Chapter One
Introduction

Despite an historical tendency to overlook, and even dismiss, the presence of depression in children and adolescents, evidence is mounting that youth do indeed experience significant levels of depressive phenomena. At any given point in time, approximately 2% of American children, ages 4 to 16, meet diagnostic criteria for Major Depressive Disorder based on adult criteria (IOM, 1989, in Kazdin, 1993), and as many as 1 in 5 people from the general population will experience a diagnosable depressive disorder at some point during childhood or adolescence (Reynolds, 1992; Reynolds & Johnston, 1994). These findings gain significance when we consider that these rates appear to be increasing (Klerman & Weissman, 1989) and that depressive symptomatology in childhood is predictive of depressive symptoms throughout the lifespan (Schwartz, Gladstone, & Kaslow, 1998).

Compared to symptoms associated with externalizing disorders such as Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder, which are regularly referred for treatment, symptoms associated with depression in children often go unnoticed or disregarded. Our failure to recognize and provide intervention for depressive symptomatology in children has resulted in an underrepresentation of childhood depression in the psychological literature. For example, in a review of 218 child psychotherapy articles published between 1960 and 1988, less than 1.8% addressed the treatment of childhood depression (Kazdin, Bass, Ayers, & Rodgers, 1990). Consequently, we have little empirical information to guide our treatment efforts.

Recent efforts within the field of clinical child psychology to identify empirically supported treatments for childhood disorders, in line with recommendations put forth by the Society of Clinical Psychology of the American Psychological Association (Task Force on Promotion and Dissemination of Psychological Procedures, 1995), have underscored our need for more research into efficacious treatments for depressed youth. Among treatment approaches for childhood depression which have been investigated, cognitive-behavioral therapy has undergone the most empirical scrutiny, and this approach indeed appears to be promising for the treatment of depressive symptoms in many children.
Cognitive-Behavioral Treatments for Depression

Cognitive-behavioral treatments for childhood depression are derived directly from etiological theories of depression, originally advanced to explain the development and maintenance of depression in adults. These theories implicate the role of cognitive distortions and errors; social, interpersonal, and intrapersonal coping skills deficits; and environmental deficits in the development and maintenance of depression in youth. The extension of adult models of depression to the treatment of children may be reasonable, given the similarities of many features of depression across age (Kaslow, Rehm, & Siegel, 1984; Kazdin, 1993), and there is evidence that cognitive and behavioral factors play a part in the expression of depression in children. Compared to their nondepressed peers, depressed youth have been found to have lower self-esteem, lower expectations for performance, more stringent criteria for failure, and a preference for punishment over reward (Kaslow et al., 1984). In addition, depression in youth has been associated with poor information processing, hopelessness, and learned helplessness. It is reasonable to expect, then, that cognitive-behavioral interventions would be effective in treating children with depressive disorders.

Treatment Outcome Studies

The apparent “goodness of fit” between theories of depression and the use of cognitive-behavioral strategies for treating depressed youth is compelling. Indeed, the emergence of an empirical literature on treatment of childhood depression provides a generally positive appraisal of cognitive-behavioral treatments. A recent meta-analysis of outcome studies (Weisz, Weiss, Han, Granger & Morton, 1995) indicated that the mean effect sizes and significance values for available studies assessing treatments (primarily employing cognitive-behavioral strategies) for depression in children were moderate (ES = .64 using weighted least squares and .67 using unweighted least squares). An examination of the descriptive statistics provided in the studies reviewed by Weisz et al., however, reveals that, while cognitive-behavioral procedures were generally effective in treating the depressive symptomatology of about two-thirds of children in these studies, roughly a third of the children did not improve, and a portion of those actually got worse (See Table 1). Assuming that these interventions possessed treatment integrity (i.e., were properly implemented and in accordance with cognitive-behavioral principles),
it appears that, although behavioral and cognitive-behavioral factors are salient to the phenomenology of childhood depression, our success at demonstrating the efficacy of cognitive-behavioral treatments for depression in children has been less than optimal. In fact, a recent review of empirically supported treatments for child and adolescent depression concluded that, although many treatments may be efficacious in ameliorating depressive symptomatology, only one treatment (Stark, Reynolds, & Kaslow, 1987; Stark, Rouse, & Livingston, 1991) met criteria for “probably efficacious” interventions, and no studies met criteria for well-established treatments according to the guidelines set forth by the Task Force on Promotion and Dissemination of Psychological Procedures (Kaslow & Thompson, 1998). This state of affairs need not cause undue alarm, as the treatment outcome literature on childhood depression is “in its infancy,” and the criteria by which it is judged has only recently been proposed. These findings do, however, emphasize the need for more well-conducted treatment outcome studies before we can conclude that any specific intervention approach is the most efficacious one (Kaslow & Thompson, 1998).

