

The experience of young people receiving cognitive behavioural therapy for major depression: A qualitative study

Natalie Ferguson¹ | Simon Rice^{2,3}  | John Gleeson⁴  |
Christopher G. Davey^{2,3,4} | Sarah E. Hetrick^{2,3,5} 

¹Royal Children's Hospital, Parkville, Victoria, Australia

²Orygen, University of Melbourne, Parkville, Victoria, Australia

³Centre for Youth Mental Health, The University of Melbourne, Parkville, Victoria, Australia

⁴Healthy Brain and Mind Research Centre, School of Behavioural and Health Sciences, Australian Catholic University, Melbourne, Victoria, Australia

⁵Department of Psychological Medicine, University of Auckland, Auckland, New Zealand

Correspondence

Dr. Sarah Hetrick, Department of Psychological Medicine, University of Auckland, New Zealand.
Email: s.hetrick@auckland.ac.nz

Funding information

National Health and Medical Research Council, Grant/Award Number: 1024570; Mary Elizabeth Watson Early Career Fellowship; Auckland Medical Research Foundation; Douglas Goodfellow Repatriation Fellowship; NHMRC Early Career Fellowship, Grant/Award Number: 567062

Abstract

Aim: Major depressive disorder (MDD) has far reaching impacts for young people, their families and society. Cognitive behavioural therapy (CBT) is one of the first-line treatments for young people experiencing MDD; however, there is limited research examining how young people with MDD experience CBT. The aim of this study was to explore their experience and their views of this intervention.

Methods: We employed a qualitative research design, with semi-structured interviews and thematic analysis. Eight participants aged between 17 and 24 years who received CBT for MDD in a randomized controlled trial were recruited.

Results: Five themes were identified: the importance of relationship with clinician; the range of useful components within CBT; the ability for CBT to accommodate different techniques and presenting issues; the importance of checking in with clients during the process of therapy; and the impacts of MDD on therapy.

Conclusions: The findings highlight the importance of clinicians having a youth friendly and collaborative approach that allows a modular delivery of a range of CBT techniques to suit the client's presenting issue and formulation. There is a need to continually check how young people are responding to interventions, and to be aware of potential cognitive deficits and adjust therapy accordingly. This is a small study that provides insight into how young people with MDD experience CBT and avenues to explore for tailoring provision of CBT to enhance the therapeutic experience for this population.

KEYWORDS

cognitive behavioural therapy, evidence-based practice, intervention, major depressive disorder, youth

1 | INTRODUCTION

Christopher G. Davey and Sarah E. Hetrick are joint senior authors.

The study was undertaken while Ms Ferguson was a student at the Australian Catholic University.

Depressive disorders are characterized by the presence of persistent and unreactive low mood, or irritability in those younger than

This is an open access article under the terms of the [Creative Commons Attribution-NonCommercial-NoDerivs](https://creativecommons.org/licenses/by-nc-nd/4.0/) License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

© 2022 The Authors. *Early Intervention in Psychiatry* published by John Wiley & Sons Australia, Ltd.

18 years, accompanied by a range of cognitive and behavioural symptoms that persist over time and cause clinically significant impairment (DSM-5, American Psychiatric Association, 2013). The 12-month prevalence of major depressive disorder (MDD) in 11- to 17-year-olds in Australia is 10.5% (Lawrence et al., 2015) and 6.3% amongst 16- to 24-year-olds (Australian Bureau of Statistics, 2015). Its onset during this time potentially disrupts the most productive years of life and is a key reason that MDD is the single largest contributor to global disability (WHO, 2017). Earlier age of onset more likely to result in adverse psychological and psychosocial outcomes (Zisook et al., 2007) such as impaired social relationships, family functioning, occupational functioning (Hirschfeld et al., Hirschfeld et al., 2000), educational underachievement and unemployment (Birmaher et al., 1996; Fergusson & Woodward, 2002; Lewinsohn et al., 1998). MDD is also associated with an increased risk of suicidal behaviour, attempts and death by suicide (Fergusson et al., 2007; Gould et al., 1998; WHO, 2014).

Guidelines recommend CBT as a first-line treatment for MDD in young people, with medication initiated if there is a poor response (Beyondblue, 2010; NICE, 2019). The most recent evidence about antidepressants shows that, on average, there are only very small improvements in depression symptoms for those on antidepressants compared with those on placebo (Hetrick et al., 2020). There is also evidence that antidepressants increase the risk of suicide related behaviours. While there is only a small evidence base, the best approach is for medication to be used in combination with psychotherapy (March et al., 2004).

Cognitive behaviour therapy (CBT) and interpersonal psychotherapy have the strongest evidence base of all the psychological treatments for MDD (NICE, 2019; Zhou et al., 2015, 2017) with CBT also showing promise as an intervention for suicidal behaviours (Hawton et al., 2015). CBT combines behavioural techniques designed to elicit alternate appraisals and change maladaptive assumptions, and cognitive techniques that assist in identification, testing and correction of dysfunctional beliefs (Feehan, 1996).

Young people's experience of therapy generally, and CBT specifically, has not been examined widely, but is increasingly recognized as an important aspect of understanding outcomes and informing ways to improve treatment delivery (Donnellan et al., 2013; Midgley et al., 2014; Neelakantan et al., 2019). The developmental context has been highlighted as important in terms of young people's motivation, engagement and experience in therapy (Sauter et al., 2009). For example, the need for autonomy, privacy and confidentiality are commonly described as important. Careful attention to the early stages of engagement, and a focus on the primary importance of the therapeutic relationship and a sense of real connection has also been described as important (Gibson & Cartwright, 2014; Neelakantan et al., 2019; Sauter et al., 2009; Wilmots et al., 2020). Also important to consider are the emotional and cognitive capabilities of young people (Sauter et al., 2009) and how this might impact on engagement. For example, various CBT techniques, particularly cognitive techniques, may be impacted by neurocognitive impairment associated with MDD, and the severity and complexity of their presentations (Allott et al., 2020; Allott et al., 2016; Hetrick et al., 2015). Importantly, the value of

manualized treatment is an important consideration with a range of views about the impact on engagement and efficacy (Addis & Krasnow, 2000; Nelson et al., 2006; Truijens et al., 2018).

