憂鬱小王子抗逆之旅
Little Prince is Depressed

抑鬱症與認知行為治療
Depression and Cognitive Behavioural Therapy

補充資料

Supplementary Reading

他不再理會仙人掌，寧願別過頭去看沙。
沙子不需要灌溉，然而雙眼還是滴水。
他知道，並不是沙子吹了入眼，而是他的眼睛已

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THE HONG KONG JOCKEY CLUB
Centre for Suicide Research and Prevention
THE UNIVERSITY OF HONG KONG

抑鬱症與認知行為治療
補充資料

Depression and Cognitive Behavioural Therapy - Supplementary Reading

抑鬱症

什麼是抑鬱症？

抑鬱症的特徵是患者長期對很有趣的活動缺乏興趣、心情低落，以及顯示相關的在認知、行為和身體上的症狀。

在美國精神科學會的診斷手冊 (DSM-IV) 中，列舉了一些認知性症狀，包括集中力低下，有自我罪咎或無用感，或者經常性想自殺。而行為性症狀方面，包括不正常睡眠循環（失眠或者睡眠過度），或者食慾減低或增加。身體上的症狀指疲勞和心理動作變化，包括心神不寧（例如無法安靜坐下、拉扯或擦拭自己皮膚）及 / 或行動、語言遲緩。這些症狀應在整天之內經常發生，而且差不多每天復發。

抑鬱症分為四個嚴重度級別，即次臨界級、輕度、中度和嚴重。這些分級是按照出現症狀次數以及功能障礙的程度界定的。功能障礙指由於患者的症狀導致他們的生活受到干擾。例如，患有抑鬱症者可能無法工作，或者無法與他人有效地進行互動。此外，他們可能在家裏也無法照顧自己和家人。

Depression

What is depression?

Depression is characterized by a disinterest in enjoyable activities, the experience of low moods and the associated cognitive, behavioural and physical symptoms for a sustained period of time.

Some cognitive symptoms as referred by the American Psychiatric Association's Diagnostic Manual (DSM-IV), can include having poor concentration, a sense of guilt or worthlessness, or recurrent thoughts of suicide. Behavioural symptoms can include abnormal sleep cycles (insomnia or hypersomnia), or a decrease or increase in appetite. Physical symptoms refer to fatigue and psychomotor changes including agitation (e.g. unable to sit still, pulling or rubbing of skin) and/or physical and verbal retardation. These symptoms should happen frequently during the day and re-occur almost daily.

There are four severity levels of depression, namely, sub-threshold, mild, moderate and severe. These categorisations are defined by the number of symptoms displayed, as well as the degree of functional impairment. Functional impairment refers to the disruption of a patient's life brought about by their symptoms. For example, a person who is depressed may not be able to work or interact with others effectively. Also, they may not be able to take care of themselves or family members at home.

青少年抑鬱症

青少年患上抑鬱症的比例，比我們預期的更高。估計有 14-25% 的青年人在成年之前起碼有一次患上較嚴重的抑鬱的經驗 (Lewinsohn, 1998; Kessler, 1998)。較早首次病發（ 20 歲之前）的人也更容易抑鬱復發。與成年人比較，青少年顯現的症狀可能不同。在這個群組之中，焦慮和狂躁較為常見。另外，抑鬱也往往與其他病理過程例如焦慮、品行障礙 / 對抗叛逆症 (對抗性反叛行為) 或物質濫用障礙等並存。有很多個案 (50-80%) 需要進行深入診斷。最常見的其中兩種伴隨障礙是品行障礙及 / 或對立性障礙。患有抑鬱症的青少年之中，約有 25% 的人會出現這些障礙。也有相約比率的青少年同時有焦慮障礙。約有 15% 患者符合強迫症症狀的定義，另有 5% 符合患有進食失調症的定義。很多青少年抑鬱症患者都試圖以藥物或酒精作為解脫 (Ryan, 2005)。

青少年抑鬱症患者的集中力或會較差， 學習表現也因而較遜色。他們可能容易發怒，以致與父母、朋輩和師長之間的關係不佳。他們當中一些人甚至可能有風險行為，例如自殘或者濫用藥物等。抑鬱症患者也較常有自殺念頭。故此，抑鬱症對於青少年的社會、情緒和身體健康有重大負面影響。

抑鬱症與自殘、自殺性表現和企圖自殺有密切關係。大概有三分之二的自殺個案發生於抑鬱症患者 (Sartorius, 2001)。抑鬱症患者的自殺傾向是一般人的四倍 (Bostwick & Pankratz, 2000)。