Manualized Treatments

A major source of controversy surrounding the promotion of efficacious and effective treatments is the recommendation put forth by the Task Force that well-established and probably efficacious treatments must use a treatment manual (Ollendick & King, in press). Consistent with this requirement, most treatment outcome studies compare manualized cognitive-behavioral packages, which include a number of strategies and a set of guidelines for the implementation of treatment, to a control condition (Kazdin, 1995). For example, Stark et al. (1991) have proposed a treatment package for the treatment of depression during childhood and adolescence which includes a number of cognitive-behavioral strategies. Specifically, the treatment package includes affective education; self-control procedures (self-monitoring, evaluation, and reinforcement); activity scheduling; social skills training; relaxation training; behavioral assignments; and cognitive modeling, self-instruction, and problem solving as primary components.

There are numerous benefits to a manualized approach to treatment, including (a) provision of treatments which are systematic, focused, and goal-oriented; (b) facilitation of training in the application of effective treatments; (c) clear communication regarding
the exact procedures under investigation; (d) increased ability to detect differences between treatment conditions; (e) better research designs and more interpretable results; and (f) increased likelihood for accurate replication (Kaslow & Thompson, 1998; Ollendick & King, in press). Despite these apparent benefits, however, the emphasis on manualized treatments has been met with mixed responses from the community of mental health professionals charged with utilizing them. While many are in favor of the development of manualized treatments, others object to the promotion of this approach for a number of reasons.

Criticisms of Manualized Approach

The use of treatment manuals in treatment outcome research has been characterized as a “nomothetic” approach to treatment selection. A nomothetic approach assumes that there is a uniform pathogenic process underlying the presentation of depression in children; therefore, treatment types and diagnostic entities represent the appropriate units for analysis (Shirk & Russell, 1996). The concern expressed by some is that a manualized approach to treatment will require that treatments be implemented in lockstep fashion, with little room for flexibility or clinical judgement in the treatment process (Ollendick & King, in press). Individual children will be treated identically, as if each possesses characteristics of the “average” child, while perhaps disregarding the need for consideration of the individual characteristics of each child (Shirk & Russell, 1996) or of the causal factors, maintaining factors, and mechanisms of change on which treatment effects depend (Kazdin et al., 1990).

These concerns are not without justification. For example, less than 3% of child and adolescent psychotherapy studies reviewed by Kazdin et al. (1990) examined treatment process in relation to outcome. This tendency is not specific to the study of childhood depression, but is true of much of the treatment outcome literature investigating cognitive-behavioral strategies for children.

The logic goes something like this: If aggressive children have been shown to be deficient in problem-solving skills, and a child is identified as aggressive, problems-solving therapy is often judged to be the treatment of choice. Such a pattern typifies contemporary psychotherapy outcome research, in which a shared diagnosis or comparable scores on overt
symptom scales (e.g., depression inventories) are the exclusive criteria for inclusion in a treatment group (Persons, 1991). In turn, a standardized treatment protocol is applied without assessment of the underlying processes that may be contributing to the disorder (Shirk & Russell, 1996, p. 266).

The nomothetic approach to the investigation of treatment effectiveness diverges from the theoretical bases on which treatments are based in a number of ways (Persons, 1991). Treatment outcome studies adopting this approach ignore the theoretical link between assessment and treatment, leading to pre-treatment assessments which (a) are standardized rather than individualized; (b) are atheoretical rather than theory driven; (c) focus almost exclusively on diagnosis at the expense of a broader understanding of a child’s problems; and (d) lead to therapies which are standardized rather than individualized (Persons, 1991).

While primarily seen as useful in conducting methodologically sound treatment outcome studies, the use of manuals in treatment outcome research also places constraints on our ability to learn from our research efforts. We are unable from the information obtained in a between-groups comparison study to determine which specific techniques will work for which individual children or why certain treatments are more effective with some children than with others. In addition, because we have not focused on specific interventions or treatment processes in our outcome research, the mechanisms by which cognitive-behavioral treatments affect outcomes is still largely unknown (Shirk & Russell, 1996).

