This issue on adolescent depression provides clinically useful information about how adolescents respond to treatment, the assessment and management of suicidal behavior, and treatment with psychotherapy.

Approximately 60% of adolescents will have a positive response to antidepressant treatment. In a review of three large controlled treatment trials, Emslie and colleagues (see page 300) have identified characteristics of adolescents who are likely to have a better initial treatment outcome, including younger age, less severe depression, no anxiety disorder or suicidal behavior, and less family conflict. These authors also provide recommendations about treatment that may lead to a better outcome, including selecting an SSRI other than paroxetine as initial treatment, and switching to another SSRI if there is minimal or no response after 4 to 6 weeks of treatment.

Cognitive behavioral therapy (CBT) has the most evidence as an effective therapy for depressed adolescents. Mahoney and colleagues (see page 307) describe the techniques of CBT, such as mood monitoring, examination of automatic thoughts, activity scheduling, and problem-solving. Sixteen sessions of CBT was identified as optimal treatment duration. On the basis of a review of treatment studies, they conclude that medication plus CBT is superior to either treatment alone for depressed adolescents.

Joiner’s theory proposes that youth will not die by suicide unless they have both the desire to die and the ability to act on it.

The family is an important component of treatment for adolescents with depression. Hughes and Asarnow (see page 314) discuss family intervention strategies that have been effective for treating depressed youth, such as family psychoeducation and attachment-based family therapy. Integrating family interventions within the primary care setting is recommended, either as direct treatment or by reducing behaviors associated with depression such as substance abuse.

Adolescents who are depressed are at risk for suicidal behavior. Using the interpersonal-psychological theory of suicidal behavior, Joiner and Ribeiro (see page 319) provide information about treatment and prevention of youth suicide. This theory proposes that youth will not die by suicide unless they have both the desire to die and the ability to act on it.

Social alienation, perceived burdensomeness, fearlessness about death, and physiological overarousal are other risk factors for suicide. The authors provide specific management and prevention strategies to address suicidal behavior in youth. Safety planning and a Hope Box are discussed to address suicidal ideation. Encouraging youth to become involved in community activities may reduce feelings of social isolation and burdensomeness. Adequate nighttime sleep may reduce physiological overarousal, and sleep hygiene techniques can improve an adolescent’s sleep pattern.

doi: 10.3928/00904481-20110512-02
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