

**CHILD and ADOLESCENT DEPRESSION and SUICIDE: PROMISING
HOPE and FACILITATING CHANGE**

**Donald Meichenbaum, Ph.D.
Distinguished Professor Emeritus,
University of Waterloo, Ontario, Canada**

**Distinguished Visiting Professor
School of Education
University of Miami**

**Research Director of The
Melissa Institute for Violence Prevention and Treatment
Miami, Florida**

*www.melissainstitute.org
www.teachsafeschools.org*

**Presented at the 14th Annual Conference
of The Melissa Institute for Violence Prevention and Treatment
May 7, 2010**

Contact Information

E-mail: dhmeich@aol.com

**Mailing Address Donald Meichenbaum
215 Sand Key Estates Drive
Clearwater, FL 33767**

For an Additional Handout see Meichenbaum, D. “35 Years of Working with Suicidal Patients: Lessons Learned” (go to www.melissainstitute.org, scroll down Author Index to Meichenbaum and call up the presentation)

TABLE OF CONTENTS

The Nature of the Challenge: Mental Disorders in Children and Youth

Epidemiological Studies of Adolescent Depression

Some Facts About Adolescent Suicide

Some Facts About Adult Suicide

Assessment and Treatment: A Checklist of Clinical Activities for Working With Depressed and Suicidal Youth

Assessment of Suicidal Potential

Suicide Assessment Strategies: Useful Mnemonics

Youth Suicide Risk Factors, Warning Signs and Predictors

Document the Record

Treatment Research Findings

Questions that are Designed to Nurture a Collaborative Therapeutic Relationship with Adolescents

Changes in Brain Function During Adolescence: Implications for Treatment

Continuum of Care for Treatment of Depression in Children and Adolescents

Examples of Cognitive-Behavior Intervention (CBT) Programs:

School-based Course on Depression

The ACTION Treatment Program for Girls

Primary and Secondary Control Enhancement Training, PASCET

Treatment of Adolescent Depression: TADS & TORDIA Studies

Dialectical Behavior Therapy

Emergency Room Initiative: SAFETY Program and Youth Partners in Care, YPIC

Other Treatment Approaches

Interpersonal Psychotherapy for Adolescents (IPT-A)

Family-based Interventions

Pharmacological Treatment

Preventing Depression Among Adolescents

Working Together To Reduce Adolescent Suicide: A “TO DO” List

Test Your Knowledge About Adolescence

References

Websites

THE NATURE OF THE CHALLENGE MENTAL DISORDERS IN CHILDREN AND YOUTH

**(Research findings gleaned from Berman et al., 2005; Bongar and Stolberg, 2009;
Kazak et al., 2010; Kelley, et al., 2010)**

It is estimated that 10% to 20% of youth (approximately 15 million children in the U.S.) meet diagnostic criteria for a mental health disorder, and many more are at risk for escalating long-term behavioral and emotional problems.

Among those with a recognized need, only 20% to 30% received specialized mental health care.

Up to 50% of youth in the child Welfare system have mental health problems.

70% of youth in the Juvenile Justice system have mental health problems.

Latino children are most likely to go without needed mental health care.

Although children comprise 25% of the U.S. population, only one-ninth of health care funding is directed at them.

Now let's consider some epidemiological data relevant to child and adolescent depression and suicide. As McLeod et al. (2007, p. 987) observed:

“Depression in childhood and adolescence is a significant, persistent and debilitating problem, undermining social and school functioning, and prompting substantial mental health service use. By age 18, nearly a fourth of all children will have experienced clinically significant depressive symptoms, making such symptoms among the most prevalent psychiatric problems of young people. Once they appear, depressive symptoms remain present and problematic for many youngsters throughout childhood, adolescence and beyond.”