在香港進行的一次社區研究 (Wong, 2008) 發現，抑鬱症症狀是青少年多次進行自殘的其中一個因素。

Depression in adolescents

Depression is more common amongst adolescents than we expect. It is estimated that 14-25% of youths experience at least one episode of major depression before adulthood (Lewinsohn, 1998; Kessler, 1998). People with early onset depression (before the age of 20) are more vulnerable to depression re-occurring. Adolescents may present symptoms in a different way compared with adults. Anxiety and irritation are more common in this group. Moreover, depression is often co-morbid with other pathological processes such as anxiety, conduct disorders/ oppositional defiant disorders, or substance abuse disorders. Numerous cases (50-80%) will have a second diagnosis. Two of the most common concomitant disorders are conduct disorder and/or oppositional disorder. These disorders occur in around 25% of young people with depression. Similarly, a similar percentage of young people have anxiety disorders as well. Around 15% affected meet the criteria for obsessive-compulsive disorder, and 5% will meet the criteria for eating disorder. Many adolescents who are depressed also utilize drugs or alcohol to cope (Ryan, 2005).

A depressed adolescent may have poor concentration and do poorly in their academics. They may become irritable and thus have poor relationships with their parents, peers, and teachers. Some of them may even engage in risk taking behaviour such as self-harm or substance misuse. Depression is also associated with a higher frequency of suicidal thoughts. Therefore, depression has a significantly negative impact on the adolescent's social, emotional and physical health.

Depression is associated with self-harm, suicidal behaviour, and attempted suicides. About two-thirds of suicides happen with people suffering from depression (Sartorius, 2001). People with depression are four-times more likely to commit suicide compared to the general population (Bostwick & Pankratz, 2000).

For instance, a community study conducted in Hong Kong (Wong, 2008), identified depressive symptoms as one of the factors for adolescents who inflict self- wounds repeatedly.

雖然抑鬱症可以發生在不論處於何種情況下的青少年身上，抑鬱症仍似較會在下列人士身上發生：

- 在童年經歷過身體或性侵犯的青少年
- 有行為問題的青少年
- 有自殘習慣的青少年
- 長期與家人爭執的青少年
- 有濫藥和酗酒問題的青少年

除抑鬱症外，抑鬱症患者特別是服用抗抑鬱藥的青少年會引起較高的自殺傾向。故此，在給青少年治療抑鬱症時，應該謹慎地選擇方法。

Although depression can happen to any adolescent regardless of the circumstances, it may be more likely to happen in the following circumstances:

- Adolescents who have experienced childhood physical or sexual abuse
- Adolescents with behavioural difficulties
- Adolescents who repeatedly harm themselves
- Adolescents with chronic family conflicts
- Adolescents with drug and alcohol problems

Apart from depression, there are also some concerns regarding heightened suicidal thoughts as a result of antidepressants treatment administered particularly in adolescents. Thus, caution should be taken with the treatment options available for adolescents.

與青少年抑鬱症相關的風險因素

對於一些人來說，情緒低落可以由多於一個風險因素觸發 (NICE, 2005, [CG28])。

脆弱因素：

女性

父母有抑鬱障礙的病史

父母已離婚

有身體、情緒或性方面受到侵害的經歷

在收養家庭中生活

刺激因素：

與朋友或家人之間的人際關係突然發生不利改變

個人受到襲擊

形成因素：

有抑鬱症狀的經歷

較嚴重的神經過敏

沉默型思考模式

社會環境中的風險因素：

受人欺凌

學業表現不佳

保護因素（有助減低發生抑鬱症的可能）：

有良好的社會支援（友誼）

與至少一名家人關係密切

有受社會重視的個人成就

Risk factors associated with depression in adolescents

For some, low moods may be triggered by different risk factors (NICE, 2005, [CG28]).

Vulnerable factors:

Being female

Parental history of depressive disorder

Parents who are divorced

History of physical, emotional or sexual abuse

Living in a foster care family

Stimulating factors:

A sudden undesirable change in interpersonal relationships in friends or family

Personal assault

Formation factors:

History of depressive symptoms

High levels of neuroticism

Ruminative thinking patterns

Risk factors in social environment:

Bullying

Poor academic performance

Protective factors (that may decrease the likelihood of depression):

Good social support (friendships)

Close relationship with at least one family member

Social valued personal achievements

抑鬱症在香港的患病率和發病率

香港至今沒有進行過關於正式的流行病學研究。因此，關於精神健康問題的患病率和發病率只能夠以全球數據進行推測。根據全球數據，精神健康問題的患病率是總人口的 15 — 25% 之間不等 (Kessler,1998)。基於這數字，估計香港有 100 萬至 170 萬人受精神健康問題困擾。

