened (the specific behaviour or event).

Practice: Stating Pleasant Feelings

Date	Record your pleasant feeling statements below
	Name of the person you made the statement to: _____ Their reaction: _____ _____ Describe how this felt to you: _____ _____
	Name of the person you made the statement to: _____ Their reaction: _____ _____ Describe how this felt to you: _____ _____

Stating Difficult Feelings

Guidelines for stating difficult feelings:

1. Be specific.
2. Describe behaviours without making a judgment.
3. Express your difficult feelings with words (body language lets the person know you're upset but doesn't tell them why).
4. Deliver it cold: Express difficult feelings when you are feeling calm.
5. Choose moments to share: It may be better to share difficult feelings about situations your child isn't already feeling bad about.

Session 6
Problem Solving, Part 1

Materials Needed

- For in-person delivery:
  - White board / flipchart and markers
  - Session handouts: Problem-Solving — Defining the Problem Worksheet
- For virtual delivery:
  - Visuals: List of problem-solving steps; Maslow's hierarchy of needs
  - PDF of session handout: Problem-Solving Worksheet

Agenda

- Review and discussion of home practice (expressing pleasant feelings)
- Introduction to problem solving
- Step 1: Defining the problem
- Review and assignment of home practice

PART 1: WELCOME & HOME PRACTICE REVIEW

- Briefly welcome caregivers back.
- Provide an overview of today's session.
- Ask caregivers what they remember from last session.
  - Sending skills:
    - Hiding your reactions doesn't improve your relationship with someone. If someone's behaviour upsets you, it may be helpful to tell them.
    - Self-disclosure strengthens relationships, and involves some risk taking. Self-disclosure doesn't involve sharing every detail.
  - A good statement of feelings has two parts:
    - Describe how you reacted (your feeling).
    - Recount what happened (the specific behaviour or event).
  - Ask caregivers to share their home practice of sharing pleasant feelings.
    - Discuss as a group and troubleshoot if any challenges arose.