EPIDEMIOLOGICAL STUDIES of ADOLESCENT DEPRESSION

- 12 month prevalence rate exceeds 6% for major depressive disorder (MDD) and 10% for dysthymic disorder in youth.
- The point prevalence for MDD alone has been estimated at 3-8%.
- By age 18, nearly 25% of all youth in the U.S. will have experienced depressive disorder. (Zalsman et al. 2006)
- Dysphoric Disorder (DD) begins earlier and lasts longer than Major Depressive Disorder (MDD). .6%-1.7% school children, 1.6%-8% adolescents. DD increases the risk of developing MDD.
- The average age of onset of MDD is around 13 years. One third of those youth with MDD which occur around age 16 have had previous episodes of depression.
- MDD in childhood tends to have an acute onset that lasts an average of 7 to 11 months. 80%-90% of youth will recover from this index episode. Recovery usually takes 11 months. The remaining 10%-20% will have persistent depression that can last longer than 18 months.
- 40% of youth with MDD will have a remission within 2 years; 70% within 5 years. Each recurrence increases the likelihood of future depressive episodes.
- Some 6% to 10% will have protracted depression that will persist into adulthood. The earlier the onset of depression, the more likely it is to persist into adulthood and more likely to recur and be associated with social handicaps.
- MDD increases the risk of developing bipolar depressive disorder (BPD). 20% - 40% of MDD adolescents develop BPD within 5 years.
- MDD precedes the onset of Substance Abuse Disorders (SUDs) by 4 to 5 years. 15% of those with MDD will go on to develop SUDs, while 20% with MDD will go on to develop a secondary anxiety disorder.
- Youth with DD & MDD are most at risk of having longer and more severe depressive episodes, with a higher incidence of suicidality and poor responsiveness to treatment.
- Half of children with MDD meet criteria for at least one other psychiatric diagnoses. For example, the overall rate of comorbidity for anxiety and depressive disorders is 30% - 40%. Anxiety disorders tend to precede the onset of depressive disorders. For example, social phobia and being shy is often a forerunner of MDD, with an onset of 11.3 years. They are also at higher risk for suicidal ideation and behaviors. Dystrophic Behavior Disorders are also often comorbid with adolescent MDD. Other comorbid disorders with adolescent MDD include PTSD, Eating Disorders, Substance Abuse Disorders, Learning Disabilities and

chronic physical illnesses like irritable bowel syndrome. (Szigethy et al. 2007). **There are multiple pathways to depressive disorders.**

- An example of the comorbidity of substance abuse, depression and suicidal behavior was examined by Bagge and Sher, (2008). They noted that alcohol use can increase psychological distress, depressed mood due to neuropharmacological changes, alcoholic “myopia” which narrows alternative thinking and constricts cognitions, and results in interpersonal academic and legal problems which are reasons adolescents attempt suicide. It has been estimated that 25% of youth who attempt suicide use alcohol or drugs at the time of the attempt. Subsequent substance abuse predicts reattempts.
- Epidemiological studies (Brown et al. 2007) have documented higher rates of internalizing disorders among Native Americans, Latino Americans, Asian Americans and African American adolescents compared to European American adolescents. Latino Americans reported the highest level of depressive symptoms of all ethnic groups. Symptom expression varies across ethnoracial groups. For example, the highest rate of somatic symptoms was reported by Latino and Asian American youth. (Anderson & Mayers, 201).
- The role of biological factors (5-HTT transporter gene) that has been linked to mood disorders, family processes, environmental/social risk factors and differential protective factors such as social support vary across diverse adolescent groups. See work by Caspi et al. (2003), Kaufman et al. (2004) and Kendler et al. (2005) for examples of the ways stressful life events and social supports impact on serotonin transporter system in predicting episodes of major depression.
- The role of acculturation, cultural identity as risk or protective factors varies across ethnic, gender and SES. There is a need to adjust therapeutic interventions with depressed youth based in ethnic/cultural needs. (Cardemil et al., 2010) (*Also see www.melissainstitute.org 13th annual conference on culturally sensitive interventions*).
- The gender ratio of diagnosable depression is roughly equal before puberty, but by early adolescence girls are two to three times more likely to be depressed than boys.
- One of the potential causal factors for this gender difference may be increased cognitive vulnerability among females (namely, the tendency to ruminate (brood about problems) and a negative inferential style (tend to choose more passive and less effective strategies for solving problems). Girls also possess a more negative orientation to problems relative to boys and a more negative view of self. They tend to focus on the fact that one is depressed, one’s symptoms of depression, and the causes, meaning and consequences of one’s depressive symptoms. Stark et al. (2010) have developed a treatment for depressed girls.
- There are developmental changes in the expression of depression. Prepubertal children evidence more somatic complaints and psychomotor agitation, as well as comorbid separation anxiety and phobias. Adolescents evidence more anhedonia, hopelessness, helplessness and hypersomnia.