香港大學在 2004 年進行了一項調查，隨機取得 2,176 名年齡在 12 至 18 歲之間的參與者的樣本，當中有超過 20% 的人顯示有抑鬱的症狀 (Wong et. al. 2008) 。

由於人們可能為避免患上抑鬱症的污名而隱瞞病情，實際的患病率可能比報稱的更高。無論如何，香港的抑鬱症患病率確實與其他高收入國家的很類似。

Prevalence and incidence of depression in Hong Kong

There has been no formal epidemiological study conducted in Hong Kong to date. Thus, prevalence and incidence of any mental health problems can only be extrapolated from worldwide data. Worldwide data suggests that the prevalence of any mental health problems varies between 15 – 25% of the general population (Kessler, 1998). Based on this figure, Hong Kong is estimated to have 1-1.7 million people suffering from a mental health problem.

According to a survey conducted by The University of Hong Kong in 2004, a random sample of 2176 participants aged 12-18 was taken and over 20% of the sampling population showed symptoms of depression (Wong et. al. 2008).

The actual prevalence may be under-reported because of the stigma attached.

Nevertheless, the prevalence of depression does closely resemble other high income countries.

抑鬱症評估量表和其使用方式

測度青少年有否患上抑鬱症，通常採用兩種篩檢工具，其一是以自我報告為根據，另一種則以訪談為根據。“憂鬱小王子之路” 網站 (www.depression.edu.hk) 內採用的篩檢量表來自美國流行病學中心抑鬱量表 (CES-D)。CES-D 是由 Radloff 在 1977 年發展出的一個自我報告量表，最先在社區調查中用於成年人身上，其後用於青少年身上。

一個量表的有用程度，乃根據其心理測量來計量的，而且當中 CES-D 的可靠性和有效性乃高於平均。CES-D 在內部是一致的，即是說，量表上的各個項目都是在計量同一個構想（例如負面思想）。此外，CES-D 可以區別出具有臨床抑鬱症狀和不具有臨床抑鬱症狀的青少年，而用於臨床診斷的以訪談為基礎的工具對此可以進行核實。有關區別工作可以分為兩部份進行。其中一個是敏感性評分，代表測試結果為陽性的人之中真正患有抑鬱症的百分比。另一個是特異性評分，代表測試結果為陰性的人之中臨床診斷為健康的人所佔百分比。在對中學男生和女生進行的一個研究中，按照 CES-D 的最佳分界評分是 83-85% 的敏感性和 49-77% 的特異性 (Garrison 1991)。這表示這個量表能夠合理較好地捕捉到有臨床抑鬱症狀的青少年，並可以媲美臨床工具。具有高敏感性的自我報告量表可以是一個很好的提示工具，可發揮專業協助用途。

但是，Garrison (1991) 的研究特別指出這個量表的其中一個限制，是有相對較高的錯誤陽性比率。此外，這個量表的焦點也不是在於青少年。一些研究人員認為，這個量表可以計量較年輕群組的一般非臨床性情緒混亂，而非臨床抑鬱症狀。

這個量表只可作為一個自我篩檢工具，來提示學生、家長或老師諮詢專業人士意見，尋求進一步的協助和評估。

Depression assessment scale and How it is used

Detection of depression in adolescents is often based on two types of screening tools, namely, a self-report based instrument and an interview based instrument. The screening scale used in the “Little Prince is Depressed” website (www.depression.edu.hk) comes from The Center for Epidemiological Studies – Depression Scale (CES-D). The CES-D is a self-report scale developed by Radloff in 1977 used firstly for adults in community studies, then later used amongst adolescents.

The usefulness of a scale is measured by its psychometrics, and of which, the reliability and validity of CES-D is above average. The CES-D is internally consistent, meaning the items on the scale are measuring the same construct (eg. negative thoughts). Moreover, the CES-D can differentiate adolescents who are clinically depressed from those who are not, which is verified by the interview based instrument used for clinical diagnosis. Differentiation can be done in two parts. A sensitivity score represents the percentage of people tested positive who are truly depressed, and a specificity score represents the percentage of people tested negative as being clinically healthy. The best cut-off score by the CES-D showed a sensitivity of 83-85% and a specificity of 49-77% in a study conducted among middle school boys and girls (Garrison, 1991). This implies that the scale captures adolescents who may be clinically depressed reasonably well, and that it may be comparable to a clinical tool. A self-report scale with a high sensitivity may be a good prompting tool for professional help-seeking.

However, one of the limitations of this scale highlighted by Garrison (1991) may be the relatively high false positive rate. Also, the focus is not on adolescents. Some researchers suggest this scale may measure general non-clinical emotional turmoil rather than clinical depression in a younger age group.