The aim of the present qualitative study was to explore young people's subjective experience of CBT for depression to further understand views regarding this treatment. To date, very little research of this sort has been undertaken, particularly in young people. We know of only one small study including three young females with depression (12–16 years). The results of this study showed that engagement, the therapeutic relationship, the impact of CBT on change, and the manner in which CBT was delivered were key change promoting factors (Donnellan, Murray, & Harrison, Donnellan et al., 2013). Understanding a client's experience and perspective helps to understand what is useful within the therapeutic relationship and content (Hodgetts & Wright, 2007) and has the potential to lead to improvements in treatment and services (Day, 2008).

2 | METHODS

2.1 | Design

This was a qualitative study using a general inductive approach, which is appropriate when there are specific research aims and objectives (Thomas, 2006). In this approach, data are examined in the context of being guided by objectives, but findings are based on those data not on a-priori expectations based on the objectives. The data were the responses of participants to semi-structured interviews (see Appendix for the interview guide).

2.2 | Setting

The study was undertaken in headspace enhanced primary care centres (Glenroy, Sunshine, and Werribee) in the Northwestern region of Melbourne (McGorry et al., 2007).

2.3 | Participants

Young people eligible for the study were aged 15–25 years, attending a headspace centre with moderate to severe MDD, who had consented to take part in the Youth Depression Alleviation Randomized Controlled Trial (YoDA-C; Davey et al., 2019). The trial ($n = 153$) investigated the effectiveness of 12 weeks of manualized CBT plus fluoxetine, compared with manualized CBT plus placebo, for the treatment of moderate-to-severe MDD (Hetrick et al., 2015). Detailed methodological information on this trial is reported elsewhere (Davey et al., 2014).

A purposive approach to sampling was used that considered age, gender, geographic location, medication, number of therapy sessions and recency of involvement in the trial. We were careful to ensure that the sampling was consistent with the characteristics of the

TABLE 1 Sample characteristics ($N = 8$)

Participant number	Gender	Age at time of therapy	Therapy sessions	Time since attended	Location
1	M	21	9	1 year 8 months	Glenroy
2	F	23	10	1 year 1 month	Glenroy
3	M	20	6	1 year 3 months	Glenroy
4	F	18	3	2 years, 3 months	Sunshine
5	F	21	3	1 year, 9 months	Werribee
6	M	16	7	1 year, 8 months	Werribee
7	F	18	8	2 years, 4 months	Glenroy
8	F	18	5	2 years, 2 months	Werribee

overall YoDA-C sample. In total, eight young people participated in this study; three were male and five were female aged between 16 and 23. They had engaged in a range of 3 and 10 sessions of CBT over a range of 1 year and 1 month to 2 years and 4 months prior to being interviewed (see Table 1 for details).

2.4 | Cognitive behavioural therapy

Cognitive behavioural therapy was delivered via a manual that was designed collaboratively with researchers and clinicians. The aim was to maximize the advantages of manualized treatment in terms of ensuring delivery of CBT with fidelity to this intervention, while allowing flexibility to ensure treatment was based on a thorough assessment and ongoing formulation of the young person's treatment needs. This flexibility was deemed necessary given concerns in the literature about negative impacts on therapeutic alliance by use of a manual (Addis & Krasnow, 2000; Nelson et al., 2006). Its development drew on existing (at the time) treatment manuals, particularly the Adolescent Coping with Depression manual (Clarke et al., 1990) and the Treatment of Adolescent Depression Study (TADS; March et al., 2004) treatment manual, which was a modular approach to treatment and also drew on the Adolescent Coping with Depression manual. Rather than allowing complete flexibility in modular delivery, as had been permitted in the TADs trial, and consistent with the central components identified in prior research studies and reviews (McCarty & Weisz, 2007; Weersing et al., 2009), seven modules were deemed 'core' with the expectation that these would be delivered; a further seven targeted modules were provided that could be delivered if indicated. Core modules included psychoeducation; understanding and monitoring emotions; behavioural activation; activating event-beliefs-consequences (ABC) model and chain analysis; identifying automatic thoughts; working with unhelpful thinking; and relapse prevention. The manual also provided comprehensive resources and handouts.

2.5 | Procedure

This study received ethics approval from the Melbourne Health Research and Ethics Committee (HREC/12/MH/151) and Australian

Catholic University (2017-344R). Young people were contacted by the first author, and those who consented were offered an interview time at a local clinical service or via telephone.

Interviews, which were all conducted by phone, followed an interview guide, and were undertaken by the lead author who was training as a clinical psychologist and had been a research assistant on the RCT. She took notes on her reflections of the interview, which took between 30 and 60 min and were audio recorded and transcribed verbatim.

2.6 | Analysis

Interview transcripts were analysed using thematic analysis as outlined by Braun and Clark (2006). This involved identifying, analysing and categorizing a pattern of themes within and across interviews (Burnard et al., 2008). The data were analysed independently by two investigators (N.F. and S.H.) as they were collected, with attention paid to the lens through which the data were being viewed (N.F. had been a research assistant on the RCT and S.H. an investigator and delivered CBT within the RCT). Observations and discrepancies were discussed and consensus reached.