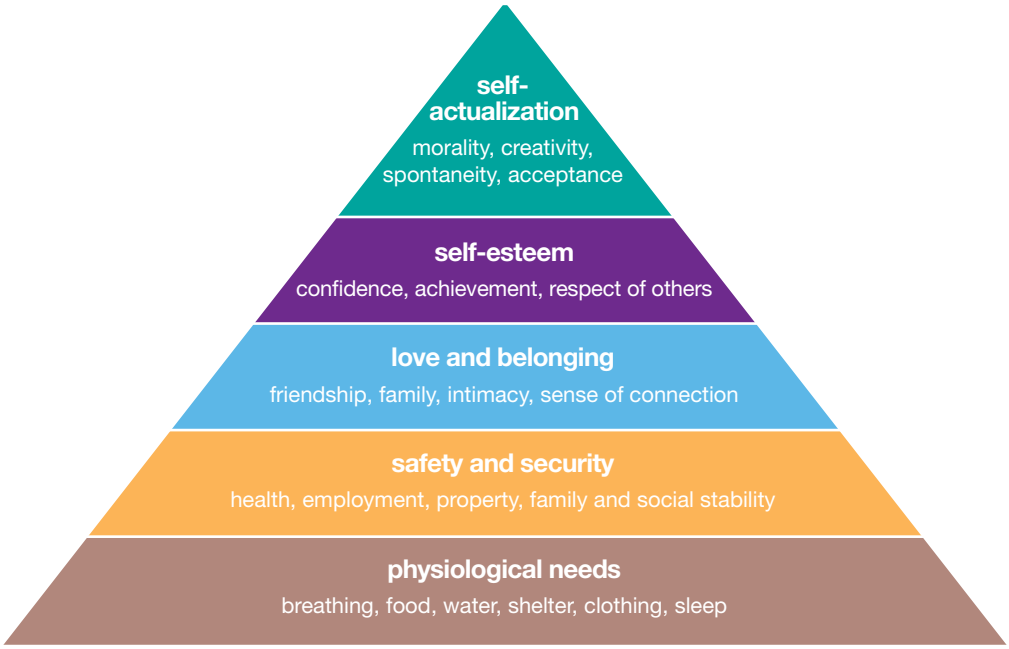
PART 2: INTRODUCING PROBLEM SOLVING

- Provide a rationale for problem solving as a helpful communication strategy.
  - Now that we have discussed communication skills, we are ready to begin working on problem solving.
  - The changes and new experiences that are part of adolescence mean that young people can run into quite a few problems – at school, with peers, or through conflict with caregivers. Individuating from caregivers creates new challenges.
  - Caregivers may also perceive certain things as problems that their child may not (e.g., not going to school, substance use).
  - If minor disagreements can't be resolved, they are more likely to become major disagreements that are more difficult for you and your child to work through.
- Provide a summary of basic rules for problem solving.
  - In all conflicts and disagreements, there is someone who has a **complaint** about someone else's behaviour. This could be you, your spouse or partner, or your child.
  - The person with the complaint has the right to be heard and the right to ask for change, regardless of how realistic or unrealistic the request may seem.
  - Listening to someone's complaint does not mean that you agree or disagree. It simply indicates that you're trying to understand what change the person wants. You can disagree later. The first step is to try to understand the point or complaint.
- Explain that you are going to introduce a structured way to solve problems that involves the following steps:

  1. Define the problem.
  2. Brainstorm solutions.
  3. Evaluate each solution.
  4. Pick a solution.
  5. Make a plan or agreement.

- Introduce the "**defining the problem**" step, including the points below.
  - Both parties must agree on what the conflict is about before it can be resolved.
  - The way you define a problem sets the stage for the rest of the discussion.
  - Defining the problem ineffectively — by using blaming or judgmental language — turns others off or makes them defensive.
  - Defining the problem effectively involves clearly and specifically stating what the other person is doing or saying that creates a problem for you.
  - Defining the problem includes describing why it's a problem from your perspective.
  - It can be helpful to describe the problem in a way that is less likely to make the other person feel angry or defensive. We will talk more about how to do this.

- Introduce Maslow's hierarchy of needs *[show diagram]*:
  - Caregivers and children often have different needs in a situation, which can contribute to problems.
  - Considering the needs of each person in the problem situation can help you understand the problem better.
  - Ask caregivers whether they are familiar with Maslow's hierarchy of needs and, if they are, to share what they know.



  - Add the following explanation: Maslow's theory is that humans have many different types of needs. These include **Physiological needs**, like food, water, and shelter; **Safety and Security needs**, like health and social stability; **Love and Belonging needs**, like friendships and family; **Self-Esteem needs**, like feeling confident and respected; and **Self-Actualization needs**, like morality and creativity.
  - The needs are organized in a pyramid. Maslow's theory was that the more basic needs, listed at the bottom of the pyramid, must be met before the needs at the top can be met.
  - We use this mostly to encourage thinking about the different kinds of needs that might be involved for adolescents and caregivers in a problem situation.
    - Example: Your child is staying up late talking to friends online. Their needs may be Love and Belonging (connecting with friends). Your needs may be Physiological (if it is affecting your sleep) or Self-Esteem (if you feel disrespected).
  - Ask caregivers to identify the needs of the youth and the caregiver in the situations below:
    - Your child uses cannabis at a party.
    - Your child is rude to you in front of your extended family.

