When low mood strikes

CBT is increasingly recommended by treatment guidelines[1] for use with younger people who present with depression. However, there are major challenges in delivering this. Chris Williams, co-author of *Overcoming teenage low mood and depression*, and Christabel Boyle discuss recent provision of CBT self-help resources for young people and how this low-intensity CBT might be delivered within younger people's services

An initial look at CBT

Cognitive behaviour therapy is often described as a short-term, problem-focused, collaborative form of talking therapy. At the heart of CBT is an assumption that thoughts, relationships and behaviours (not simply events) affect how the person feels. CBT helps the person identify unhelpful patterns of responding. These patterns may include unhelpful thought patterns and also activities or behaviours that have become part of the problem.

CBT is one of a range of evidence-based talking therapies. Such treatments tend to share:

1 a structure and model that helps make sense of '*why do I feel like I do?*'

2 a focus on changing problems relevant to the *person* (ie ones they want to change)

3 an approach where there is an effective working/supportive relationship that helps guide and support the person through the process of discovery (see 1) and change (see 2).

CBT shares each of these elements. It aims to help people to help themselves – helping the person 'become their own therapist'. CBT can therefore be seen as a self-help form of therapy[2].

CBT has gone through several phases of development. In the *first phase* of development the specialist CBT model was refined, evaluated and offered by specialist workers based in specialist teams. This traditional CBT approach typically provides 12-20 one-hour sessions by a qualified and accredited practitioner. Often, when someone is described as being 'referred for CBT', this model is what they expect to receive.

Developing low-intensity self-help

There is good evidence that CBT offered in such ways can be an effective treatment. However, CBT can be offered in a range of other ways that also have an evidence base. These have led to a *second phase* of CBT development[3], where the focus has moved away from expert delivery in expert settings alone, to a wider dissemination of delivery. The so-called 'new ways of working' aim to provide greater access to CBT by utilising a number of 'low-intensity' treatments – one of which is CBT self-help. These have been incorporated into the Increasing Access to Psychological Therapies (IAPT) model in England, and the Widening Self-help (WISH) Programme in Scotland. Both aim to increase capacity of services to offer evidence-based talking therapies.

The challenge is to produce materials that retain fidelity to the CBT model while being usable and written specifically for the younger age range – paying attention to systemic factors and being sensitive to developmental issues

Why CBT self-help?

One way of thinking about CBT is as an educational model. This reframes the delivery of CBT into the question 'how do you like to learn?' – for example, using books, DVDs or online resources, as well as the traditional one-to-one tutor/therapist style of working. CBT delivered in these ways is effective[4] and the structure and step-by-step nature of CBT translates readily into a self-help format. But to get the most from the approach, supportive encouragement and monitoring is needed from either a practitioner or other supporter (eg a voluntary sector worker). This echoes the key components for an effective intervention referred to earlier: the model/structure of working can be reproduced in a book or computer programme, as can a focus on problems relevant to the person. However, for effective change, a supportive/encouraging relationship from a practitioner is also required. It is clear, therefore, that while supported self-help is effective, unsupported approaches are far less so.

Will any self-help do?

There are some practical problems when it comes to delivering CBT self-help. It seems sensible to choose materials that are evidence-based, use the CBT model and are usable. However, very few resources have been formally evaluated. Some use the CBT model, but many use the *traditional language* of CBT. This has a reading age of 17[2]. Sometimes materials appear accessible but the reality disappoints. For example, adding 'young-looking cartoons' and making print larger than would be seen in an adult-focused book is not the same as boosting accessibility.

Problems in availability of CBT self-help resources for younger people

The IAPT project is a major plan to fund training and the development of new teams providing wider access to evidence-based psychotherapies[5]. But the focus has generally not been on developing such ways of working in younger people's services. Delivery models for CBT self-help and other low intensity ways of working are less developed, and there is often no direct equivalent of graduate mental health workers and self-help support workers/coaches. Similarly, it is only relatively recently that CBT courses with the systemic focus required for child and adolescent services have

been available. These have focused predominantly and understandably on training people in high-intensity (traditional) CBT. This raises all sorts of issues about how low-intensity CBT can be delivered within younger people's services. The challenge is to produce materials that retain fidelity to the CBT model while being usable and written specifically for that age range. Some excellent examples exist[6], but these address a general range of problems, not just depression or anxiety. Many resources are, however, not so well structured or written. How, then, can resources be created specifically with depression and anxiety in young people in mind?