3 | RESULTS

3.1 | Themes

Five themes and nested sub-themes emerged from the data: the importance of relationship with clinician, the range of useful components within CBT, the ability for CBT to accommodate different techniques and presenting issues, the importance of checking in with clients in the process of therapy, and the impacts of MDD on therapy. Below is a description of each with illustrative quotes in Table 2.

3.2 | Theme 1: The importance of relationship with clinician

Young people described a range of initial experiences, which highlighted the importance of engagement (sub-theme 1) whereby

TABLE 2 Themes, subthemes and illustrative quotes

Identified themes		
Themes	Sub-Themes	
(i) The importance of relationship with clinician	- The importance of engagement	... (Clinician) was very professional, very friendly, very easy to connect with (P1). She made me feel like safe and like very comfortable (P8). It kind of made me feel like he was being a little bit condescending... it made me feel really uncomfortable (P5).
	- Initial ambivalence with the need for time to develop a relationship and trust in therapy	... after the first session I was dubious still. Because I believe (clinician) was laying out the ground work and that wasn't as effective as the rest of it... but that quickly changed (P1). I had some anxiety going into it... It subsided after a session or two (P3). I sort of noticed towards the last few sessions that I was able to sort of open up.... (P2). I think overtime she had more of an understanding of what I was going through.... things were easier to talk about and that sort of thing (P6).
	- Use of a manual did not have negative impacts	She did try to introduce something new each session which was good... (P2). She was giving me more things to read and brochures and how to write down your feelings and that sort of stuff. Like I remember thinking when I first started the study that it was just a little bit different and it sort of like actually made me want to do it - It didn't feel like homework (P7).
(ii) The range of useful components within CBT	- Various modular components have their place and are useful <i>Behavioural skills are important and useful.</i>	<i>Just ah seeing friends more... that was something I'd stopped doing. Trying to engage in my hobbies more - Playing piano, reading... If anything they were a distraction, but also just enriching in themselves (P1).</i>
	- Young people found cognitive restructuring useful - For those who need it, social skill training was crucial and helpful - Problem solving is practical and useful	I remember (clinician) talking to me about keeping my mind busy, trying to get out of the house more and stuff. I felt it worked (P4). 'I was able to step back and shift that in to 'where are these thoughts coming from'. recognising when they come and understanding why they come and move on in a not negative way (P2). I think talking about the stuff like.. talking about breaking cycles and stuff was probably the most useful thing for me (P8). She (clinician) sort of gave me good advice about what we should do to make our time a little bit more manageable and calm I suppose (P2). I guess it just made social interactions easier, and helped reduce anxiety (P3). Being able to break the problem down into manageable chunks... it felt like I had sort of had someone there telling me you can do this...if you sort of take it step by step, it's going to be okay (P2). I implement that now, yeah probably, there was a more of a practical approach to it (P6).
	- Homework is accepted when presented in a manageable way	They were achievable, reasonable and... ah I didn't even feel burdened by them or anything (P1). I felt good about that kind of stuff because it felt like I was making an effort to sort of tackle the problems, I didn't find them to be intrusive or anything (P2). I think he asked me to write down a list of things... but I didn't do it... I just didn't have any motivation. After I'd go home I'd already forgotten about it (P5). I just kind of forgot about that because the timing of it was when school was really busy. It just kind of got lost in a pile of stuff (P8).
	- CBT techniques that work, young people carry on with	It worked, so I carried it on; I believe these are long term skills (P1). Even now in everyday life just learning how to be assertive in a way that is not being rude... that was something that helped me solve my problems even until now (P7). If I'm having a shitty week I will always try and plan something for the end of the week so I've got something to look forward to. Like that is something I've taken with me since the study (P7).
(iii) CBT is an umbrella term that can accommodate different techniques and presenting issues	- Clinicians integrate other techniques	She sort of taught me some mindfulness like to slow down and that was really helpful (P2). She used to sit there and we'd start talking about something and she would just give me a piece of paper and she'd be like 'draw or write down whatever you think' (P8).

TABLE 2 (Continued)

Identified themes		
Themes	Sub-Themes	
	<ul style="list-style-type: none"> - Young people find other things useful - Clinicians need to be able to implement CBT in the context of presenting issues 	<p><i>...I really liked writing and she was like maybe you should start journaling... I still do it now and it's really helpful because it gets all the stuff out of your brain on to a piece of paper...(P8).</i></p> <p><i>One of those things where you close your eyes and you imagine the word being spelt out in block letters ... It was trying to show that my feelings.. like if I was feeling angry (P7).</i></p> <p><i>I'd had this problem with my shoulder...and we spent an hour writing a poem about my shoulder ... and that's all we did for an hour... I got to talk about everything but I also got to something creative but with words and it made me feel like all of the feelings that I'd be trying to push away and bottle up - That someone was acknowledging that they were a real thing and that it was okay for me to feel that way (P8).</i></p> <p><i>I don't think it was the main sort of focus of what I should have been doing (P6).</i></p>
(iv) The importance of checking in with clients during the process of therapy	<ul style="list-style-type: none"> - Need for psycho-education to be tailored - Importance of collaboration 	<p><i>It was kind of frustrating to have it there in paper, like 'this is the thing that's wrong with you (P2).</i></p> <p><i>I just always thought that everybody kind of felt that way.... I was overwhelmed and I didn't want to believe it (P5).</i></p> <p><i>It sort of just gave me like that reassurance that what I am going through is just symptoms. Like when you have a headache you just feel shitty. So I'm just like feeling shitty and me feeling tired is a symptom of that. It doesn't really mean I am a shitty person, like I'm not depressed... Well I am depressed but I just have depressive symptoms (P7).</i></p> <p><i>I didn't feel so much that he was trying to do his sort of therapist job... I started understanding him and what he was trying to help me with. I felt a bit more confident about it. So I felt like it was a bit more even (P1).</i></p> <p><i>If I didn't like something, I would say it as soon as she would bring it up. Like if she said I'm going to give you this to fill out during the week, I'd be like yeah nah, I'm not going to do that one. And it would be fine. It wouldn't be a big deal (P7).</i></p> <p><i>I just felt like it wasn't going to work. Even though now I know that it should of helped if I actually paid attention (P5).</i></p> <p><i>I don't think that was the main sort of focus of what I should have been doing (P5).</i></p>
(v) MDD and its impact on therapy	<ul style="list-style-type: none"> - Negative view of self - Lack of motivation was a barrier for engagement - Cognitive challenges 	<p><i>I just felt like I was going to stuff up the research. I felt like I wasn't going to be able to give proper results (P5).</i></p> <p><i>It was so much effort and motivation for me to get there (P5).</i></p> <p><i>I remember parts of the therapy (P3).</i></p> <p><i>I remember talking about it, but I just can't remember anything really from it (P4).</i></p> <p><i>He was pretty informative and explained a lot of things at the start, but it was just so much information. I don't think I really retained all of it (P5).</i></p>