- Introduce rules for defining a problem:

  1. **Begin with something positive** (encourages cooperation, sets the stage for success).
  2. **Be specific** (lets the other person know exactly what the problem is).
     - For example, "Your room is a mess" is too general, whereas "There are dirty dishes in your room and I'm worried they will attract ants" focuses on the specific behaviour.
  3. **Describe what the other person is doing or saying.**
     - Tell them what needs to be changed by focusing on their actions.
     - e.g., "You're being rude!" focuses on the person, and may make them defensive. Instead, saying, "Yelling at your sister really hurts her feelings" focuses on the problem behaviour.
  4. **Don't name call or use judgmental language.**
     - Describing the problem by making global statements about the person's "flaws" (e.g., saying, "You never…" or "You always….") will make them defensive and they will stop listening.
  5. **Express your feelings as a reaction to what the other person is saying or doing.**
     - Don't assume the other person knows how you feel about this problem.
     - Use feeling words (e.g., angry, concerned, hurt, worried).
  6. **Admit your contribution to the problem.**
     - If you look at the problem objectively, you will likely see that you have played an active role in some aspect of it (e.g., not being consistent, not being a good example, not letting the person know how upset you are about it).
  7. **Don't accuse or blame others.**
     - This will make them angry and defensive.
     - Accusing or blaming means you are judging the other person rather than describing their behaviour. For example, "You don't care about school" makes a judgment about their perspective, while "You haven't been to English class this week" describes the behaviour.
  8. **Be brief.**
     - If you give too much information, the person may miss the main point or get overwhelmed.

- Provide examples of problem definitions and ask caregivers what is good and bad about these comments, and how they can they be improved. *[Refer to the list of rules for defining the problem.]*
  - *"My problem is that you haven't been responsible about attending your doctor's appointments."*
  - *"I want to talk about how you're always on your phone at dinner."*
  - *"I got a call from the school saying you were absent today. Seems like this is starting to be a pattern for you."*

- Practise as a group creating problem definitions for various problem situations. Although example situations are included below, it may also be helpful to solicit examples of problems from caregivers in the group to make sure the topics are relevant to them.
  - You find out that your child has been smoking cannabis.
  - Your child isn't attending school.
  - Your child is going to bed at 2:00 a.m. on school nights.

PART 3: WRAP UP & HOME PRACTICE

- Ask caregivers what they found the most helpful from today's group.

Home Practice

- Try defining the problem for a challenge you encounter frequently with your child. Share your definition with someone else (not your child) and get their feedback on how it sounds to be on the receiving end of this problem definition.

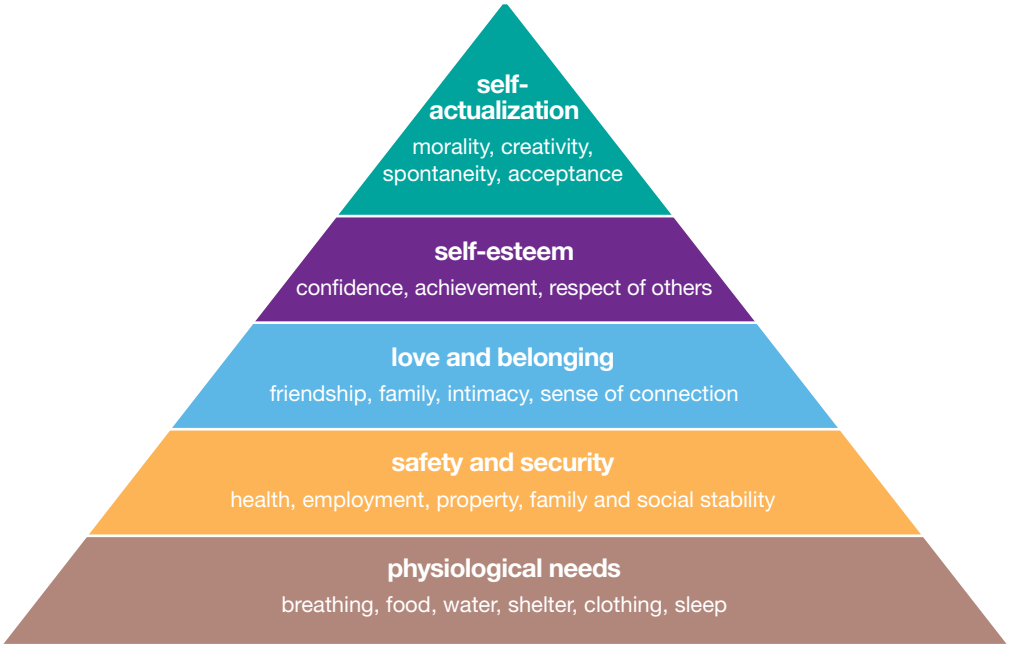
Session 6 – Handout
Problem Solving – Defining the Problem

