FOR PROVIDERS: FAST-D FAQS AND COMMON CHALLENGES

Q  When do I stop FAST-D?

A  FAST-D is designed to be a brief, first step intervention. By keeping it brief, you help create access for more youths and families on your caseload. Brief treatments also sometimes motivate teens and families to really invest in learning and applying the skills. Setting a limit on the number of sessions at the outset can help set the stage for this. That said, you can also choose when to stop based on the teen’s progress and needs as well as your availability to continue supporting them.

Q  Why don’t you cover negative thinking (i.e., cognitive focus)?

A  It’s true that many evidence-based programs for depression include a focus on negative thinking patterns. Given the brevity of this program and the goals of making it easy for providers to learn and implement, and easy for teens to grasp, we did not include a cognitive focus. Research also suggests that negative thinking can resolve on its own through behavioral activation, as the patient’s mood and circumstances improve.

Q  What about when teens are also anxious or dealing with trauma reactions?

A  There is huge overlap between anxiety and depression. In many cases anxiety comes first and is the driver of depressed mood (because anxiety is blocking healthy activities, social connection or other goals). We recommend targeting anxiety first using the FAST-A program. Supplementing FAST-A with some basic education about depression and focusing on brave practice that is activating (e.g., involves social connection, moving toward goals, doing rewarding activities) is expected to be more effective than targeting depression alone.

The same is true for posttraumatic stress. Traumas often precede depression and stress reactions frequently block healthy activities, social connection or other goals. Research suggests depression-focused programs often do not work as well for youth with significant interpersonal trauma histories. Focusing on resolving post-traumatic reactions is recommended (via treatments such as TF-CBT, CBT-T, CBITS, PE-A or FAST-T), rather than starting with FAST-D.

Q  What if the parent/caregiver is struggling with their own mental health or other challenges, and there is a lack of healthy structure or support for the teen?
A Try the “Parenting is Hard” worksheet in the Bonus section of the FAST-D workbook to have a nonjudgmental conversation about the parent’s challenges and what might help.

Q What if teens don’t want to make changes that seem important? Like addressing substance use, patterns of video game use, or self-isolation that appear to make things worse?

A Feel free to call out things you think may be important, and why, but it’s often OK to follow what the teen is interested in working on, as long as it seems healthy. Often the issues with substance abuse, video games, etc. will interfere with progress on whatever the teen is trying to accomplish, reinforcing the need to address them. If you know motivational interviewing skills, you can also draw on those to build motivation for change when the teen is ambivalent.

Q What about when teens can’t seem to follow through despite in-depth planning?

A This is common and gives you an opportunity to explore and better understand what has been getting in their way for them when they try to make positive changes. Challenges might be anything from insufficient sleep or poor organization to destabilizing conflict with parents. Validate that change is hard and see if you can troubleshoot whatever seems to be interfering.

Here are some additional strategies to consider:

- Try to really break it down and identify exactly where the plan is falling through. Are they forgetting or getting sidetracked? Do they lack a necessary skill? Can you identify changes that might have made a difference? Often factors like staying up late the night before, or choosing to start a screen-based activity that is difficult to put down, are part of the problem.

- Other times it becomes apparent that more external structure is necessary for the teen to have success. Parents/caregivers may need to remove devices and turn off internet at a reasonable bedtime, or remove access to distracting screen activities during the daytime. Parents/caregivers can also set “when-then” expectations such that screen privileges are only granted when certain activities of daily living have been met (e.g., left the house, attended school, showered, completed schoolwork). When-then or other behavioral strategies (rewards, consequences) can be used to shape the teen’s behavior toward healthier functioning. This may require
significant planning and support of the caregiver, and may be beyond what you are able to offer in a brief care setting.

- Other times clever changes to the routine may be enough to help get things rolling. For example, the parent of a teen who struggled to get out of bed for school was able to get them into a healthy rhythm by offering to walk together for a special coffee drink in the morning before school. The teen’s mood was improved and the transition to school was much easier afterward.

- Adding a medication may be helpful when teens are not responding to FAST-D alone.

Q What about CHILD depression? Can we use FAST-D for that?

A FAST-D is not designed for depression in children, but here are a few considerations if you are tasked with treating child depression:

- Depression is much less common in children (under 2%)
- Environmental factors may be at play (such as trauma, adversity, or impaired caregivers). Be sure to screen for traumatic events, such as abuse, which may be ongoing.
- Work to solve any obvious problems that seem to be contributing (e.g., stressors at home or school that coincide with mood changes).
- Bolster the child-caregiver relationship (e.g., through regular 1-on-1 time, parental praise, reducing criticism) and consider opportunities for other healthy connections (e.g., school staff, other relatives)
- Increase rewarding, healthy, and social activities in the child’s life.
- Bolster the child’s healthy coping skills, with caregivers supporting skills use at home through modeling, creating practice opportunities, prompting the skills when needed, and praising or rewarding their use.
- Use functional behavior analysis to identify ways depression-like behaviors (e.g., saying “I suck” “I want to die” “I hate myself”) may be rewarded (e.g., getting escalated parents to reduce their anger or consequences).
- Address negative thinking patterns that interfere with healthy functioning.

Q What about caregivers who seem defensive and unwilling to change?

A Validate how difficult their situation is, and that there is no single right way to parent a teen. Be clear you aren’t blaming them for the teen’s challenges. Acknowledge that parenting a depressed teen is especially hard and calls for special strategies. Point out that some strategies that might work perfectly well
for many teens (e.g., criticizing a bad choice, or lecturing about how their future will be ruined) may not work as well for a teen who has become depressed. Identify parent concerns and goals and highlight how your treatment recommendations can help with them.

Q What about teens who have a lot of shame or defensiveness about their depression and functioning?

A Try lots of validation. Normalize their behavior and feelings as perfectly understandable given their circumstances. Emphasize that depression is tricky for most people to get out of, and the ways to feel better are often not very intuitive. When teens feel accepted and understood, they will often be more open to trying new things.