the clinician is able to ensure the young person feels comfortable in the therapeutic relationship and is put at ease. Secondly, there was initial ambivalence and time was needed to develop a relationship (sub-theme 2). This initial ambivalence was related to how the clinician was perceived to first engage (e.g., friendly or condescending), and the perception of being heard and understood developed over time, which impacted on trust and allowed the relationship to build over time. The *use of a manual did not impact therapy (sub-theme 3)* in the same way as the therapeutic relationship. Not all clients were aware of the use of a manual until the interview, and reflection on the manual-based therapy in this context appeared as positive. One participant, who had received CBT from the same clinician prior to

participation in the YODA-C trial, expressed a preference for the manualized approach.

3.3 | Theme 2: The range of useful components within CBT

Participants identified that *various modular components have their place and are useful (sub-theme 1)*. Participants described how behavioural skills were utilized, reflecting on the emphasis in the therapy of behavioural activities. Young people appeared to integrate cognitive skills into their lives and found them useful; their description of these

skills demonstrated how they interpreted the therapeutic technique in a way that had meaning for them. For those who received it, social skills training was crucial and helpful, for example for one participant having challenges with her sister. Problem solving was described as practical and useful and it was a skill that continued to be used. *Homework is accepted when presented in a manageable way (sub-theme 2)*. Most participants were positive about homework tasks, describing them as manageable and helpful. However, there were challenges relating to homework that were related to motivation and memory. Finally, if a particular technique worked for them, participants expressed a willingness to continue using it: *Techniques that work, young people carry on with (sub-theme 3)*. This was noted generally but participants also noted particular CBT techniques that they continued to use. For example, problem solving was used by one participant and another participant described her ongoing use of social skills and the usefulness of behavioural activation.

3.4 | Theme 3: CBT is an umbrella that can accommodate different techniques and presenting issues

While certain aspects of CBT emerged as practical and useful (as described above), it was evident that a variety of different techniques and skills were incorporated into therapy. Participants described moments in therapy that indicated that *Clinicians integrate other techniques (sub-theme 1)* that were not necessarily part of the manualized CBT into therapy. Participants also indicated that *Young people find other things useful (sub-theme 2)*. Participants described a range of techniques that were useful, for example, one participant spoke about journaling; another participant reflected on a technique whose description appeared to be part of Acceptance and Commitment Therapy. Finally, the participants highlighted that *clinicians need to be able to implement CBT in the context of the presenting issue (sub-theme 3)*. There was a range of experiences with regard to how well this was done. When clinicians were not able to deliver CBT in relation to the presenting problem participants were less engaged in therapy.

3.5 | Theme 4: The importance of checking in with clients in the process of therapy

Participants described how imperative it is for clinicians to check in with their clients throughout therapy. This included the *need for psycho-education to be tailored (sub-theme 1)*. Participants described a range of reactions to information given to them about their diagnosis with some describing finding it difficult to accept a diagnosis of MDD and others reflecting positively on the way the diagnosis was explained. Also highlighted was the *importance of collaboration (sub-theme 2)*. Participants were positive about collaboration but the data showed that collaboration was not always achieved, which resulted in negative experiences.

3.6 | Theme 5: The impact of MDD on therapy

All participants described symptoms of depression that appeared to have impacted their ability to engage in therapy. This included a *negative view of self (sub-theme 1)*. A core experience that emerged from the data was the perception participants had of themselves in the context of their depression and therapy. A *lack of motivation was a barrier for engagement (sub-theme 2)*. Participants explained how their symptoms impacted their ability to attend appointments. As already noted, motivation had a significant impact on engaging with homework. *Cognitive challenges (sub-theme 3)* were common with all participants describing challenges with memory and reporting difficulties retrospectively recalling aspects of the therapy. Some participants also reported difficulties with memory at the time. As already noted, memory also impacted on engagement with homework.

4 | DISCUSSION

Within a qualitative framework, the current study investigated the experiences of eight young people diagnosed with MDD who received CBT with placebo or fluoxetine in a research trial. The themes identified in this study provide insight into how CBT is experienced. There were five key themes that emerged from the data highlighting that there are a range of useful CBT skills and techniques that young people learn in the context of a positive relationship with their therapist, as well as the importance of a collaborative approach that is sensitive to the various presenting issues and reactions to information and therapeutic techniques that are delivered.