We are therefore left with a somewhat confusing picture when we attempt to apply our current fund of knowledge to an understanding of individual response to treatment. For example, it has been observed that in treatment outcome studies, within-group variability often increases from baseline to post-treatment. This may be explained by the presumption that children with the same diagnosis do not have in common the same developmental pathways to, or maintaining variables associated with, the disorder. “Thus for some, treatment remediates the underlying problem, whereas for others, it misses the source of the disorder or, in fact, aggravates it” (Shirk & Russell, 1996, p. 264). Elsewhere, it has been documented that some of the most intuitively appealing
variables hypothesized to mediate childhood depression - anxiety reduction, increase in pleasant activities, and reduced depressive cognitions - have been found to be unrelated to treatment outcome (Kazdin & Weisz, 1998). These results may appear puzzling until we consider the sources of information: treatment outcome studies in which children were treated uniformly with a broad range of techniques rather than matched to specific techniques on the basis of their individual strengths and areas of need (e.g., provided relaxation training, increased scheduling of pleasant events, or cognitive restructuring without an assessment of their need for intervention in these areas).

When dismantling studies (in which component procedures are specified and controlled) are conducted, it is often without regard to individual needs of children. For example, children might be randomly assigned to one of two treatment groups (e.g., social skills or cognitive modeling) and taught related skills or strategies without an initial evaluation of whether they are deficient in these areas (Mann & Borduin, 1991). This approach to the study of specific procedures also leads to confusing results. For example, both cognitive skills training and relaxation training have been shown to be about equally effective in reducing depression in adolescents (Reynolds & Coats, 1986). Although it would seem logical that cognitive skills training would work best with some children and relaxation training would be the treatment of choice for others, current methods of treatment selection employed in outcome research leave us with little empirical evidence to support the implementation of specific interventions for children with specific types of problems (Shirk & Russell, 1996).

**Developmental Psychopathology and Cognitive-Behavioral Therapy**

The introduction of developmental psychopathology marks an important theoretical shift in the conceptualization of childhood disorder (Cicchetti & Toth, 1992). At its most basic level, developmental psychopathology is a joining of developmental and abnormal psychology (Ollendick, 1992) into a theoretical framework for understanding individual differences as they relate to disorder. This approach emphasizes the development of psychopathology via divergent pathways, and it seeks to elucidate both the recent and historical influences on psychopathology (Cicchetti, Rogosch, & Toth, 1994). Thus, developmental psychopathology incorporates normative data, which allows us to define the features that distinguish depressed and nondepressed children, while also
considering individualized accounts of developmental outcome. A primary focus of this approach is the articulation of developmental differences, both *between* depressed and nondepressed youth, and *among* depressed youth with different underlying causes for their depression. This conceptual refocusing has resulted in the recent emphasis of developmental and systemic considerations in the design of appropriate treatments for childhood depression and other disorders of childhood (Cicchetti & Cohen, 1995; Cicchetti & Toth, 1992; Sameroff, 1995; Schwartz et al., 1998).

An integration of cognitive-behavioral treatments for depression with a developmental psychopathology perspective represents a logical expansion of current approaches. The behavioral tradition, from which cognitive-behavioral theories emerged, emphasizes an individualized approach to treatment design, which takes into account learning history, environment, and the identification of causal and maintaining factors as essential to the development of maximally effective clinical interventions (Wolpe & Turkat, 1985).

Cognitive-behavioral treatments are based on theories of social learning, which seek to explain the effects of learning history and experience on producing, modifying, or maintaining behavior through reciprocal determinism. These notions are conceptually allied with theories of developmental psychopathology (Lease & Ollendick, 1993). **Case Formulation Approach to Treatment Selection**

Consistent with a developmental psychopathology perspective, there has been a renewed interest in the selection of treatments which target not only children’s presenting symptoms, but also the pathogenic mechanisms contributing to their presenting problems. The case formulation approach to treatment selection (Persons, 1991, Shirk & Russell, 1996) goes beyond symptom clusters or psychiatric diagnoses to provide an etiological framework for the selection and design of psychosocial treatments. In this “idiographic” approach to treatment selection, assessment and treatment are inextricably linked. Working hypotheses about the nature of the underlying mechanisms contributing to a child’s symptoms and problems are derived from assessment and are used to individualize treatment efforts. The application of this approach to the selection of cognitive-behavioral treatments for childhood depression would allow us to select
treatments which are linked to the etiology of disorder, consistent with theories of developmental psychopathology.