- 30% of depressed adolescents will experience a relapse. Long-term follow up indicates that 50% of youth will have another depressive episode.
- Youth depression predicts low academic achievement and school failure, substance abuse and dependence, and later in life, unemployment and early parenthood. It is associated with psychiatric comorbidity and increased risk of attempted and completed suicide (Fergusson & Woodward, 2002).

SOME FACTS ABOUT ADOLESCENT SUICIDE

(Research findings gleaned from Berman et al., 2005; King, 1997; McIntosh, 2000; NIMH, 2008 and Nock et al. 2008)

- Adolescent suicide is a major health problem and accounts for at least 100,000 deaths in young people worldwide, according to the World Health Organization.
- Suicide is the third leading cause of death among 10 to 19 year olds in the U.S..
- Among young adults (15-24), there is one suicide for every 100 to 200 attempts. Nearly 20% of adolescents in middle school and high school report having seriously considered attempting suicide during the past year.
- The Youth Risk Behavior Surveillance Survey (YRBS) found that nearly 15% of adolescents had made a specific plan to attempt suicide. 700,000 received medical attention for their attempts.
- Boys who identify as being gay or bisexual are up to 7X more likely to attempt suicide than other boys in their high school.
- 10 % of adolescents, who attempt suicide, reattempt within 3 months, up to 20% reattempt within 1 year, and 20% to 50% reattempt within 2 to 3 years. Prior suicide attempts is one of the most important predictors of completed suicide, with a 30-fold increase risk for boys and a 3-fold increase for girls. With each repeated attempt, the risk of lethality increases as attempters use more severe methods.
- The presence of a co-morbid psychiatric disorder significantly increases the risk of suicide attempts, particularly conduct disorders and substance abuse. 90% of adolescents and 60% of preadolescents who complete suicide had a mental disorder.
- The rate of suicide among adolescents has quadrupled since the 1950's.
- In the U.S., youth suicide is alarmingly high. White youth have higher rates than African American youth, with Asian Pacific Islanders having the lowest rate. Hispanics have a relatively low suicide completion rate, but they are significantly more likely than either white or African

American adolescents to report suicidal ideation. Suicide rates among Native American groups vary, but some groups have been found to be as high as 13 times the rate for all races.

- Surveys of youth in grades 9-12 indicate that:
 - a. 15% of students reported seriously considering suicide.
 - b. 11% reported creating a suicide plan.
 - c. 7% reported trying to take their own life in the past 12 months.
- In a typical high school class of 30 students, one student will seriously consider suicide, 2 or 3 (one boy and 2 girls) will attempt suicide, and one student will make an attempt sufficiently harmful to require medical attention.
- One half of those who are clinically depressed do not receive any treatment.
- Only 1 in 3 youth who attempt suicide receive help following the attempt. 45% of adolescents who attempt suicide do NOT attend one psychotherapy session after an emergency visit for their suicide attempt.
- Each suicide intimately affects at least 8 people.
- Recent years have witnessed major advances in the treatment of depressed and suicidal youth, including the use of Social Internet Media. (*See list of Websites below*). However, it is critical to note that the Internet can also lead at-risk youth to material that increases their risk such as information regarding methods of suicide which can lead to increased lethality of attempts.

SOME FACTS ABOUT ADULT SUICIDE

As you consider the following statistics on adult suicide and comorbid psychiatric disorders, it is important to remember that most forms of adult depression begin during childhood and adolescence.

The suicide risk in adults with a history of adolescent Major Depressive Disorder is 5X higher than adults with late onset depression.

Suicide is a significant cause of death in the general population with approximately one million deaths by suicide each year world-wide.

In the U.S., the suicide rate is approximately 11 deaths by suicide for every 100,000 people.

15% of the U.S. population seriously considers suicide at some point in the course of their life, but only 1.4% of the population dies by suicide.

The suicide attempt to completion ratio is estimated to be 25 to 1, further indicating that a substantial number of people try to die by suicide, but only a few do. Many of whom do so only after multiple previous attempts.

Each year, approximately 33,000 individuals die by suicide in the U.S. (NIMH, 2009).

A quarter million suicide attempts in the U.S. are estimated to occur each year.

15% of those who attempt suicide will eventually take their lives. One third of those who complete suicide have had nonfatal attempts in their past.

Suicide death rate is approximately 10.9 per 100,000 people and this rate has remained unchanged for the past decades.