Participants highlighted the importance of having a positive and engaging relationship with their clinician. Specifically, that it is important for clinicians working with this population to be warm and friendly. Most participants acknowledged feeling initial ambivalence, and that the client/clinician relationship developed over time, assisting their engagement in treatment. It emerged that it is crucial for clinicians to be sensitive to clients' reactions from the outset of the therapeutic relationship, particularly with regard to delivering information about diagnosis, and to modify their approach based on these reactions. Also crucial is the ability to ensure that the concerns of the young person, as they present them, are central to understanding their needs. This is consistent with prior research highlighting the central importance of the therapeutic relationship, which also requires the therapy to understand and respond to the development needs for autonomy, privacy, confidentiality (Gibson & Cartwright, 2014; Neelakantan et al., 2019; Sauter et al., 2009; Wilmots et al., 2020). Further, it is consistent with guidelines around developing a therapeutic relationship, which encourage making collaborative decision-making and seeking feedback throughout therapy (Beck, 2011).

Importantly, this research has demonstrated that young people in this qualitative study responded differently to various components of CBT, supporting the use of a modular approach to implementing CBT that can be tailored to individual needs. In this context, it appeared that clinicians were able to use a manual in an unobtrusive and effective way.

This type of approach has been successfully implemented by Weisz et al. in adolescents with depression, anxiety and conduct problems (Weisz et al., 2011). The usefulness and practical benefits of the behavioural components were highlighted, and this is perhaps not surprising given they align with what young people identify as natural or habitual coping mechanisms (Ng et al., 2016). However, the data indicated that cognitive restructuring and homework, which are potentially more challenging aspects of CBT, can be presented in a way that facilitates young people's engagement with them. The data indicated that young people interpreted these cognitive approaches in ways that had meaning for them. Further, young people's descriptions demonstrated that a flexible approach to treatment was important in terms of allowing clinicians to integrate other techniques (e.g., mindfulness, art therapy, ACT). This highlights the possibility that other therapeutic approaches, or at least elements of them, are engaging and acceptable to young people.

Depressive symptomology (e.g., lack of motivation) may impact on participants' ability to engage in and retain aspects of CBT. This was observed in subjective reports about lack of motivation, negative view of self and reported cognitive challenges. It may have also impacted on what was often observed as difficulty recalling aspects of the treatment they had received at the time of the trial, although treatment had been at least a year prior for all participants. A lack of motivation may also indicate poor therapeutic engagement and reflect the acceptability of CBT, or therapy generally. Nevertheless, the descriptions of subjective neurocognitive deficits are consistent with developmental stage (Sauter et al., 2009) and prior studies of young people with depression (Allot et al., 2020; Allott et al., 2016; Goodall et al., 2018; Lee et al., 2012). In particular, a prior qualitative study showed neurocognitive deficits similarly interfered with psychological treatment of depression in youth (Morey-Nase, 2017). Neurocognitive deficits are an important area for early intervention in MDD and a key consideration in the delivery of treatment (Allot et al., 2020; Allott et al., 2016; Goodall et al., 2018; Lee et al., 2012).

Notably, this study was restricted to a help-seeking population recruited into an RCT, therefore generalizations to other young people with MDD may be limited. As the interviews were conducted between 16 and 31 months after the termination of treatment, it is possible, and indeed the reports of participants revealed it was the case, that participants had challenges recalling details of their experience of CBT. It is a relatively small sample size, largely to do with the time that had passed since the main study so that it was challenging to reengage young people in this secondary study. The study included participants who completed between 3 and 10 sessions, meaning there were a range of experiences; the relationship between the number of sessions and the experience of therapy was not reflected in the narratives. Those receiving fewer sessions may have disengaged because the treatment was unacceptable to them or because they experienced sufficient symptom relief (which they may or may not attribute to therapy). Strengths of this study included that recruitment was from a large geographical area across Melbourne's North-Western region, increasing external validity. Two investigators analysed the data as it was collected, reflecting on their interpretation given their professional and role in the larger trial.

Further research could be conducted with participants from naturalistic clinical and community settings (i.e., outside of the clinical trial setting)

where therapy is not usually delivered according to a manual. Interviews could also be conducted whilst young people are receiving therapy, or shortly afterwards to ensure recall accuracy. Finally, conducting qualitative research with mental health professionals who have delivered interventions to this cohort may assist in further refining this treatment.

This qualitative study provides important insights about young people's experience of CBT and has the potential to inform how CBT is delivered. Findings support clinicians having a youth friendly, collaborative and client-centred approach with this population. This should include ensuring that they are aware of how their client is responding to information and therapeutic interventions as they are delivered throughout the therapeutic process. Participants' descriptions of their experience revealed themes highlighting that CBT has a range of useful skills and techniques that young people can learn in the context of a positive relationship with their clinician. The current study suggests that a modular approach does not have a negative impact but allows clinicians to deliver various components of CBT on the basis the client's presenting issue and formulation, which contributes to ensuring a collaborative approach. Finally, and importantly, there is a need for clinicians to consider how clients' symptoms may impede treatment. In the case of MDD, clinicians must enquire about and be aware of cognitive deficits and adjust therapy accordingly. Continuing to investigate and explore the experiences of young people with MDD is important in order to ensure enhancement of existing treatments.

ACKNOWLEDGEMENTS

The study was funded by an Australian National Health and Medical Research Council (NHMRC) project grant (1024570). SEH was funded by an NHMRC Early Career Fellowship (567062) and an Auckland Medical Research Foundation Douglas Goodfellow Repatriation Fellowship and is a CureKids Research Fellow. SR was supported by a Mary Elizabeth Watson Early Career Fellowship in Allied Health from the Royal Melbourne Hospital.