Problem Solving – Step 1

Define the problem:

1. Begin with something positive.
2. Be specific.
3. Describe what the other person is doing or saying that is creating a problem for you.
4. No name-calling; don't describe the problem in terms of "flaws" in the other person or global statements (e.g., avoid "always" and "never").
5. Express your feelings as a reaction to what the other person is doing or saying.
6. Admit your contribution to the problem.
7. Don't accuse or blame others.
8. Be brief.

Also, consider the needs of each person involved in the situation.



Session 7
Problem Solving, Part 2

Materials Needed

- For in-person delivery:
  - White board / flipchart and markers
  - Session handouts: Collaborative Problem Solving
- For virtual delivery:
  - Visuals: List of problem-solving steps; Maslow's hierarchy of needs, Problem-Solving Diagram
  - PDF of session handout: Collaborative Problem Solving

Agenda

- Review and discussion of home practice (defining the problem)
- Remaining problem-solving steps
- Problem-solving practice
- Review and assignment of home practice

PART 1: WELCOME & HOME PRACTICE REVIEW

- Briefly welcome caregivers back.
- Provide an overview of today's session.
- Ask caregivers what they remember from last session.
  - Problem solving involves a series of steps that can help increase the likelihood of an outcome everyone is satisfied with.
  - **Step 1 is to define the problem.** Review important components of a good problem definition:
    - Begin with something positive.
    - Be specific.
    - Describe what the other person is doing or saying that is creating a problem for you.

- No name-calling; don't describe the problem in terms of "flaws" in the other person.
- Express your feelings as a reaction to what the other person is doing or saying.
- Admit your contribution to the problem.
- Don't accuse or blame others.
- Be brief.

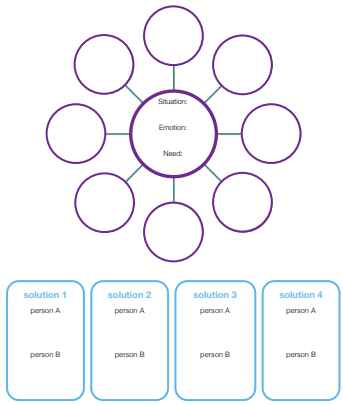
- Also consider the needs of each person involved in the situation.
- Ask caregivers to share examples of problem definitions they came up with as part of their home practice. Provide feedback as needed.

PART 2: REMAINING PROBLEM-SOLVING STEPS

- List the remaining steps after defining the problem:

1. **Define the problem.**
2. **Brainstorm solutions.**
3. **Evaluate each solution.**
4. **Pick a solution.**
5. **Make a plan or agreement.**

- Introduce and discuss each step using the collaborative problem-solving diagram *[show diagram]* with one of the following examples (depending on relevance to caregivers in the group). Ask caregivers which they would like to discuss, or if they have other ideas:
  - Your child isn't attending appointments with their psychiatrist.
  - Your child has barely gotten out of bed for three days.
  - Your child has been having thoughts of suicide and you want to be able to check on how they are doing.



- **Brainstorming** – 4 important rules *[show rules]*:

1. **List as many solutions as you can.** The more ideas you generate, the more likely it is that you will find one that works.
2. **Don't be critical or judgmental; all ideas are allowed.** Being critical or judgmental makes people reluctant to offer suggestions. You will have time to evaluate the solutions later.
3. **Be imaginative.** Suggest some outlandish solutions. You never know, these solutions may have some merit, or they may help you look at the problem from a new perspective. Remember, the reason there is a conflict is because what you are both doing now is not working.
4. **Begin by offering to change one of your own behaviours.** You may think that the other person is the only one who should change, but "compromise solutions" that are partially satisfying for each person have the best chance of success.
   - Brainstorm solutions as a group using the Collaborative Problem Solving handout.