In the end, this scale serves only as a self-screening tool to prompt students, parents or teachers to consult professionals for further help and assessment.

我可如何提供協助？

如果你懷疑你的學生有抑鬱症：

嘗試認識抑鬱症，了解抑鬱症的成因、風險因素和症狀。觀察他在行為表現方面的變化，積極聆聽他的說話，保持與他之間的關係。如果你發覺你的學生有抑鬱症的症狀，應鼓勵他向專業人士尋求協助。同時，你應繼續給予支持和關懷。很多時候，受抑鬱症困擾的人不能完全意識到自己的問題，社會對抑鬱症加上的污名而拒絕尋求外界協助。你應鼓勵他們面對困難，並尋求專業協助。讓他們明白到尋求專業協助的重要性，以及讓他們知道事情會以保密的方式處理。

如果你懷疑朋友 / 同事患上抑鬱症：

如果你有朋友患上抑鬱症，只要他知道你在身旁給他支持和愛護，對他總是有益的。你可嘗試認識抑鬱症，了解抑鬱症的成因、風險因素和症狀。如果你發覺你的朋友有抑鬱症的症狀，應鼓勵他向學校老師或者精神健康科的專業人士尋求協助。同時，你應保持與他的溝通。避免說「放鬆自己！」、「堅強一些！」、「不要想這麼多！」、「我比你也好不了多少！」等這樣的話。相反，應說一些例如“雖然我不能完全明白你為什麼不開心，我可以看到你正在經歷一段艱難的時刻。我會一直在你的旁邊。”這樣的肯定的話。但是最重要的，還是讓他知道一定要尋求專業協助。

如果你懷疑自己有抑鬱症：

與你信任的人（父母、朋友、老師）傾談，並尋求專業協助。你或者沒有參與任何活動的精神或動機，但是，踏出尋求協助的第一步，就可以幫助你挽回控制困難的一些力量。積極地嘗試找尋關於抑鬱症的更多資料、了解可行的治療方法、知道抑鬱症是可以治療的，這些都能夠幫助你痊癒。

What can I do to help?

If you have a student who you suspect to have depression:

Try to seek knowledge and understand the causes, risk factors, and symptoms of depression. Observe changes in his/her behaviour, and maintain relations by actively listening to him/her. If you find that your student displays symptoms of depression, encourage him/her to seek professional help. Meanwhile, maintain your support and concern for your student. It is common for people who are depressed to either not be fully aware of it, or refuse to seek external help due to social stigma. Encourage them to face their difficulties and in turn seek professional help. Let him/her understand the importance of seeking professional help, and that it will be dealt with in a confidential manner.

If you have a friend/colleague who you suspect to have depression:

It is always beneficial for a friend suffering from depression to understand that you are there to support and love them. Try to seek knowledge and understand the causes, risk factors, and symptoms of depression. If you find that your friend displays symptoms of depression, encourage him/her to seek help from your school teachers, or mental-health professionals. Meanwhile, keep the lines of communication open with him/her. Avoid using phrases like "Relax!", "Be Strong!", "Just don't think about it!", or "I'm no better than you!". Instead, reassure them by saying things like "Though I can't fully understand why you are so unhappy, I can see that you are passing through a rough patch. I'll be by your side!" But most importantly, let him/her understand the importance of seeking professional help.

If you suspect you have depression:

Talk to someone you can trust (your parents, your friends, your teacher), and seek professional help. You may not have the energy or motivation to engage in any activities, however, taking the first step to seek help may aid you to regain some sort of control in your difficulties. Also, actively trying to find out more information about depression, understanding the available treatment options, and knowing that it is a treatable condition will help you recover.

本港的學生轉介途徑

當懷疑有學生患上抑鬱症或者他對自己或朋輩構成風險時，教職員應該清楚危機管理程序，應將情況通知駐校教育心理學家和社工，諮詢他們的意見。

具體詳情，請參考教育局編製的“學校危機處理手冊”（2005 年 4 月）與“關於學生自殺的學校電子書：早期偵測、干預和善後”（2011 年 6 月）：

http://www.edb.gov.hk/filemanager/EN/content_2348/crisise.pdf

http://www.edb.gov.hk/filemanager/EN/content_8605/An%20eBook%20on%20Student%20Suicide%20for%20Schools%20EDIP.pdf

如屬較不嚴重或者輕微的情況，應通知社區支援專家（心理學家、精神科醫生、社工、輔導治療師等），並可交由基層醫療護理機構對有關人士作出治療。如屬較嚴重的個案（例如自殘或對朋輩造成傷害的個案），應給予有關人士加護住院治療。

此外，醫院管理局為 2010 至 2015 年草擬的精神健康服務計劃表明，有關難度在於涉及多個範疇的專業人員之間互相合作，以及由於香港的精神健康系統存在結構性問題，對醫護工作的連貫性造成限制。

Local referral paths of suspected students to professionals

Teachers and staff members should be familiar with the crisis management procedures in order to help students suspected of depression or who pose risk to self or peers. School education psychologists and social workers should be notified and consulted.