Open access publishing facilitated by The University of Melbourne, as part of the Wiley – The University of Melbourne agreement via the Council of Australian University Librarians.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ORCID

Simon Rice  <https://orcid.org/0000-0003-4045-8553>

John Gleeson  <https://orcid.org/0000-0001-7969-492X>

Sarah E. Hetrick  <https://orcid.org/0000-0003-2532-0142>

REFERENCES

- Addis, M. E., & Krasnow, A. D. (2000). A national survey of practicing psychologists' attitudes toward psychotherapy treatment manuals. *Journal of Consulting and Clinical Psychology, 68*(2), 331–339. <https://doi.org/10.1037//0022-006x.68.2.331>

- Allot, K. A., Gao, C., Hetrick, S., Folia, K., Menssink, J., Fisher, C., Hickie, I. B., Herrman, H., Richwood, D., Parker, A., McGorry, P., & Cotton, S. (2020). Subjective cognitive functioning in relation to changes in levels of depression and anxiety in youth over three months of treatment. *British Journal of Psychiatry Open*, 6(5), e84.
- Allott, K., Fisher, C. A., Amminger, G. O., Goodall, J., & Hetrick, S. (2016). Characterizing neurocognitive impairment in young people with major depression: State, trait, or scar? *Brain and Behavior*, 6, 1–12. <https://doi.org/10.1002/brb3.527>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association.
- Australian Bureau of Statistics (2015). *Mental health of young people, Australia 2007*. Canberra: Australian Bureau of Statistics; 2010. <https://www.abs.gov.au/statistics/health/mental-health/national-survey-mental-health-and-wellbeing-summary-results/latest-release>
- Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond*. The Guildford Press.
- Beyondblue. (2010). *Clinical practice guidelines: Depression in adolescents and young adults*. Beyondblue.
- Birmaher, B., Ryan, N. D., Williamson, D. E., Brent, D. A., Kaufman, J., Dahl, R. E., et al. (1996). Childhood and adolescent depression: A review of the past 10 years. Part I. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35, 1427–1439. <https://doi.org/10.1097/00004583-199611000-00011>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77–101.
- Burnard, P., Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Analysing and presenting qualitative data. *British Dental Journal*, 204, 429–432.
- Clarke, G. N., Lewinsohn, P. L., & Hops, H. (1990). *Leaders manual for adolescent groups: Adolescent coping with depression course*. Kaiser Permanente Centre for Health Research.
- Davey, C. G., Chanen, A. M., Cotton, S., M., Hetrick, S. E., Kerr, M. J., Berk, M., Dean, O., Yuen, K., Phelan, M., Ratheesh, A., Schafer, M., Amminger, P., Parker, A. G., Piskulic, D., Harrigan, S., MacKinnon, A. J., Harrigan, B. J., & McGorry, P. (2014). The addition of fluoxetine to cognitive behavioural therapy for youth depression (YoDA-C): Study protocol for a randomised control trial. *Trials*, 15, 1–9. <https://doi.org/10.1186/1745-6215-15-425>
- Davey, C. G., Chanen, A. M., Hetrick, S. E., Cotton, S., M., Ratheesh, A., Amminger, P., Koutsogiannis, J., Phelan, M., Mullen, E., Harrison, B. J., Rice, S., Parker, A. G., Dean, O. M., Weller, A., Kerr, M. J., Quinn, A. L., Catania, L., Kazantzis, N., McGorry, P., & Berk, M. (2019). The addition of fluoxetine to cognitive behavioural therapy for youth depression (YoDA-C): A randomised, double-blind, placebo-controlled, multicentre clinical trial. *Lancet Psychiatry*, 6(9), 735–744.
- Day, C. (2008). Children's and young People's involvement and participation in mental health care. *Child and Adolescent Mental Health*, 13, 2–8. <https://doi.org/10.1111/j.1475-3588.2007.00462.x>
- Donnellan, D., Murray, C., & Harrison, J. (2013). An investigation into adolescents' experience of cognitive behavioural therapy within a child and adolescent mental health service. *Clinical Child Psychology and Psychiatry*, 18, 199–213. <https://doi.org/10.1177/1359104512447032>
- Feehan, C. J. (1996). Cognitive-behavioural therapy for depressed children: Children and therapists' impressions. *Behavioural and Cognitive Psychotherapy*, 24, 171–183. <https://doi.org/10.1017/S1352465800017422>
- Fergusson, D. M., Boden, J. M., & Horwood, L. J. (2007). Recurrence of major depression in adolescence and early adulthood, and later mental health, educational and economic outcomes. *British Journal of Psychiatry*, 191, 335–342. <https://doi.org/10.1192/bjp.bp.107.036079>
- Fergusson, D. M., & Woodward, L. J. (2002). Mental health, educational and social role outcomes of adolescents with depression. *Archives of General Psychiatry*, 59, 225–231. <https://doi.org/10.1001/archpsyc.59.3.225>
- Gibson, K., & Cartwright, C. (2014). Young people's experience of mobile phone text counselling: Balancing connection and control. *Children and Youth Services Review*, 43, 96–104.
- Goodall, J., Fisher, C., Hetrick, S., Phillips, L., Parrish, E. M., & Allott, K. (2018). Neurocognitive functioning in depressed young people: A systematic review and meta-analysis. *Neuropsychology Review*, 28, 216–231.
- Gould, M. S., King, R., Greenwald, S., Fisher, P., Schwab-Stone, M., Kramer, R., Flisher, A. J., Goodman, S., Canino, G., & Shaffer, D. (1998). Psychopathology associated with suicidal ideation and attempts among children and adolescents. *Journal of American Academy Child Adolescent Psychiatry*, 37, 915–923. <https://doi.org/10.1097/00004583-199809000-00011>
- Hawton, K., Witt, K. G., Taylor Salisbury, T. L., Arensman, E., Gunnell, D., Townsend, E., ... van Heeringen, K. (2015). Interventions for self-harm in children and adolescents. *Cochrane Database of Systematic Reviews*, 12, CD012013.
- Hetrick, S. E., Cox, G. R., Fisher, C. A., Bhar, S. S., Rice, S. M., Davey, C. G., & Parker, A. G. (2015). Back to basics: Could behavioural therapy be a good treatment option for youth depression? A critical review. *Early Intervention in Psychiatry*, 9(2), 93–99. <https://doi.org/10.1111/eip.12142>
- Hetrick, S. E., Parker, A. G., Bailey, A., Cahill, S., Rice, S., Garvin, T., Phelan, M., & Davey, C. (2015). Cognitive-behavioural therapy for depression in young people: A modular treatment manual. Melbourne, Orygen, The National Centre of Excellence in Youth Mental Health.
- Hetrick, S. E., Meader, N., Bailey, A. P., Badcock, P. B., Moller, C. I., Cox, G. R., Merry, S.N., & McKenzie, J. E. (2020). New generation antidepressants for depression in children and adolescents: a network meta-analysis (Protocol). *The Cochrane Database of Systematic Reviews*, Issue 7. Art. No.: CD013674. <https://doi.org/10.1002/14651858.CD013674>
- Hirschfeld, R. M. A., Montgomery, S. A., Keller, M. B., Kasper, S., Schatzberg, A. F., Möller, H.-J., ... Bourgeois, M. (2000). Social functioning in depression: A review. *Journal of Clinical Psychiatry*, 61, 268–275. <https://doi.org/10.4088/JCP.v61n0405>
- Hodgetts, A., & Wright, J. (2007). Researching clients' experiences: A review of qualitative studies. *Clinical Psychology & Psychotherapy*, 14, 157–163. <https://doi.org/10.1002/cpp.527>
- Lawrence, D., Johnson, S., Hafekost, J., Boterhoven De Haan, K., Sawyer, M., Ainley, J., & Zubrick, S. R. (2015). *The mental health of children and adolescents. Report on the second Australian child and adolescent survey of mental health and wellbeing*. Department of Health Canberra.
- Lee, R. S., Hermens, D. F., Porter, M. A., & Redoblado-Hodge, M. A. (2012). A metaanalysis of cognitive deficits in first-episode major depressive disorder. *Journal of Affective Disorders*, 140, 113–124. <https://doi.org/10.1016/j.jad.2011.10.023>
- Lewinsohn, P. M., Rohde, P., & Seeley, J. R. (1998). Major depressive disorder in older adolescents: Prevalence, risk factors, and clinical impressions. *Clinical Psychology Review*, 18, 765–794.
- March, J., Silva, S., Petrycki, S., Curry, J., Wells, K., Fairbank, J., Burns, B., Domino, M., McNulty, S., Vitiello, B., & Severe, J. (2004). Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents with Depression Study (TADS) randomized controlled trial. *Journal of the American Medical Association*, 292, 807–820.
- McCarty, C. A., & Weisz, J. R. (2007). Effects of psychotherapy for depression in children and adolescents: What we can (and can't) learn from meta-analysis and component profiling. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46(7), 879–886.
- McGorry, P. D., Tanti, C., Stokes, R., Hickie, I. B., Carnell, K., Littlefield, L. K., & Moran, J. (2007). Headspace: Australia's National Youth Mental Health Foundation—Where young minds come first. *Medical Journal of Australia*, 187, S68–S70.