- **Evaluate Each Solution (+/-):**
  - Each person evaluates every solution by putting a plus (+) or minus (-) sign by each solution in the solution web. This is a quick way to find out what ideas are acceptable to each person.
  - Each person must say **why** a particular solution could be good or bad.
  - Be **positive** and **open-minded**. The goal is to find an idea that will resolve the problem.
  - **Compromise solutions** usually have the best chance of being selected.
  - Ask half of the group to take the view of the caregiver, and half to take the role of their child. **Evaluate each solution (+/-) from the caregiver's perspective and from the adolescent's perspective.**
- **Pick a Solution.**
  - Choosing a solution can be difficult because everyone has to agree on it, or it won't work.
  - Cross out any solutions that are rated negatively by both caregiver and adolescent (-/-).
  - As a group, choose the solution most likely to be successful (e.g., +/+ if available or a solution that is a good or workable compromise for everyone).
- **Make a Plan or Agreement.**
  - The final step is to make a clear plan that spells out the details of the agreement (who, what, when and how).
  - If helpful for you and your child, write down the plan or agreement so it is clear for everyone.
  - Review and discuss the **next steps** page (i.e., which solution was chosen; whether it meets each person's needs; what barriers there are, if any; and any other relevant details).
  - Practise completing this section as a group with the problem you have been working through together.

PART 3: GROUP PRACTICE

- If time allows, go through another example as a group, or ask two caregivers to volunteer to work through the steps with the help of the group. The following are sample problems, in case the group does not identify any:
  - leaving things until the last minute
  - being late for appointments/school/etc.
  - not maintaining personal hygiene
  - staying out or staying awake extremely late.

PART 4: OTHER POINTERS ON PROBLEM SOLVING

- Before raising a problem for discussion, consider if the issue is a priority compared to other challenges you may be supporting your child with. For example, a messy room would take lower priority than missing school or mental health appointments.
- Approach the situation collaboratively. Consider using phrases like "find a solution together," or "figure out what we can each do that might help."

- Using the word “problem” might feel stigmatizing or negative. It may be helpful to instead use terms like “challenges,” “difficulties” or “situation.”
- We have mostly presented problem solving for “collaborative” situations, involving two people; however, you can also use the same structure to help your child think through challenges affecting them only (e.g., they have a big assignment due; their friend has been saying mean things about them online).
    - If coaching your child to use problem-solving steps, always start with active listening and validation first; otherwise, it can come across as rushing in or dismissing their concerns.
    - Present problem solving as a possibility and see if they are interested in trying it together, or accepting your offer of support. Avoid pressing them if they aren’t interested or would prefer to solve the problem on their own.