Making CBT self-help accessible

1 Materials need to be interesting, relevant and hence gripping.
2 Length: if materials are long they should be divided into bite-sized chunks. A danger in creating resources is to aim to be comprehensive at the expense of being comprehensible.
3 Practical: learning is more effective when people interact and make changes rather than just read text theoretically. This fits with the CBT model, which emphasises putting what has been learned into practice ('homework').
4 Case examples can be used to help people 'see themselves' and identify with what they are discovering.
5 A personal language such as 'I' and 'you' is generally more engaging than a third-person tone.
6 People are different and have different needs. Ideally, longer and shorter versions of materials should be available – with larger books and shorter booklets, as well as TV versions for people who struggle or prefer not to read. These can also address different reading ages and be available in different translations.
7 Blending learning: letting people learn via a variety of resources ('blended learning') allows them to learn relearn and supplement what they are learning with other resources, information and skills. For example, the www.livinglifetothefull.com online course, and class-based Living Life to the Full (LLTTF) course/class (which includes a young person version) use written self-help resources supplemented by web-based learning, or in-class discussion to encourage the person to reflect, discuss and put into practice what they are learning (see below).
8 Language and CBT: long paragraphs and complex words such as 'negative automatic thoughts' and 'dysfunctional assumptions' are difficult to learn. If someone is feeling low, it is asking too much of them to have to learn these new terms before they can use a resource. Everyday words should be used with short sentences and short words.

Building on these principles

Over the last 12 years, a range of resources using the so-called Five Areas model has been created and evaluated based on these principles[7].

Case study 1: Humanistic
Groupwork at a college, by Dorothy Griffiths

A number of students at the college of further education where I work were suffering from depression. Two of these students asked me if there were any support groups they could join as they both felt it would help them to know that there were other people who had similar problems to their own. I asked 10 of my clients if any of them would be interested in joining such a group. Five of them came forward and I set up our first meeting.

For the first session, I asked the group to introduce themselves and to voice their hopes and expectations of the group. We also agreed a set of ground rules which included the importance of confidentiality, allowing everyone to have their say (or not, if they wished) and be listened to in a supportive and non-judgmental manner. The group members were all female, aged 18 to 20 and from different courses and not known to one another, so we spent some time just getting to know each other. They all felt that it was important that they attended each session and we agreed to try out a pilot of just six sessions to start with. The college runs enrichment programmes on a Wednesday afternoon so it was agreed that we would all meet then to prevent the risk of anyone missing lessons. We agreed topics for the first four weeks that included coping strategies, healthy diets, exercise and relationships.

Each week, we spent 20 minutes reflecting on the highs and lows of the week. We then went on to the topic of the week and spent 20 minutes exploring this in more depth. I had asked everyone to bring in any resources that might be useful on the topic areas and this worked well as we were able to share ideas, articles and web pages. The final 20 minutes were used for looking towards the coming week, as the group wanted to have time to identify and agree individual personal goals. For example, on the first week, one of the students was struggling with her revision and her goal was to set a realistic time frame for this and stick to it for the whole week. The rest of the group supported her in this and gave ideas of how she could meet this goal.

The first four weeks of the programme worked extremely well and the group bonded quickly. I hadn't suggested sharing mobile phone numbers or emails but, by week three, they had all done this. Although they didn't actually meet up outside the group, they felt it was important that they could contact one another if they felt the need to talk. After week four, I was a little concerned as we hadn't agreed a focus, but by then, the students wanted more time to share highs and lows rather than 'topics'. They didn't want it to be prescriptive in any way but expressed the view that the group now had a life of its own and they wanted it to evolve naturally. We completed six sessions in total and met for a final session just before the summer holidays for an evaluation of the programme. This was very positive and the students said they had all missed the group sessions but knew they could contact each other if they wanted to talk. The group restarted in September and members have changed the format by introducing 'journal time' when any writing can be shared with the rest of the students. The support network they have developed is a positive one that has enabled students to continue studying and remain at college despite their frequent low moods.