For specifics, please visit the Crisis Management Handbook (April 2005) and the eBook on Student Suicide for Schools: Early Detection, Intervention & Postvention (EDIP) (June 2011) developed by the Education Bureau

http://www.edb.gov.hk/filemanager/EN/content_2348/crisise.pdf

http://www.edb.gov.hk/filemanager/EN/content_8605/An%20eBook%20on%20Student%20Suicide%20for%20Schools%20EDIP.pdf

For less severe or mild cases, community support specialists (e.g. psychologists, psychiatrists, social workers and counsellors) should be notified and the individual can be treated in a primary care setting. For more severe cases (such as self-injurious or peer–harm cases) one should receive intensive inpatient care in a hospital.

Furthermore, the mental health service plan drafted by the Hospital Authority for 2010-2015 states that the challenges lie in the collaboration between multi-disciplinary professionals and the continuity of care limited by the structural issues in Hong Kong’s mental health system.

認知行為治療

歷史

認知行為治療由 Aaron Beck 在 1970 年代發展出來，顧名思義是結合了行為治療和認知治療 (Beck,1976)。在有認知行為治療之前，行為治療已經廣泛使用於治療神經紊亂（焦慮性障礙），但當單獨使用於治療抑鬱症患者時效果並不顯著。Beck 及其研究成員認為，負面思維和推理引致抑鬱症的持續。這些思維方式的運作源於相關的認知模式或信念。認知行為治療最初稱為理性情緒治療。它與心理分析模型的分別，在於認知行為治療的焦點放在目前而非放在過去。Beck 探索認知和情緒之間的關係，認知行為治療在 1970 年代後期確立為治療方法。認知模型提出，抑鬱症患者對自己、周圍環境和未來持有負面看法。基於這個模型，認知行為治療採取了教育性的治療方法。

Cognitive Behavioural Therapy (CBT)

History

CBT is literally a combination of behaviour therapy and cognitive therapy, developed by Aaron Beck during the 1970s (Beck, 1976). Prior to CBT, behavioural therapies were widely used for neurotic disorders (anxiety disorders), but when used alone had not been very successful in treating patients with depression. Beck and his colleagues believed that the maintenance of depression was sustained by negative thinking styles and reasoning. Such thinking styles were operated by underlying cognitive schemas or beliefs. It was first called rational emotive therapy, and it differentiated itself from the psychoanalytic model by focusing in the present rather than the past. Beck explored the relations between cognitions and emotions, and CBT was formalized into a treatment in the late 1970s. Based on the cognitive model, which suggested that depressed people hold negative views on themselves, the environment around them, and the future, the therapy took on an educative approach.

理論及治療模式

認知行為治療師與患者互相合作，以自我發現的方法引導患者，特別是要使患者意識到和辨別出自己的負面思維方式。治療師會給患者家課，讓患者練習辨別出自己的思維模式和行為表現。患者意識到自己的負面模式後，治療師便會引導患者作出行為改變和進行重組過程。簡單來說，認知行為治療是認知治療和行為治療的結合。與心理動力學療法不同，認知行為治療不鼓勵患者審視過往，而是一種強調目前、以問題為焦點的療法。

認知行為治療也隨著時間而演變和修改。近年，研究人員開始對認知行為治療作出重大變革，將其改變為“第三代認知行為治療”(Hayes, 2004)。與認知行為治療相比較，“第三代”認知行為治療較少集中於改正和控制被認定為“錯誤”的思維，而是轉為集中於思考過程。以實例性的說法來說，認知行為治療的目標是改變負面思維模式，而“第三代”認知行為治療的目標則是改變我們處理負面思維模式的方式。“第三代”認知行為治療的例子，包括靜觀認知療法 (MBCT) 和接受與實現療法 (ACT)。簡單的說，靜觀認知療法旨在提高患者對自己思想的意識，並選擇對思想作出回應的方法，而不是自動作出反應。接受與實現療法則混合靜觀方法，提高患者對自我的認識，接受和理解該等思想，並採取行動基於患者的價值系統達致一個目標。

Theory and therapeutic approach

The therapist collaborates with the patient and guides them through self-discovery. In particular, the patient is to be made aware of and identify their negative thinking style. The patient is given homework to practice identifying their thinking patterns as well as their behaviours. Once the patient has been made aware of his/her negative schema, the therapist guides them towards a behavioural change and restructuring process. In simplified terms, CBT is a combination of cognitive and behavioural therapy. Unlike psychodynamic therapy, CBT does not encourage patients to look into their past. It is a very present problem focused therapy.