As many as half of individuals who die by suicide are in active treatment at the time of their death.

90% of them are suffering from a mental disorder at the time of their death.

The average re-attempt rates during treatment is as high as 47%.

Up to two thirds of those who die by suicide have had contact with a health-care professional in the month before their death.

A variety of psychiatric diagnoses increase the risk of patient suicide. These include generalized anxiety disorder, obsessive compulsive disorder, and substance abuse disorder.

Mood disorders account for 50% of all completed suicides.

Mental disorders are a risk factor for suicide. For example, patients with bipolar disorder, 25% to 50% will make a suicide attempt during the course of their illness, with 10% to 20% dying. For those suffering from schizophrenia, between 20% and 40% will make a suicide attempt and 5% will die. For major depression, 2% receiving outpatient treatment will die by suicide and 9% of depressed patients receiving inpatient treatment will die by suicide.

80% of all suicides are committed by males. Females attempt suicide more often than males, yet men are three times more likely to die from their attempt.

As compared to single attempters, multiple-suicide attempters evidence more significant suicidal thinking, depression, helplessness, higher rates of alcohol and substance abuse, poorest histories of interpersonal coping, greater perceived stress and the lowest reports of available and accessible social support. They also have more comorbid Axis I and Axis II disorders. They are also at greater risk for reattempts or death by suicide.

ASSESSMENT AND TREATMENT: A CHECKLIST OF CLINICAL ACTIVITIES

1. Take a complete patient history. Use a Case Conceptualization Model that assesses for both proximal and distal risk and protective factors, potential barriers and strengths. For example, **Distal Risk Factors** that include prior suicidal behaviors; history of mental disorders such as depression, anxiety and personality disorders, disturbed family context and parental loss before age 12; sexual orientation. **Proximal Risk Factors** that include stressful life events, sexual and physical abuse; academic difficulties; functional impairment due to physical illness and injury; suicide in social milieu; and a cultural belief that suicide is “noble” and accessible means of suicide.

Proximal risk factors in combination with one or more distal risk factors heightens suicide risk.

2. This combination of proximal and distal risk factors was highlighted in Joiner’s (2005, 2010) Interpersonal-Psychological Theory of Suicide. He highlighted the role of
 - a) thwarted belongingness-unmet need to belong that involves a lack of frequent, positive social interactions and feelings of not being cared about by others;
 - b) perceived burdensomeness - - belief that one is a burden and liability to others
 - c) acquired capability to enact lethal self-injury and withstand the fear of death. This acquired capacity is developed over time through repeated exposure to painful and provocative events (habituation to fear and pain in self-injury).

The clinician should assess for each of these psychological areas.

Thwarted belongingness: “***Do you feel connected to other people?”***
 “***Do you have someone you can call when you are feeling badly?”***”

The clinician should consider the client’s social support network, interpersonal losses and the level of social involvement, lack of family cohesion.

Perceived Burdensomeness “***Sometimes people think that the people in my life would be better off if I was gone. Have you been thinking like that?”***”

The clinician should assess for feelings of “expendability”; significant others would be better off without them.

Assess Acquired Capability ***Consider history of self-injuries and high-risk behaviors and Resolve Plans and Preparations.***

A history of nonsuicidal self-injury (NSSI) is a risk factor for suicidal behavior. Such NSSI may be intended to relieve tension, produce a feeling of aliveness, alter

consciousness, gain attention, or reflect a “cry for help.” Messer and Fremouw (2008) have discussed various explanatory models of NSSI in adolescents. They highlight that up to 28% of individuals who self-mutilate have had suicidal ideation at some point. There is a need to determine if the self-mutilation was deliberate, repetitive, was normative for peer group, provided a sense of relief from the sense of tension, anxiety and anger that existed prior to the act and whether the adolescent had intent to die from self-injury. The rate of NSSI varies across adolescent populations (15% in community population to 60% in institutional and residential youth). They are often categorized as “lonely,” “sad” and “alone” and have a history of sexual abuse with difficulties in regulating and coping with negative emotions. The significance of NSSI as a risk marker for suicidal behavior is underscored by the following findings. The risk of suicide increases 50-100 times within the first 12 months after an episode of self-injury compared to the general population. Approximately one-half of persons who die by suicide have a history of self-injury and this proportion increases to two-thirds in younger age groups (Appleby et al. 1999; Cooper et al. 2005).