Dorothy Griffiths is a counsellor in North Wales.
Email dorothy.griffiths@talktalk.net

Case study 2: Play therapy
Work with Jemma, by Augene Nanning

Jemma, Year 2, was referred to our service by the school SENCO as she was crying a lot 'for no reason'.

Her grandmother was caring for her, as Mum's whereabouts were unknown. Aged 65, Gran found Jemma 'young, difficult, tiresome and ungrateful'. Jemma's constant crying was getting on Gran's nerves. Jemma's teacher described her as sad, isolated, quiet but obedient, with no close friends, little energy, simply sitting about in the playground but wanting 'lots of cuddles'.

At Journeys-CBLS, we are not concerned with diagnosis, although the small amount of information available indicated Jemma might be depressed. Our criteria for offering help include: experiencing a significant loss and consequently not coping with daily living – which appeared to describe Jemma.

When I met Jemma, she grasped my hand instantly and smiled up at me, before settling herself at the craft table. She stared at the poster of wild animals lounging around a pond and talked about her family: Mommy, Daddy, baby, big brother, and a little sister whose name she couldn't remember. She pointed out the animals and told me who in her family liked which ones.

The following week, Jemma made a card 'for my grandma or teacher – I don't have a mom' and in a later session, talked of a mother. As a counsellor using non-directive therapeutic play, I observed this but didn't challenge. My role is to be with the child in the present moment.

Jemma continued to be articulate and interact easily with the toys. Common themes of nurturing emerged: tea parties, feeding and caring for dolls, and doing first aid and healing a sick dog.

In the sixth session, Jemma began telling me stories – a new direction that continued in each of our remaining contracted sessions. Using plasticine, she moulded a forest on A3 paper. Then she drew a black dot at the edge of the paper – 'the wolf'. She added a brown squiggle far away from the wolf. Using a thick red marker, she drew the journey Red Riding Hood took through the forest.

Here, there, around and between the trees, Jemma directed the red marker as she told the story: 'Red Riding Hood is trying to get to Grandma. The woodman is trying to get to Red Riding Hood and the wolf is at Grandma's house... Red Riding Hood goes there.' The red marker trailed around more trees. 'Don't worry, woodman sees her.' The red marker went to house and wolf – the black dot.

Jemma removed the plasticine trees, turned the paper over and drew a bed. 'Wolf is there.' Jemma trailed the red marker to the bed. 'Red Riding Hood comes. The wolf gets out of bed. Red Riding Hood goes round. Woodman comes. Chops the wolf. They wonder where Grandma is. She's in the cupboard.' Jemma moved the red and brown markers about on the paper creating strong tangled movements. 'They hear her. They open the doors.' Jemma drew open doors. 'They all eat.' Pause. 'They've eaten it all up.'

In the remaining 10 minutes, she told me her story of three bears and Goldilocks, again with paper, markers and plasticine. Her story finished with: 'Goldilocks is discovered by a very angry growling mama, papa and crying baby bear and runs home. Her mom and dad tell her not to go out alone. Bears have followed her. They're hiding in the bush. They go in her house and do what she did to them: eat up her porridge, break the chairs, mess up the beds. The parents come. They are angry. Bears run back to their house and never go to Goldilocks again.'

Jemma put the plasticine away, leaving the paper for me to clear up. She took my hand and we left the room. From there on, Jemma created her own very descriptive stories each week, and continued to use paper and plasticine, or toys in the telling. Our contract ended all too quickly. When later I visited the school, Jemma happened to see me. She ran up and gave me a big hug. The head teacher saw and said: 'You've made a big impact on her.'