CBT has evolved and has been modified over time as well. In recent years, researchers have started to revolutionalize CBT into a “third-wave CBT” (Hayes, 2004). Compared to the CBT, “third-wave” CBT focuses less on correcting and controlling the thoughts that are identified as “wrong” but moves on to focus on the process of thinking. To put it in illustrative terms, CBT aims to change negative thinking styles, while “third-wave” CBT aims to change how we process negative thinking styles. Some examples of “third-wave” CBT are mindfulness based cognitive therapy (MBCT), and acceptance and commitment therapy (ACT). In a nutshell, MBCT aims to heighten patients’ awareness of their thoughts, and how to respond to thoughts instead of automatically reacting upon them. ACT mixes in mindfulness approaches by raising patients’ self-awareness, acceptance and understanding of such thoughts, and encourages action to reach a goal based on the patient’s value system.

Beck的思想謬誤和日常例子

a. 一概而論

比方說，阿德沒能獲選為學校足球隊員，因此他相信自己不是好的運動員，不會獲選參加其他任何的運動。（事實上，他可能精於籃球球藝。）

b. 黑就黑，白就白

比方說，珊珊在她喜歡的物理科老師的課堂上回答問題。但是，她不是每次舉手時都被選中回答問題。她相信老師不很喜歡她。（事實上，老師很欣賞她的熱誠態度，但老師覺得應該給其他學生機會回答問題。）

c. 還需要證據嗎？

比方說，阿詩越來越多的朋友都開始約會了，但她自己還是形單隻影。她相信是因為自己不夠魅力的緣故而還沒有找到男朋友。（事實上，阿詩沒有擴大自己的社交圈子，而她的朋友都有參加聯校活動認識新朋友。）

d. 悲觀地扭曲世界

比方說，在這次測驗裏，杰仔最有信心的一科卻不及格。他覺得自己連最喜歡、最有信心的一科都無法掌握，於是對全部學科的信心都崩潰。（事實上，這只是一時失手。他原來最沒有信心的一科成績卻很好。）

Beck's cognitive errors and daily examples

a. Overgeneralisation

e.g. Peter did not get selected as a member of the school's soccer team, and believed that he will not be picked in any other sports team because he was not good at sports. (In fact, he may be good at basketball.)

b. All or Nothing Thinking/ Black and White Thinking

e.g. Susan liked to answer questions in her favourite teacher's physics class. However, she did not get picked every time she raised her hand. She believed her teacher dislikes her. (In fact, the teacher appreciates Susan's enthusiasm, yet she believes she should give other students a chance to answer questions.)

c. Jumping to Conclusion

e.g. More and more of Christy's friends began to date. However, Christy was still single. She believed she was unattractive and thus she did not have a boyfriend. (In fact, Christy has not expanded her social circle, whilst her friends have been socializing in joint-school activities.)

d. Magnification and Minimisation

e.g. Robert failed his test in his most confident subject. He felt his confidence in his whole academic portfolio was shattered, as he was not able to manage his most favourite and confident subject. (In fact, this was a one-time event. He had done well in another subject that he was least confident about.)

e. 想到最壞處

比方說，安仔收到他的成績單，他發現有其中一科考試不及格。他立即想到他的將來會生活困苦，難以生存。（事實上，安仔是將事情往壞處想，一科考試不及格可能把他的生命畫上句號。）

f. 是自己的問題

比方說，愛梅是籌款活動的主席。她今年籌得的款額不及去年，使她感覺自己領導不力。（事實上，是目前的經濟低迷環境降低人們捐款的意欲。）

e. Catastrophisation

e.g. Ken received his report card and found one of his subjects failed. He immediately leapt to think that he will be living poorly and will not survive in the world (In fact, one subject failure cannot awfully conclude his life.)

f. Self-blame/ Personalisation

e.g. Amy is the chairperson of a fund-raising event. She did not raise as much money as the year before, and she felt she was such a failure in leadership. (In fact, the current economic turmoil made people less willing to donate money.)