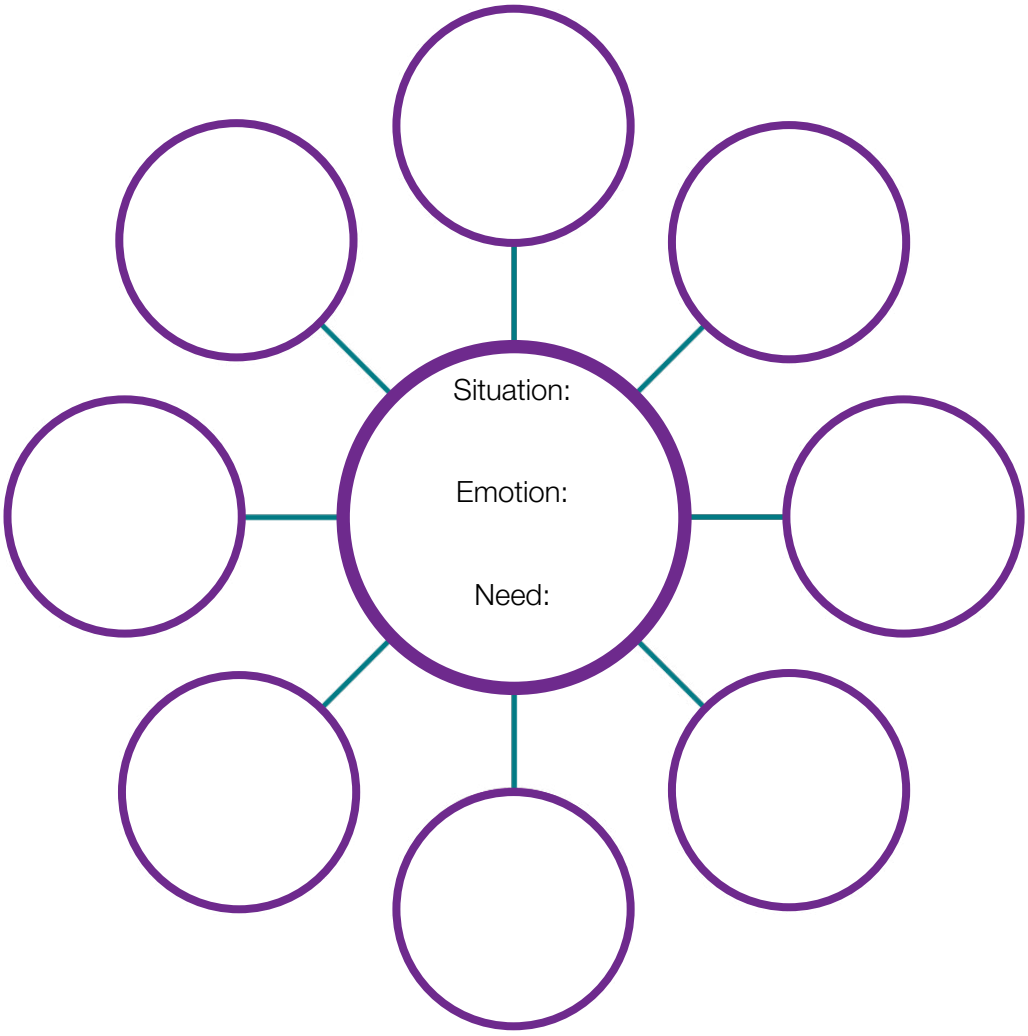
PART 5: WRAP-UP & HOME PRACTICE

- Ask caregivers what they found the most helpful from today’s group.
- Remind caregivers that next week is the last session of group.
    - Ask caregivers about outstanding issues they would like to discuss next session.

Home Practice

- Try the problem-solving steps yourself and with your child. Use the handouts to document your problem-solving practice.
- Reflect on outstanding issues to discuss in our final session next week.

Session 7 – Handout
Collaborative Problem Solving



solution 1	solution 2	solution 3	solution 4
person A	person A	person A	person A
person B	person B	person B	person B

Next Steps…

1

Select

Which solution did you choose?

2

Reflect

Will this meet both of your needs (not just one, but overall)?

3

Detect barriers

Is there anything that could get in the way of carrying out your solution? How will you deal with this?

4

Details

Now that you have identified your plan:

When will you do it?

Where will you do it?

Who will be there?

How will you do it, step-by-step?

Session 8
Review & Maintenance

Materials Needed

- For in-person delivery:
  - White board / flipchart and markers
  - Package of all session handouts
  - Satisfaction questionnaires (if using)
- For virtual delivery:
  - PDF of session handouts: Package of all session handouts
  - Link to online evaluation survey (if using)

Agenda

- Review and discussion of home practice (problem solving)
- Review program content
- Discuss other challenges
- Plan for maintaining progress
- Conclusion and evaluation

PART 1: WELCOME & HOME PRACTICE REVIEW

- Briefly welcome caregivers back.
- Provide an overview of today's session.
- Ask caregivers what they remember from last session.
- Review the steps of problem solving:
  1. Define the problem.
  2. Brainstorm solutions.
  3. Evaluate each solution.
  4. Pick a solution.
  5. Make a plan or agreement.