Augene Nanning is a bereavement and loss therapist at Journeys - Children's Bereavement and Loss Service. augene@journeys-cbls.org.uk

The approach encourages people to consider how their low mood or anxiety affects them in five key areas of their life[8]:

- people and events around them (including practical resources and problems, family and friends) or lack of people (loneliness)
- altered thinking: getting trapped in habits of unhelpful thinking that worsen how the person feels – for example mind-reading, or jumping to the worst conclusions
- altered feelings: for example low, anxious, guilty, angry or ashamed
- altered physical symptoms: such as low energy and disrupted sleep in low mood, or tension and restlessness in anxiety
- altered behaviour – with reduced activity in depression, avoidance in anxiety, helpful behaviours (to be built upon) and unhelpful behaviours (which keep problems going or worsen the situation, such as drinking).

The resources aim to have a low reading age and clear, structured content.

A recent randomised controlled study in adults has confirmed better outcomes at four and 12 months at no greater cost than usual care[9]. Collaborative work with various child and adolescent practitioners and others has led to child and adolescent versions

of these materials being produced. The aim has been to produce materials for young people, using the CBT model but also paying attention to systemic factors and being sensitive to developmental issues.

Three main sets of resources have been created:

1 Living Life to the Full (LLTTF) booklet series[10]. Currently consists of 11 books addressing problems such as 'Why do I feel so bad?', 'Why does everything go wrong?', 'I can't be bothered doing anything', 'How to fix almost everything', 'Are you strong enough to keep your temper?', 'I'm not good enough' and others (see Table 1). The books are small, printed in colour, and use an accessible design and layout. Written in collaboration with a script editor (Steve Yelland) and designer (Philip Munroe), there has been a focus on teaching key principles of change in clear attractive ways.

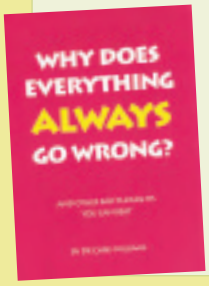
2 Living Life to the Full Class (www.fiveareas.com) This is described as '12 hours to change your life'. The class consists of eight short sessions addressing eight of the LLTTF booklets. The class aims to provide a fun group setting to help people learn key life skills. The classes have so far been run with young people, students, and as part of Personal, Social and Health Education in a school setting. A key is the labelling of it as a life skills course – rather than a course addressing depression and anxiety (although this is a target).

3 A book: *Overcoming teenage low mood and depression*[11]. This resource is jointly written by one of the present authors (CW) and Dr Nicky Dummett – a past Chair of the BABCP's Child and Adolescent Special Interest Group and an expert in CBT with younger people. The book is deliberately longer than the LLTTF booklets and provides additional structure for working on problems (see Table 2). Case examples of 'Helen' and 'Mark' are developed across the book. The book itself consists of 16 workbooks – and comes with a licence to allow copying of the workbooks for use clinically and in teaching (this does not apply to the LLTTF materials described above). A key element of the book is that it is designed to be torn up and copied.

In fact, a key element of *all* the resources is that the person can choose to use whichever workbooks they deem relevant (thereby boosting engagement and motivation). Practitioners don't 'prescribe' or tell the person what to read. Instead, decisions are client-led and, crucially, based on the person's choice, interests and needs. Research in adult settings has also confirmed that the materials can do much of the work of therapy, so the amount of support required is reduced. The Gellatly et al review[4] confirms that the support need only focus on supportive monitoring, and can be delivered by non-mental health workers as well as those specialising in mental health. Resources can therefore be delivered in a range of ways and settings, and by a range of staff, thus providing great flexibility. This can include, of course, staff using them as resources alongside high-intensity CBT interventions.

Table 1: Current LLTTF booklets

- *Write all over your bathroom mirror: and 14 other ways to get the most out of your little book*
- *Why do I feel so bad?*
- *How to fix almost everything*
- *Why does everything always go wrong*
- *I can't be bothered doing anything*
- *The things you do that mess you up*
- *Are you strong enough to keep your temper?*
- *I'm not good enough: how to overcome low confidence*
- *10 things you can do to make you feel happier straight away*
- *I feel so bad I can't go on*
- *How to use the little CBT books: a practitioner's guide*



Source: www.fiveareas.com

Table 2: Overview of *Overcoming teenage low mood and depression*

Part 1: Understanding why I feel as I do
Understanding why I feel as I do
Why bother changing?