認知重塑的應用示範

想法（認知）	支持證據	反對證據	認知上出了什麼錯誤？	什麼是較現實的思考方式？（認知重塑）
中國人重男輕女，爸爸媽媽喜歡哥哥多於喜歡我。	爸爸媽媽總會讓哥哥在晚上與朋友外出，卻不准我在晚上外出。	爸爸媽媽說過他們也關心我。	一概而論	爸爸媽媽可能擔心女孩子在晚上的安全。
我所有朋友都買了*JC*頭飾帶。如果我不買，我會被排擠。	*JC*頭飾帶是潮流物，所有朋友都有一條。	即使我還沒有買那種頭飾帶，朋友們仍然如常與我交往。	黑就黑，白就白。	朋友們重視的是與我之間的友誼。他們不會因對我擁有什麼來對我作出判斷。
家裏無法給我買一個智能電話。他們不關心我。	朋友的爸爸媽媽都有給他們買智能電話。	家裏早已讓我上同樣昂貴的鋼琴課。	還需要證據嗎？	家人認為我仍是學生，不需要智能電話這種奢侈品。但是，他們會支持我學習鋼琴的熱情。

Applications on cognitive restructuring

Cognition (Belief)	Evidence to support	Evidence to reject	What went wrong with the cognition?	What is a more realistic way of thinking? (Cognitive Restructuring)
Chinese has feudal view of esteeming men above women. My parents favor my brother more than me.	My parents always allow my brother to hang out with his friends at night, whilst I have a curfew to meet.	My parents do say they care about me.	Overgeneralisation	My parents may be worried about their daughter's safety at night.
All my friends have bought *JC* headbands and if I don't I will be expelled from my group.	*JC* headband is the trendy item and all my friends have it.	My friends are still talking to me even when I have not (yet) purchased the headband.	All or Nothing thinking	My friends value me as a friend, and will not judge me by the possessions I have.
My family cannot afford buying me a smart phone. They do not care about me.	My friends' parents are buying them smart phones.	My family is still paying for my equally expensive piano lesson.	Jumping to Conclusion	My family thinks I do not need a smart phone as a student. It is a luxurious item. They will rather support my passion in piano.

想法（認知）	支持證據	反對證據	認知上出了什麼錯誤？	什麼是較現實的思考方式？（認知重塑）
我今年學年有一個遲到記錄，老師不會選擇我作為下一學年的學會領袖。	老師提過準時很重要。	老師讚賞過我的努力，說她信任我。	悲觀地扭曲世界	雖然我有遲到記錄，但是我積極守時，我這個學期的表現能說服老師。他仍可信任我。
我的球隊將永久解散。	優秀球員將於今年畢業。	其他球員，正為明年的比賽努力。	想到最壞處	我們可以趁今年的師兄還未畢業，加強訓練，為下年度的比賽作準備。
由於我的錯誤，我們的小組作業失敗了。	我在計算上出了錯誤。	小組成員們沒有責怪我。	是自己的問題	作業失敗，純粹是因為聚焦點出錯，而不是因為小小的計算錯誤。

Cognition (Belief)	Evidence to support	Evidence to reject	What went wrong with the cognition?	What is a more realistic way of thinking? (Cognitive Restructuring)
I was late once to school last year. The teacher will not pick me as the leader of the club for the next academic year.	The teacher did mention the importance of punctuality.	The teacher praised my effort and said she trusted me.	Magnification and Minimisation	Although I have a bad record for being late, I have not been late ever since and I am able to show my teacher I learn from my mistake and I am trustworthy.
My team will be dismissed permanently.	The good players will graduate this year.	The other players are catching up for next year's games.	Catastrophisation	We can start preparing for next year's game by providing more trainings for the younger players with the help of the seniors now.
We failed the group project due to the mistake I made.	I made a mistake in calculation.	My group mates did not blame me.	Self-blame	The project failed only because the focus was out of what had been required. It was not due to a small calculation error.