In summary, Joiner’s interpersonal psychological theory of suicidal behavior states that the desire for suicide arises when an individual feels that he or she is a burden on other people and simultaneously feels disconnected from others. In addition, an individual with a desire to commit suicide will not make a serious attempt or die by suicide unless he or she has acquired the capability for lethal injury.

3. Directly assess for suicidality (suicidal thoughts, intentions, plans, accessibility and potential lethality). As Berman (2010) observes:

“Suicidal patients quite often conceal their thoughts and/or simply deny having suicide ideation, particularly when they are intent on dying by suicide and wish not to be stopped. Verbalized suicidal ideation, while a cardinal indicator of heightened risk for potential, overt suicidal behavior is neither a necessary, nor a sufficient condition for the assessment of risk for that behavior. A formulation of a patient’s risk instead rests on an assessment of a number of acute risk factors reflecting a patient’s intense suffering (despair, anguish). (See mnemonic below IS PATH WARM?).”

4. Assess for the presence of both depression and comorbid disorders using a life-span perspective. Depression is a risk factor in approximately 60% of those who die by suicide or who make a non-fatal attempt. But 40% have no evidence of depression. Only about 1% of Americans who have clinical depression will die by suicide within the next year. (Berman, 2010). Since only 10%-40% of those adolescents who attempt suicide have made a previous attempt, it is necessary to assess for other risk factors such as other mental disorders. See Miller et al. (2007) for a discussion of possible assessment instruments.
5. Obtain releases to connect with past therapists and secure the patient’s medical and mental health records.

6. Formulate a diagnosis using DSM.
7. Document, document, document... **“Thinking out loud for the record” (See Below).**
8. Obtain Informed Consent **(See Rudd et al. 2009).**
9. Use supervisors, colleagues to discuss patient’s suicidal risk and therapeutic steps taken. Document these contacts.
10. Build in a safety plan. A caveat has been offered by Berman (2010) who observed:

“There is no evidence that No Suicide Contracts are effective in preventing suicide. Safety planning is considered a best practice, but it’s empirical effectiveness has not been tested.”

The primary focus of a Safety Plan should be on reducing acute risk factors and then treat the underlying vulnerability that predisposes the patient to be suicidal. The Safety Plan Model reduces the patient’s capability and desire to act by removing access to means, counteracts substance abuse, helps calm anxiety and aggression, engages significant others, improves sleep and helps stabilize the environment.

11. Assess for the family dynamics and involve them if indicated.
12. Provide hope by assessing for strengths and signs of resilience (**“In spite of” behaviors**) and engage clients in collaborative goal-setting. For a discussion of how goals and accompanying beliefs lead people in and out of depression, see Rothbaum et al. (2009). They highlight how the cognitive vulnerability of adopting the goal of avoiding proof of worthlessness combined with self-handicapping behaviors (effort withdrawal and rumination) predispose individuals to bouts of depression. They view rumination as an “excuse generating machine” that contributes to self-blame and self-denigration in the desire to avoid feelings of worthlessness (Nolen-Hoeksema et al., 2008). Treatment should help depressed individuals shift from such performance-focused goals and face-saving self-handicapping behaviors to learning-focused goals which are designed to improve and grow, cultivate existing abilities, develop new skills and strategies and master new tasks. The presence of social supports, the engagement and enjoyment of prosocial activities, religiosity, plans for the future, a history of coping skills, generally suggests lowered suicidal risk (Ramey et al. 2010). However, as Berman (2010) observes, “The presence of acute risk factors will trump the presence of protective factors every time.”
13. Continually assess for ongoing risk for suicide and the possible need for increased supervision (e.g., psychiatric hospitalization). The days and weeks immediately subsequent to psychiatric hospitalization are a period of significant risk for suicide. Given this increased risk, Berman (2010) recommends that the first outpatient appointment following discharge occur within 48 hours of discharge; or less, if at all possible.