- Midgley, N., Ansaldo, F., & Target, M. (2014). The meaningful assessment of therapy outcomes: Incorporating a qualitative study into a randomized controlled trial evaluating the treatment of adolescent depression. *Psychotherapy, 51*(1).
- Morey-Nase, C., Phillips, L. J., Bryce, S., Hetrick, S., Wright, A. L., Caruana, E. & Allott, K. (2019). Subjective Experiences of Neurocognitive Functioning in Young People with Major Depression *BMC Psychiatry, 19*(1), 209. <https://doi.org/10.1186/s12888-019-2197-1>
- National Institute for Health and Clinical Excellence (NICE). (2019). *Depression in children and young people: Identification and management*. National Clinical Practice Guideline <https://www.nice.org.uk/guidance/ng134/>
- Neelakantan, L., Hetrick, S., & Michelson, D. (2019). Users' experiences of trauma-focused cognitive Behavioural therapy for children and adolescents: A systematic review and Metasynthesis of qualitative research. *European Child and Adolescent Psychiatry, 28*(7), 877–897. <https://doi.org/10.1007/s00787-018-1150-z>
- Nelson, T. D., Steele, R. G., & Mize, J. A. (2006). Practitioner attitudes toward evidence-based practice: Themes and challenges. *Administration and Policy in Mental Health, 33*(3), 398–409. <https://doi.org/10.1007/s10488-006-0044-4>
- Ng, M. Y., Eckshtain, D., & Weiss, J. R. (2016). Assessing fit between evidence-based psychotherapies for youth depression and real-life coping in early adolescence. *Journal of Clinical Child & Adolescent Psychology, 45*(6), 732–748.
- Sauter, F. M., Heyne, D., & Westenberg, P. M. (2009). Cognitive behavior therapy for anxious adolescents: developmental influences on treatment design and delivery. *Clinical Child and Family Psychology Review, 12*(4), 310–335.
- Thomas, D. R. (2006). General inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation, 27*(2), 237–246. <https://doi.org/10.1177/1098214005283748>
- Truijens, F., Zühlke-van Hulzen, L., & Vanhuele, S. (2018). To manualize, or not to manualize: Is that still the question? A systematic review of empirical evidence for manual superiority in psychological treatment. *Journal of Clinical Psychology, 75*(3), 329–343.
- Wilmots, E., Midgley, N., Thackeray, L., Reynolds, S., & Loades, M. (2020). The therapeutic relationship in Cognitive Behaviour Therapy with depressed adolescents: A qualitative study of good-outcome cases. *Psychology and Psychotherapy: Theory, Research and Practice, 93*, 276–91.
- Weersing, V. R., Rozenman, M., & Gonzalez, A. (2009). Core components of therapy in youth: Do we know what to disseminate? *Behavior Modification, 33*(1), 24–47.
- Weisz, J. R., Chorpita, B. F., Palinkas, L. A., Schoenwald, S. K., Miranda, J., Bearman, S. K., ... Research Network on Youth Mental Health. (2011). Testing standard and modular designs for psychotherapy treating depression, anxiety and conduct problems in youth. *Archives of General Psychiatry, 69*, 274–282. <https://doi.org/10.1001/archgenpsychiatry.2011.147>
- WHO. (2014). *Preventing suicide: A global Imperative*. World Health Organisation.
- WHO. (2017). *Depression and other common mental disorders: Global Health estimates*. World Health Organisation.
- Zhou, X., Hetrick, S. E., Cuijpers, P., Qin, B., Barth, J., Whittington, C. J., ... Xie, P. (2015). Comparative efficacy and acceptability of psychotherapies for depression in children and adolescent: A systematic review and network meta-analysis. *World Psychiatry, 14*, 207–222. <https://doi.org/10.1136/bmjopen-2015-008572>
- Zhou, X., Hou, Y. F., Liu, D., & Zhange, X. Y. (2017). Effect of cognitive behavioural therapy versus interpersonal psychotherapy in patients with major depressive disorder: A meta-analysis of randomized controlled trials. *Chinese Medical Journal, 130*, 2844–2851. <https://doi.org/10.4103/0366-6999.219149>
- Zisook, S., Lesser, I., Stewart, J. W., Wisniewski, S. R., Balasubramani, G. K., Fava, M., Gilmer, W. S., Dresselhaus, T. R., Thase, M. E., Nierenberg, A. A., Trivedi, M. H., & John Rush, A. (2007). Effect of age at onset on the course of major depressive disorder. *AJ Psychiatry, 164*(10), 1539–1546.