有用網站及社區資源
Additional Help Directories

機構	Organisation	電話 Tel	網站 Website
學生 Students			
突破輔導中心	Breakthrough Counselling Centre	2632 0000	http://www.breakthrough.org.hk/cc.xhtml
香港聖公會青年服務	Hong Kong Sheng Kung Hui Welfare Council Youth services	2521 3457	http://www.skhwc.org.hk/~orweb_prod/tc_chi/ser_network/ser_services/ser_services.php
香港撒瑪利亞會友伴同行大使計劃	Samaritans Hong Kong – The Young Samaritans Peer Support Program	2515 0423	http://www.samaritans.org.hk/index.php?page=309
啟勵扶青會	The Kely Support Group	2521 6890	http://www.kely.org
心 see 樂園 青少年精神健康資訊網站	心 see 樂園 Youth mental health information website	2332 4343	http://www.seeingheart180.com/
老師 Teachers			
香港心理衛生會教育中心	The Mental Health Association of Hong Kong – Mental Health First Aid course	2528 4656	http://www.mhfa.org.hk/
公眾 Public			
愛羣社會服務處	Baptist Oi Kwan Social Service	3413 1556	http://www.bokss.org.hk/bokss.org.hk/hk/default.htm
明愛向晴軒	Caritas Family Crisis Support Centre	2383 2122	http://fcsc.caritas.org.hk/
香港大學香港賽馬會防止自殺研究中心	HKJC Centre for Suicide Research and Prevention of The University of Hong Kong	2831 5232	http://www.hku.hk/csrp
基督教家庭服務中心	Christian Family Service Centre	2318 0028	http://www.cfsc.org.hk
香港中文大學心理學系臨床及健康心理學中心	Clinical and Health Psychology Centre, Department of Psychology, Chinese University of Hong Kong	2696 1073	http://www.psy.cuhk.edu.hk/chpc/
香港循道衛理輔導及就業綜合中心	Counseling and Integrated Employment Services, Methodist Church, Wan Chai	2527 2250	http://www.methodist-centre.com/cies/index.html
香港樹仁大學輔導暨研究中心	Counselling and Research Centre, Department of Counselling and Psychology, Hong Kong Shue Yan University	2570 7110	http://www.hksyu.edu/counpsy/crc/c.crc.htm
衞生署	Department of Health	2961 8989	http://www.info.gov.hk/dh/
扶康會	Fu Hong Society	2745 0424	http://www.fuhong.org
香港大學家庭研究院	HKU Family Institute	2859 5300	http://hkufi.hku.hk/services.html
香港家庭福利會心理健康服務	Hong Kong Family Welfare Society Mental Health Service	2832 9700 2720 5131	http://www.hkfws.org.hk
Mindmap - 心理健康資訊樞紐	Mindmap - The Mental Health Information Hub	2831 5232	http://www.mindmap.hk

機構	Organisation	電話 Tel	網站 Website
新生精神康復會	New Life Psychiatric Rehabilitation Association	2332 4343	http://www.nlpra.org.hk/services/overview.aspx
利民會	Richmond Fellowship of Hong Kong	2529 1323	http://www.richmond.org.hk
聖雅各福群會	St. James' Settlement, Family and counseling services; Youth services	2574 5201	http://www.sjs.org.hk/
聖約翰輔導服務	St.John's Counseling Services	2525 7207 2525 7208	http://www.sjcshk.com/
香港善導會	The Society of Rehabilitation and Crime Prevention, Hong Kong	2527 1322	http://www.sracp.org.hk
熱線服務 Hotline Services			
浸會愛群社會服務處青少年服務	Baptist Oi Kwan Social Service Youth Service	3413 1556	http://www.bokss.org.hk
明愛向晴軒熱線	Caritas Family Crisis Support Centre	18288	family.caritas.org.hk/ser/crisis.html
明愛男士成長中心熱線	Caritas Male Service Hotline	2640 1100	family.caritas.org.hk/ser/male.html
香港健康情緒中心熱線	Hong Kong Mood Disorders Centre Hotline	2833 0838	http://www.hmdc.med.cuhk.edu.hk
香港心理衞會 24 小時心理健康熱線	Mental Health Association of Hong Kong – Mental Health 24 -hour Hotline	2772 0047	http://www.mhahk.org.hk

機構	Organisation	電話 Tel	網站 Website
醫院管理局思覺失調熱線	Hospital Authority Easy Program Hotline	2928 3283	http://www.ha.org.hk/easy
醫院管理局 24 小時精神科熱線	Hospital Authority Mental Health 24-hour Hotline	2466 7350	http://www.ha.org.hk
群福婦女權益會「風雨同路」婦女熱線	Kwan Fook Wok Women Hotline	3145 0600	
社會福利署熱線	Social Welfare Department Hotline	2343 2255	http://www.info.gov.hk/swd/
香港神託會青年新領域熱線	Stewards Youth Outlook Hotline	2635 7709	http://www.stewards.org.hk
聖雅各福群會兒童及少年心理健康服務	St. James Settlement Children and Youth Mental Health Service	2835 4342	http://hs.sjs.org.hk
生命熱線	Suicide Prevention Service	2382 0000	http://www.sps.org.hk/
香港撒瑪利亞防止自殺會熱線	The Samaritan Befrienders Hong Kong Hotline	2389 2222	http://www.sbhk.org.hk
香港撒瑪利會熱線	The Samaritans Hong Kong	2896 0000	http://www.samaritans.org.hk

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http://www.depression.edu.hk
http://www.mindmap.hk

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