The case formulation approach to treatment is not a new idea. Identification of underlying problems is commonplace among clinical practitioners of all orientations (Persons, 1991). Certainly, case formulations are essential to treatment selection in the behavioral tradition (Wolpe & Turkat, 1985), and assessment based, theoretical rationale for the application of cognitive-behavioral procedures has also been emphasized as critical within the cognitive-behavioral camp (Kendall, 1985).

An idiographic approach to treatment selection follows logically from cognitive-behavioral theories of depression in children, which specify a number of underlying pathogenic mechanisms which may contribute to the development and/or maintenance of depression. Indeed, a need for knowledge of underlying pathogenic processes in the development and selection of treatment techniques has been demonstrated within the cognitive-behavioral tradition. For example, an early focus on skills deficits within this tradition was not wholly successful in treating childhood disorder, leading to a subsequent focus on cognitive distortions as potential targets for treatment (Shirk & Russell, 1996). Further, recent movements within the field of psychology have encouraged the empirical investigation of more individualized, specific, and flexible treatments for children (Henggeler, 1994). The importance of individualized treatment selection, then, has been repeatedly emphasized.

This approach has gained some empirical support within the cognitive-behavioral literature. For example, in a study on the treatment of depression in adults, McKnight, Nelson, Hayes, and Jarrett (1984) compared the effectiveness of treatments that were either directly related to or unrelated to an initial assessment of social skills and irrational cognitions. They found that depressed subjects with problems in social skills significantly improved more in both social skills and depression after receiving the related treatment of social skills training as compared to the unrelated treatment of cognitive therapy. Similarly, depressed subjects with problems in irrational cognitions significantly improved more in both cognitions and depression after receiving the related treatment of cognitive therapy as compared to the unrelated treatment of social skills training. Subjects who were assessed as having problems in both social skills and
cognitions showed equivalent improvements in depressive symptomatology with both of the two types of treatments; however, the social skills training produced greater improvements in social skills, while cognitive therapy produced greater improvement in irrational cognitions. In a more recent study, Eisen and Silverman (1998) found that children with anxiety disorder who received “prescriptive” interventions (which were matched to their cognitive or somatic symptoms) enjoyed better outcomes than children who were treated with nonprescriptive treatments.

The tradition of matching diagnosis to treatment has, nevertheless, persisted as standard practice in empirical investigations of treatments for childhood depression. Despite the saliency of research in the development of cognitive-behavioral treatment strategies, and although many treatment approaches specify the critical mechanisms of change on which outcome is considered to hinge, little treatment research appears to be theory-driven (Kazdin et al., 1990). In addition, subject characteristics such as age, developmental stage, sex, ethnicity, culture, and family functioning, which are likely to influence treatment outcome, are still greatly neglected in child treatment research (Kazdin, 1995).

Several reasons for the perseverance of the nomothetic approach to treatment selection in the research literature are worth noting. First, the application of individualized assessment and treatment procedures makes it difficult for clinicians to identify a manageable repertoire of efficacious approaches. In focusing on the individual characteristics of children, clinicians might find that they are “overwhelmed by uniqueness” and forced to begin anew with each child (Shirk & Russell, 1996). Similarly, the field of clinical child psychology as a whole will be unable to validate treatments that are so idiosyncratic that they cannot be empirically investigated and compared. In addition, no independent criterion measure of the case formulation exists to aid in the evaluation of the accuracy of the case formulation (Persons, 1991). Although researchers in the psychodynamic tradition have identified indirect approaches to the validation of case formulations (Barber & Crits-Christoph, 1993), cognitive-behavioral therapists have not (Persons, 1991).

It might appear, then, that research and clinical practice are doomed to exist as separate entities, with research failing to provide direction for clinical practice. Shirk and
Russell (1996) have proposed that one solution lies in the clustering of similar clinical case formulations into meaningful groups on the basis of shared pathogenic processes. A system for grouping case formulations would reduce the amount of “trial and error” in treatment selection, allow practitioners to select treatments on the basis of their “goodness of fit” with underlying mechanisms (Shirk & Russell, 1996), and advance the study of psychotherapy in accord with its theoretical underpinnings (Persons, 1991).

A major question, and challenge, for this perspective is: Are there meaningful clusters of case formulations or does uniqueness prevail? To this question the idiographers are likely to respond that infinite variability rules when we turn to individual histories and underlying processes. The differential diagnosticians are likely to join them in an unusual alliance, and to assert that such variability raises the titanic problem of reliability. (Shirk & Russell, 1996, p. 267).