Part 2: Making changes
Doing things that make me feel good
Using exercise to boost how I feel
Helpful things we do
Unhelpful things we do
Restarting things we've avoided
Practical problem solving
Noticing and changing extreme and unhelpful thinking
Being assertive
Building relationships
Overcoming sleep problems
Alcohol and drugs and me
Understanding and using antidepressant medication
Planning for the future

Part 3: Support materials for relatives and friends
Ideas for families and friends – how can I offer the best support?

A key element of the book ***Overcoming teenage low mood and depression*** is that it is designed to be torn up and copied

Case study 3: Psychoanalytic
Work with Ralph, by Judith Sonnenberg

My reading and my own experience in counselling children have led me to equate depression with a blockage in the pathway from loss to recovery, arising from an unconscious wish to keep hold of the lost loved object. I have found this to result in some rather unusual behaviour. It is my aim through counselling to gain the child's trust, enabling him or her to feel safe enough to reach inside and explore the deep-seated, painful feelings in order to let go of them and move on once more.

I aimed to achieve this with a nine-year-old boy I shall call Ralph. He was referred to me because he was withdrawn and not relating to his peers. He was not unduly unhappy, but exhibited strange behaviour, such as leaving the class and roaming round the school during lesson time, as well as complaining of imaginary ailments. His mother was very worried about him. She cared for him in a practical way, but could not reach him on an emotional level.

Ralph came to counselling, a pale, thin child who would wear a tee-shirt even in cold weather. He said that he didn't like the heat or 'hot air'. I hoped this was not a warning to me. He wore a blank expression on his face and for many of our initial sessions he diverted my attention with factual books. Eventually, he revealed that life had stood still for him the moment his father left home. Since then, he seemed to neither laugh nor cry. He was frozen in time. He would relate some of his nightmares and frightening imaginings in a cold unemotional way, turned off from any feelings. My aim was to help him to 'thaw out' so that he could move again. He appeared to be stuck in the first stage of loss work, at which point he had internalised his feelings and kept them lodged inside. The dragons he drew breathed flames like angry thoughts and the scaly patches on their chests seemed to represent the hard core of his painful feelings.

At this time, the only exchanges he managed to have with his mother were angry outbursts followed by retreat. He idealised his father, but would blame him for minor accidents that would occur. Sessions were repetitive. I hung on to the frustration, but at the end of the summer term, I decided to see how he might progress during the break and extended that break somewhat into the autumn term.

In late September, I found him crying outside my room. My absence seemed to have precipitated a shift. We arranged some sessions. These were animated, to say the least, as he killed and maimed figures in the doll family. He was brutal and ruthless. Although this seemed like a turn for the worse, I experienced it as cathartic as all his feelings of rage and hate poured out again and again. During this time, our conversations became more realistic. We spoke about how let down he felt by his parents and how helpless he had felt. In the secure environment of my room he was able to release his feelings without fear of reprisal.

'Getting stuck' seemed to define Ralph's depression. In his case, I stayed with the feelings of immobility until I felt it was safe enough to take action to see if things could become 'unstuck'. By giving Ralph the space to use the work we had done together, he came back to me bursting to release his pent-up, turbulent emotions, enabling him to gradually move out of his depression.

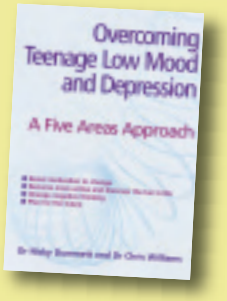
His relationship with his mother grew warmer and he came across as quite protective towards her. When it was time for him to move on to secondary school she contacted me, as she feared he might regress, but I was able to put in place continued support for him.

Judith Sonnenberg is a school counsellor and teacher.