14. ***“Throughout the therapy process continually communicate that you care and convey your commitment to doing whatever needs to be done to keep the patient alive- that every effort will be made to help the patient to decrease his/her pain, hopelessness and lethality” (Bongar and Stolberg, 2009, p. 16).***

ASSESSMENT OF SUICIDAL POTENTIAL
(See Meichenbaum, 2009 on www.melissainstitute.org)

An evaluation should assess the patient’s

- a) suicidal ideation
- b) suicidal intent
- c) presence of an identified suicidal plan
- d) availability of means of self-harm (weapon, pills, peer encouragement of suicidal behavior such as Internet guidance)

Suicidal ideation refers to how much the individual is thinking about suicide as an option for psychological distress. This may be a concrete plan or expressed as a form of longing or fantasy. The clinician may ask:

“Have you been thinking about killing yourself in any way?”

“Have you tried to kill yourself or done anything that could have killed you?”

Shneidman (1996, p. 137) suggests the following questions to help the suicidal patient get out of a constricted mental state:

“Where do you hurt?”

“What is going on?”

“What is it that you feel you have to solve or get out of?”

“Do you have any formal plans to do anything harmful to yourself, and what might those plans be?”

“What would it take to keep you alive?”

“Have you ever before been in a situation in any way similar to this and what did you do and how was it resolved?”

“Such questions can help suicidal persons generate alternatives to suicide, first by rethinking (and restating) the problem, and then looking at possible other courses of action. New conceptualizations may not totally solve the problem the way it was formulated, but they can offer a solution the person can live with. And that is the primary goal of working with a suicidal person.” (Shneidman, 1996, p. 137)

The greater the magnitude and persistence of suicidal thoughts, the higher the risk level for eventual suicide. But the clinician should keep in mind that transient thoughts about the meaning of life and suicide is normative for adolescents, with some 63% of high school students reporting

some degree of suicidal ideation at some point. For instance the data from the Youth Risk Behavior Survey of some 15,000 high school youth indicated that 17% reported seriously considering suicide. Such suicidal ideation becomes clinically significant when it is more than transient and when it becomes a major preoccupation and it is tied to accompanying behavioral actions or when it is tied to reattempts (Berman et al., 2006).

Suicidal intent refers to the patient's commitment to die. Does the patient have a suicidal plan? The more detailed and specific the plan, the greater the risk of patient suicide. It is important to determine the potential lethality, accessibility of the method, and any actions taken by the patient to prepare for the event.

Youth Suicidal Risk Factors

- Previous Attempts
- Depression and/or Substance Abuse
- Family history of mental disorders, Substance Abuse
- Stressful situation or loss
- Exposure to repetitive and excessive bullying that may be tied to sexual orientation, sexual identity and social rejection. Victim of cyber-bullying. The recent cases of youthful suicides attest to this risk factor (Cases of Phoebe Prince- - 14 years of age; Jaheen Herrera and Carl Joseph Walker-Hoover, both 11 years of age who committed suicide).
- Exposure to other teens who have died by suicide
- LGBT orientation
- History of physical and/or sexual abuse
- Poor communication with parents
- Incarceration
- Lack of access or unwillingness to seek treatment

Youth Suicide Warning Signs

- Depressed mood
- Substance abuse
- Frequent running away or incarcerations
- Family loss or instability, significant problems with parents
- Expressions of suicidal thoughts, or talk of death/afterlife
- Withdrawal from friends and family
- Difficulties in dealing with sexual orientation
- Anhedonia
- Unplanned pregnancy
- Impulsive, aggressive behavior, frequent expressions of rage
- Rumination- focus on the fact that one is depressed or one's symptoms of depression, and or the causes meanings and consequences of depressive symptoms. Repeated self-focused negative thinking (brooding).
- Sudden changes in behavior, friends or personality
- Changes in physical habits or appearance

- Non-suicidal self-injurious behavior (NSIB). Youth who cut themselves regularly have a significant risk of suicide.

Strongest Predictors

- Previous suicide attempt
- Current talk of suicide/making a plan
- Strong wish to die/preoccupied with death (i.e. thoughts, music, reading)
- Depression (hopelessness, withdrawn)
- Substance use
- Recent attempt by friend or family member
- Suicidal plans/methods/access
- Making final arrangements

SUICIDE ASSESSMENT STRATEGIES: USEFUL MNEMONICS (*See Berman, 2010; Somers-Flanagan & Somers-Flanagan, 1995*)

IS PATH WARM?