Shirk and Russell have proposed that the application of prototype theory to the identification of case formulation clusters would help to address this potentially paralyzing problem.

Application of Prototype Theory to Childhood Disorder

Shirk and Russell (1996) describe a theoretical framework in which meaningful clusters of case formulations can be derived. The concept of a prototype has been developed in the literature of cognitive psychology as a means of dealing with categories that are not, or cannot, be defined precisely (Horowitz, Wright, Lowenstein, & Parad, 1981). Shirk and Russell describe three levels of prototype categorization. At the most fine grained, “subordinate” level, all members of a category are distinct. For example, specific types of chairs (barstool, highchair, desk chair) can be identified, and each is identifiably different from the others. At the most broad, “superordinate” level, no distinction can be made between members of a category because they belong to some larger category (all chairs are furniture, for example). The middle, “basic” level of categorization, however, allows for clusters while retaining the ability to distinguish between categories. For example, chairs can be grouped together and identified as distinct from other forms of furniture.
The basic level of categorization holds promise for researchers attempting to categorize case formulations of childhood disorder. Shirk and Russell (1996) offer for illustration five distinct case formulations of childhood depression. In the first example, a child’s depressive symptoms reflect faulty beliefs that high achievement is the principal criterion for self-acceptance. In the second example, a child’s depressive symptoms reflect the belief that the child is essentially unlovable and will be rejected in close interpersonal relationships. In the third example, a child’s depressive symptoms are a reaction to feelings of sadness with withdrawal and passivity which lead to further depressive symptoms. In the fourth example, a child’s depressive symptoms are a reaction to feelings of sadness with acting out, causing social isolation which leads to further depressive symptoms. In the fifth example, a child’s depressive symptoms are the result of loyalty conflicts between divorced parents. The child’s preoccupation with conflict interferes with his/her ability to engage in scholastic activities or participate in close peer relationships. At the subordinate level, the case formulations are all distinct. At the superordinate level, the case formulations all fall under a broader category, “pathways to negative emotion”, perhaps, and are therefore indistinguishable. At the basic level, however, similarities and differences emerge which allow us to cluster the case formulations into meaningful groups. Cases one and two fit the category of maladaptive beliefs or expectations, cases three and four involve affect regulation deficits, and case five involves internal conflict (Shirk & Russell, 1996). As suggested by these examples, Shirk and Russell propose that a set of basic-level case formulations can be identified which will serve as fundamental building blocks for treatment planning. These authors propose six basic formulations: the internal conflict formulation, the ego deficit formulation, the skill deficit formulation, the cognitive deficit formulation, the low self-esteem formulation, and the emotional interference formulation. As is evident from a cursory examination of these proposed categories, Shirk and Russell advocate for an inclusive framework for delineation of case formulations.

The current proposal follows closely from Shirk and Russell’s model but seeks to elucidate formulations of disorder within the parameters of cognitive-behavioral theory and which are salient to the development of depression in children within this model. We know that cognitive-behavioral interventions have been effective in treating many
children with depression, but by no means all. In the absence of research attempting to match children to treatment techniques, we do not know which children are likely to respond to which techniques or why some children do not respond or actually get worse. Indeed, in the absence of theoretically derived treatment selection procedures, we have little basis for choosing one technique over the other. In other words, we have no knowledge of the theoretical validity of our treatment efforts, nor have we demonstrated the ability to judiciously apply our theories to the process of treatment selection. The identification and application of case formulations to the cognitive-behavioral treatment of childhood depression will allow us to empirically examine not only the efficacy of our treatments, but also the validity of the theories on which they are based.

**Proposed Categories of Cognitive-Behavioral Case Formulations**

A review of the major cognitive-behavioral theories of childhood depression yields three basic case formulation categories: (1) the cognitive distortion case formulation; (2) the skills deficit case formulation; and (3) the environmental deficit case formulation (See Table 2).

The *cognitive distortion formulation* holds that distorted thinking processes are the foundation for depressive phenomena. Cognitive distortions which lead to the emergence of depression include negative distortions of information about oneself, others, and the future (Beck, 1967) and the tendency to make internal, stable, and global attributions for negative events (Abramson, Seligman, & Teasdale, 1978; Seligman, 1975). While an environmental or skills deficit may have initially contributed to the emergence of negative cognitions, it is the pervasive negative, distorted thinking processes that give rise to depressive symptomatology and help to maintain it.