PART 2: CONTENT REVIEW

- Review the major topics covered in the group. Ask caregivers what they remember about the following concepts, how they have used them, and how they worked *[show the list below]*:
  - CBT Model (in relation to depression and caregiving)
  - Downward and upward spirals (and how to support upward spirals)
  - Empathy in action caregiving
  - Positive caregiving strategies
  - Active listening and validation
  - Sharing pleasant and difficult feelings
  - Problem solving

PART 3: DISCUSS OTHER ISSUES AND CHALLENGES

- Allow caregivers time to raise other issues and challenges.
- Discuss as a group and consider applying one or more of the following strategies from the program:
  - Active listening/validation
  - Positive caregiving
  - Supportive upward spirals
  - Empathy in action caregiving
  - Sharing pleasant and difficult feelings
  - Problem solving

PART 4: MAINTENANCE AND LONG-TERM PLANNING

- Ask each caregiver to identify:
  - One positive change they have made over the course of the group.
  - What they think would help them to continue their progress.
  - How they will handle future challenges.

PART 5: CONCLUSION & EVALUATION

- Ask caregivers to share any feedback they have on the group, if they feel comfortable doing so.
  - Consider using an evaluation or satisfaction questionnaire anonymously to collect caregiver feedback on the program.
- Provide caregivers with the package of handouts from the group.
- Thank caregivers for their participation in the group.

References

Aitken, M., Sagar, A., Courtney, D., & Szatmari, P. (2023). Development, reach, acceptability and associated clinical changes of a group intervention to improve caregiver-adolescent relationships in the context of adolescent depression. *JCPP Advances*, 3(4), e12168. https://doi.org/10.1002/jcv2.12168

Avenevoli, S., Swendsen, J., He, J., Burstein, M., & Merikangas, K. (2015). Major depression in the National Comorbidity Survey —- Adolescent Supplement: Prevalence, correlates, and treatment. *Journal of the American Academy of Child & Adolescent Psychiatry, 54* (1), 37–44. https://doi.org/10.1016/j.jaac.2014.10.010

Beauchaine, T. P. (2015). Future directions in emotion dysregulation and youth psychopathology. *Journal of Clinical Child & Adolescent Psychology, 44* (5), 875–896. https://doi.org/10.1080/15374416.2015.1038827

Brent, D. A., Emslie, G. J., Clarke, G. N., Asarnow, J. R., Spirito, A., Ritz, L., et al. (2009). Predictors of spontaneous and systematically assessed suicidal adverse events in the treatment of SSRI-resistant depression in adolescents (TORDIA) study. *American Journal of Psychiatry, 166* (4), 418–426. https://doi.org/10.1176/appi.ajp.2008.08070976

Courtney, D. B., Bennett, K., Henderson, J., Darnay, K., Battaglia, M., Strauss, J., et al. (2019). A way through the woods: Development of an integrated care pathway for adolescents with depression. *Early Intervention in Psychiatry, 24*, 1–9. https://doi.org/10.1111/eip.12918

Courtney, D. B., Watson, P., Krause, K. R., Chan, B. W. C., Bennett, K., Gunlicks-Stoessel, M., et al. (2022). Predictors, moderators, and mediators associated with treatment outcome in randomized clinical trials among adolescents with depression: A scoping review. *JAMA Network Open, 5* (2), 1–22. https://doi.org/10.1001/jamanetworkopen.2021.46331

