This edition on adolescent depression addresses the clinically important topics of predictors of treatment response, management of suicidal behavior, cognitive behavior therapy, and family-focused interventions.

Response rates are approximately 60% in the acute treatment of adolescent depression. A clinically important question is which adolescent will respond to treatment. Emslie and colleagues (see page 213) describe patient characteristics related to treatment response, based on a review of three controlled studies of antidepressant and cognitive behavioral therapy (CBT) treatment for adolescents with major depression. Severity of depression, baseline suicidality, comorbid anxiety, high levels of hopelessness, family conflict, or high family stress were some of the predictors of treatment response.

Moreover, these authors stress that early response to treatment predicts a higher rate of remission and lower relapse rates. They recommend that more aggressive treatment, such as combination medication or combination medication and psychotherapy, be utilized for adolescents who do not demonstrate an initial response to monotherapy treatment.

Depressed adolescents are at significant risk for suicidal behavior. Joiner and Ribeiro (see page 220) address risk factors for suicidal behavior and provide clinical management strategies. These risk factors are based on the interpersonal-psychological theory of suicidal behavior, which proposes that suicidal ideation, perceived burdensomeness and social alienation, and overarousal are risk factors for suicidal behavior.

The authors provide vignettes and clinically useful strategies to address important risk factors of suicidal behavior. To manage suicidal ideation, the development of a safety plan is recommended. Strategies, such as getting adolescents involved in activities, may help to deal with the experience of social alienation. Overarousal with sleeplessness and nightmares may be addressed by behavioral techniques, such as stimulus control, sleep restriction, and sleep hygiene.

CBT has been the most studied psychotherapeutic treatment for youth with major depression. Kennard and colleagues (see page 226) provide an overview of CBT for adolescent depression. Based upon controlled trials, combination of medication and CBT have been shown to be superior to either treatment alone for the treatment of adolescents with depression. Some predictors of response to CBT in youth include less severe depression, low levels of cognitive distortion, and no abuse history.

These authors note that a greater number of treatment sessions for CBT may be necessary so that an adolescent can acquire skills in cognitive restructuring, behavioral activation, and problem solving. They recommend CBT treatment be continued beyond the acute episode of depression to increase the likelihood of sustained remission.

Hughes and Asarnow (see page 235) present a compelling rationale for the inclusion of the family in the treatment of depressed adolescents,
especially for adolescents who have attempted suicide. A review of family-focused treatments demonstrates the benefit of this treatment for depressed adolescents. These authors recommend that further research is needed to clarify the interface between individual therapy and family involvement in the treatment of adolescent depression. It is the hope of both the authors and myself that we have provided a well-rounded review that will help us to yield a higher rate of remission and lower relapse rates for these young patients.

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