The *skills deficit formulation* asserts that at the root of depressive phenomena are basic deficits in one or more critical areas of functioning. These deficits lead to negative interactions or events that serve to facilitate the development of depressive behaviors and thinking. Critical skill deficits may occur in the areas of self-reinforcement, social interactions, interpersonal behaviors, coping, ability to engage him/herself in pleasant activities, or other specific domains of functioning (academics, sports, etc.), and lead to failure within these contexts. As the child experiences failures in a particular area of functioning, he or she begins to experience heightened aversive physiological arousal in
those situations and begins to engage in negative thoughts about his/her performance. This, in turn, further heightens the child’s arousal and discourages him/her from participating (Linn & Stark, 1989; Seligman, 1975).

The environmental deficit formulation holds that deficits in the child’s environment are the basis for the emergence of depressive symptomatology. Environmental deficits include frequently occurring aversive events that are beyond the child’s control and a lack of reinforcing contingencies for behavior (either because contingencies are no longer reinforcing or because they are unavailable) (Lewinsohn & Shaw, 1969). Examples of environmental deficits include insufficient parental praise and reinforcement, excess punishment, harsh or unpleasant environmental conditions, and underinvolvement in enjoyable activities. Chronic exposure to punitive, harsh, unrewarding, unpleasant, or socially impoverished conditions contributes to the development of depression by fostering feelings of helplessness and hopelessness, negative thoughts, and low self-esteem.

A review of these formulations reveals similarities among them: all three, to some extent, assert that distorted cognitions arise from negative events or experiences, which, in turn, are the result of deficits in a child’s environment or skills repertoire. An environmental or skills deficit formulation, however, would contend that environmental or skills deficits are maintaining the distorted thinking and are at the heart of the depressive cycle. A cognitive distortion formulation, on the other hand, would argue that negative cognitive processes are maintaining the depressive state in the absence of current environmental and/or skills deficits, or they are preventing the child from developing needed skills or making necessary environmental changes. In this formulation, it is the distorted cognitive process which drives the depression.

Purpose of Study

A number of problems with the child depression treatment literature have been noted. Among these, some of the most frequently cited obstacles to the development of effective treatments include: (a) the use of treatment manuals which do not allow for individual differences among children; (b) the neglect of environmental influences on the development and maintenance of depression; and (c) a failure to accommodate developmental differences in children’s competencies when selecting or assessing
effectiveness of treatments (Kaslow & Thompson, 1998). For example, the treatment model proposed by Stark et al., while a good beginning point for treatment, does not provide for the differential selection of strategies for individual children. Although the package is comprehensive, addressing each of the three major pathways to depression delineated by cognitive-behavioral theories (i.e., cognitive distortions, skills deficits, and environmental deficits), it does not address the vast differences among children with regard to the etiological and maintaining variables influencing their depressive symptomatology. The package also assumes that the children undergoing treatment will possess a certain level of cognitive sophistication and ability to actively engage in treatment. In addition, although parents are brought into the treatment process as a way to promote the acquisition of skills and the generalization of treatment effects, there are not specific directives for engaging them in the treatment process. Limitations such as these have led to a lack of data indicating which treatments and treatment components are most effective for which depressed children. In addition, they have discouraged clinicians in real-world practice from embracing standardized treatment packages.

A case formulation approach provides a method for developing hypotheses about the processes related to the onset and maintenance of the disorder, thereby providing a framework for the differential selection of treatments. A major tenet of the case formulation approach is that treatments based on case formulations will be quantitatively different from those based on diagnostic information alone (Persons, 1991; Shirk & Russell, 1996). Shirk and Russell suggest that an analogue study, in which child clinicians are given formulations for particular cases and then asked to develop treatment plans, would allow us to evaluate both the degree to which different formulations yield consensus about treatment methods and the degree to which clinicians vary their planned interventions as a function of varied formulations. The proposed study directly addresses these issues within the realm of cognitive behavioral theories of childhood depression.

This study is designed to address the following empirical questions:

1. Do cognitive-behavioral clinicians vary their treatment recommendations on the basis of varied case formulations?
2. Can cognitive-behavioral clinicians “match” treatment recommendations to pathogenic process based on case formulations?
3. Are treatment recommendations based on case formulations different from those recommended on the basis of symptomatology and diagnosis alone?

4. Do cognitive-behavioral clinicians agree in their selections of appropriate treatments for children based on case formulations?

5. To what extent does the age of the child affect the selection of treatment?

These findings will provide guidance for the systematic selection of cognitive-behavioral treatment strategies for depressed youth, both in clinical practice and in empirical investigations of treatment outcome.