Curry, J., Silva, S., Rohde, P., Ginsburg, G., Kratochvil, C., Simons, A., et al. (2011). Recovery and recurrence following treatment for adolescent major depression. *Archives of General Psychiatry, 68* (3), 263–270. https://doi.org/10.1001/archgenpsychiatry.2010.150

Davies, S. E., Neufeld, S. A. S., van Sprang, E., Schweren, L., Keivit, R., Fonagy, P., Dubicka, B., et al. (2020). Trajectories of depression symptom change during and following treatment in adolescents with unipolar major depression. *Journal of Child Psychology and Psychiatry, 61* (5), 565–574. https://doi.org/10.1111/jcpp.13145

Garber, J. & Flynn, C. (2001). Predictors of depressive cognitions in young adolescents: Negative interpersonal context leads to personal vulnerability. *Cognitive Therapy and Research, 25* (4), 353–376. https://doi.org/10.1023/A:1005530402239

Hale, W. W., Crocetti, E., Nelemans, S. A., Branje, S. J. T., van Lier, P. A. C., Koot, H. M., et al. (2016). Mother and adolescent expressed emotion and adolescent internalizing and externalizing symptom development: A six-year longitudinal study. *European Child and Adolescent Psychiatry, 25* (6), 615–624. https://doi.org/10.1007/s00787-015-0772-7

Lahey, B. B., Van Hulle, C. A., Singh, A. L., Waldman, I.D., & Rathouz, P. J. (2011). Higher-order genetic and environmental structure of prevalent forms of child and adolescent psychopathology. *Archives of General Psychiatry, 68* (2), 181–-189.

Lewinsohn, P. M., Rohde, P., Hops, H., & Clarke, G. N. (1991). *Leader's Manual for Parent Groups: Adolescent Coping with Depression Course*. Castalia Publishing. https://research.kpchr.org/Research/Research-Areas/Mental-Health/Youth-Depression-Programs

Maalouf, F. T., Porta, G., Vitiello, B., Emslie, G., Mayes, T., Clarke, G. et al. (2012). Do sub-syndromal manic symptoms influence outcome in treatment resistant depression in adolescents? A latent class analysis from the TORDIA study. *Journal of Affective Disorders, 138* (0), 86–95. https://doi.org/10.1016/j.jad.2011.12.021.Do

National Institute for Health and Clinical Excellence (NICE). (2019). *Depression in Children and Young People: Identification and Management*. https://doi.org/10.1211/CP.2018.20204575

Rengasamy, M., Mansoor, B. M., Hilton, R., Porta, G., He, J., Emslie, G. J., et al. (2013). The bi-directional relationship between parent-child conflict and treatment outcome in treatment-resistant adolescent depression. *Journal of the American Academy of Child and Adolescent Psychiatry, 52* (4), 370–377. https://doi.org/10.1016/j.jaac.2013.01.012

Stapley, E., Midgley, N., & Target, M. (2016). The experience of being the parent of an adolescent with a diagnosis of depression. *Journal of Child and Family Studies, 25* (2), 618–630. https://doi.org/10.1007/s10826-015-0237-0

Weersing, V. R., Jeffreys, M., Do, M. C. T., Schwartz, K. T. G., & Bolano, C. (2017). Evidence base update of psychosocial treatments for child and adolescent depression. *Journal of Clinical Child and Adolescent Psychology, 46* (1), 11–43. https://doi.org/10.1080/15374416.2016.1220310

Wilkinson, P., Kelvin, R., Roberts, C., Dubicka, B., & Goodyer, I. (2011). Clinical and psychosocial predictors of suicide attempts and nonsuicidal self-injury in the Adolescent Depression Antidepressants and Psychotherapy Trial (ADAPT). *American Journal of Psychiatry, 168* (5), 495–501. https://doi.org/10.1176/appi.ajp.2010.10050718

REPRINTED MATERIALS

Depression and Anxiety Facts handout reprinted from the CAMH *Mood Foundations* guide.

camh | Cundill Centre for Child and Youth Depression