How to cite this article: Ferguson, N., Rice, S., Gleeson, J., Davey, C. G., & Hetrick, S. E. (2023). The experience of young people receiving cognitive behavioural therapy for major depression: A qualitative study. *Early Intervention in Psychiatry, 17*(1), 47–56. <https://doi.org/10.1111/eip.13290>

APPENDIX: INTERVIEW QUESTIONS

Questions pre interview

- Confirm names of therapists/doctor with client
- What do they call therapy? (counselling, psychology sessions?)
- Confirm distinction between psychiatrist and psychologist.

Experience of therapy

- Tell me the story of your therapy as you see it
- What was the experience of the counselling that you received?
- What were your first impressions?
- How did you connect with your therapists?
- Do you think that had an impact?

Possible prompts:

How would you describe your relationship with your therapist? How did it change during the therapy?

- Can you think of a word to describe your therapist? Can you think of a particular moment when your therapist was [word]?

- Are there any specific moments or events that you remember about the therapy?

[E.g. of prompts: Things that happened that seemed important?

Things that you or the therapist did or said that you particularly remember?]

What was it like for you knowing that your therapy was a time-limited intervention?

- Looking back, how did it feel to be in therapy? What has it been like for you overall?

Had you had therapy before? What ideas did you have about therapy?

What did you not like about the face-to-face counselling you received?

What did you find the most helpful thing about the face to face counselling you received? What do you still remember and use?

Were you aware that the counsellor was following a manual?

If yes, what was your experience?

If no, what do you think?

Were your sessions recorded by the counsellor? How much did this affect your willingness to speak openly/honestly in sessions?

Experience of CBT

Were you aware they you were receiving a specific model of therapy? CBT?

Were you aware that it that it has a strong evidence base?

What things do you remember being most helpful? (then prompt for “skills” generally, and then specifically).

CBT is a skill based intervention. What did you learn from the therapy?

What helped most/least with learning and generalizing skills?

(Give examples from manual to aid memory)

Did you receive information about what depression was like and the effect it can have on you? How did you find this?

Where there any skills you learnt about managing your mood by doing more fun or enjoyable activities? What did you think of this? How did you find this?

Where there any skills you learnt about identifying and working on unhelpful thinking? What did you think of this? How did you find this?

Where there any skills you learnt about problem solving? What did you think of this? How did you find this?

Where there any skills you learnt about anger management? What did you think of this? How did you find this?

Where there any skills you learnt around or information about Alcohol and other drugs and your mood? What did you think of this? How did you find this?

Where there any skills you learnt around interaction with family and friends? What did you think of this? How did you find this?

What helpful things do you still use?

What did you think about the resources/ homework tasks you were given?

To your knowledge, have you received CBT counselling previously? Do you have any comments on how it differed to the manualised counselling you received as a part of the study?

Post interview

Would you like to choose your own pseudonym?