Summary

There is a growing evidence base that CBT self-help resources provided with support from a practitioner can be effective. That support can be delivered by a wide range of practitioners, not just those with formal CBT or mental health training. This approach offers the potential to significantly increase access to evidence-based treatments. Part of the challenge will be to produce a range of materials addressing how young people like to work and learn. The new resources outlined in this article attempt to provide accessible and usable CBT self-help resources. New materials are by definition new! There is no current evaluation available on these versions of the materials. As practitioners and researchers, we firmly believe that the way forward is to research and test the various models, and the authors welcome independent evaluations of how best to introduce and support such resources in adolescent settings. ■

Dr Chris Williams, Senior Lecturer in Psychiatry, University of Glasgow, is an expert and trainer in CBT and a past president of BABCP (www.babcp.com). He is co-author of Overcoming teenage low mood and depression: a five areas approach[11]. *Email chris.williams@clinmed.gla.ac.uk*



Dr Christabel Boyle is Specialty Registrar 5 in Child and Adolescent Psychiatry, West of Scotland, and works in the Department of Child and Adolescent Psychiatry at the Royal Hospital for Sick Children, Glasgow. Email christabel.boyle@ggc.scot.nhs.uk

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Case study 4: Integrative
Work with Peter, by Os Filmalter and Anne Turnbull

Our integrative approach is underpinned by Clarkson's five-relationship model and informed by systemic, narrative and solution-focused ideas.

Peter is 12 years old and in Year 7. He was referred for sustained disruptive behaviour inside and outside the class after usual classroom strategies had no lasting effect. Until the previous term (eight weeks before) Peter's behaviour was deemed normal, his learning progress average and social integration good. Peter's older sister, Nancy, had died in a car accident 28 weeks earlier. Accounts from school and Peter converged in that both parents were left angry, distraught and revengeful after the death of their daughter and virtually ceased their parental responsibility to Peter. Peter had a sense of being invisible. He once said that the only attention he got was because of his dead sister, although he did also miss her: 'No one talks to me about my stuff, they don't care, they just talk about how bad it was what happened to Nancy.'

It seems his personal narrative had shifted from him as a person, to the poor boy whose sister had died in an accident under questionable circumstances, whose parents were distraught but revengeful. Low mood/depression seemed to be triggered initially by the loss of his sister but subsequently exacerbated by the systemic reaction to the fallout. Depression/low mood in young boys is often linked with acting out and behaviour excesses.

Initial work with Peter focused on building a working alliance to ensure he felt his personal accounts were respected and accepted. This included helping him formulate his feelings and understanding of his situation. An analysis of strengths and weaknesses was completed to identify what worked for him in the past and what resources he had. Peter mentioned that in Year 3, completing a behaviour chart in conjunction with his teacher or learning support assistant in class had helped him to improve his behaviour by making helpful choices. This strategy was agreed with his teachers. Once this produced positive outcomes, on Peter's suggestion it was extended to home. Mum was very glad that behaviour at school had improved and, although slightly puzzled, agreed to do the chart at home as well. Over this time, Peter's behaviour returned to acceptable parameters and his learning improved. The weekly sessions were changed to fortnightly for half a term and then ended. The behaviour chart continued at home.

Providing a conducive relationship and safe therapeutic space culminated in an opportunity for Peter to construct, then deconstruct and eventually re-construct his self-narrative, which proved helpful. Enabling him to evaluate and identify his strengths helped him to design a solution that he already had a positive transference about, thus enhancing his inherent motivation to make it work. The chart generated clear achievable targets, explicated behaviour boundaries but most importantly created a valuable daily opportunity for conversation about him, which was unlikely to include a reference to his family's trauma.

The chart served as an auto-regulator for him to develop and guide his self-regulation but also became a valuable narrative prop to extract information from his environment about him and his being. This narrative shift liberated many to tell a different story about him – shifting the focus from the loss-saturated recent stories to more positive current and forward-looking accounts.

A few awareness points from this case:

- Low mood could be masked by acting out, particularly with adolescent boy clients.
- Even depressed/low-mood clients can be resourceful and design solutions when enabled, encouraged and permitted.
- Relationships generally benefit from (quality) conversations – the behaviour chart generated conversation, which built and sustained the relationship in this case both at school and home.

This meld of systemic, narrative and solution-focused ideas provides an epistemology where narrative ideas serve to objectify the problem and help to liberate people from problems. Solution-focused aspects highlight the client's resources and wisdom while systemically it helps to work one to one but always to keep the wider systems such as school and family in mind.

Os Filmalter and Anne Turnbull are counsellors for Conscire (www.conscire.com), an onsite counselling service to primary and secondary schools in Thurrock, Essex.

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