- **I** Ideation- threatened, communicated or otherwise hinted at such as by looking for ways to kill oneself
- **S** Substance Use - excessive or increased use of alcohol or drugs
- **P** Purposelessness - feelings of lacking in purpose, value or increased seeing no reason for living
- **A** Anxiety – increased anxiety, agitation or insomnia
- **T** Trapped – feeling like there is no alternative, no way out, other than suicide to escape intolerable feelings; need to terminate oneself to end feelings of shame or guilt
- **H** Hopelessness – feelings and/or thinking that nothing can or will ever change for the better
- **W** Withdrawal – increased isolation from family, friends, work or usual activities
- **A** Anger – feelings of rage, wish to seek revenge against alleged evil others, uncontrolled anger
- **R** Recklessness – acting with disregard for consequences, engaging in risky activities seemingly without thinking
- **M** Mood Changes – experiencing dramatic mood changes, cycling

ASSESSING THE PLAN: SLAP

- **S** Specificity: suicide plan details
- **L** Lethality: how quickly could plan lead to death
- **A** Availability: how quickly could patient implement the plan

- Proximity: how close are helping resources

MAP I3

- **M** – Motivation
- **A** – Access to Lethal Means
- **P** – Plan
- **I #1**- Intent
- **I #2** – Identifiable Victim (self or other, in case of homicidal threat)
- **I #3** – Inability to identify factors which might prevent them from following through

Assessment: SAD PERSONS

- Sex
- Age
- Depression
- Previous attempt
- Ethanol/substance abuse
- Rational thinking
- Social supports lacking
- Organized plan
- No spouse/unavailability of parent
- Sickness

Assessment: SAD PERSONS

- 3-4 = close follow up
- 5-6 = strong consideration of hospitalization
- 7-10 = hospitalization

D-HIPIS

1. DEPRESSION:
 - a. *How have you been feeling lately?*
2. HISTORY:
 - a. *Have things ever gotten so bad that you thought about killing yourself?*
(If no, document this, if yes follow below)
 - b. *Have you ever attempted suicide?*
3. IDEATION:
 - a. *Are you worried about killing yourself now?*
4. PLAN:
 - a. *Do you have a plan to harm yourself? When, where, how would they carry out their plan?*
 - b. *If they have a plan, do they have access to the firearms to carry it out?*

Are the means lethal?

5. INTENT:
 - a. *How likely do you think it is that you will follow through on your plan? (Rate on scale from) 0 (no intent) to 10 (total intent)*
6. SELF-CONTROL:
 - a. *If you felt like harming yourself, what would you do to make sure you are safe? They should agree to contacting someone (parent or guardian or trusted adult) before acting.*

Note: Thoughts of death or wanting to “go to sleep” should be pursued, but are not specifically suicidal.

There is a need to ensure that the assessment approach is developmentally sensitive given the child’s changing concept of death. The following set of sample questions offered by Jacobsen et al (1994) provides examples.

SAMPLE QUESTIONS FOR INTERVIEWING CHILDREN ABOUT SUICIDE IDEATION AND BEHAVIOR

(Source: Jacobsen et al., 1994. Interviewing prepubertal children about suicidal ideation and behavior. Journal of American Academy of Child and Adolescent Psychiatry, 33 (4), 439-451.)

Ascertaining the Presence of Previous or Current Suicidal Ideation of Behavior

1. Did you ever feel so upset that you wished you were not alive or wanted to die?
2. Did you ever do something that you know was so dangerous that you could get hurt or killed?
3. Did you ever hurt yourself or try to hurt yourself?
4. Did you ever try to kill yourself?
5. Have you ever tried to make yourself dead?

Assessment of Suicidal Intent

1. Did you tell anyone that you wanted to die or were thinking about killing yourself?
2. Did you do anything to get ready to kill yourself?
3. Was anyone near you or with you when you tried to kill yourself?
4. Did you think that what you did would kill you?
5. After you tried to kill yourself did you still want to die or did you want to live?

Interviewing Children Whose Grasp of the Concepts of Time, Causality, and Death May Not Be Mature

1. Do you think about killing yourself more than once or twice a day?
2. Have you tried to kill yourself since last summer/since school began?
3. What did you think would happen when you tried to...jump out the window?
4. What would happen if you died? What would that be like?

Assessing The Potential Impact of the child's Current Emotional State Upon Recall of Suicidal Ideation or Behavior

1. How do you remember feeling when you were thinking about or trying to kill yourself?
2. How is the way you felt then different from how you feel now?

USE THE ART OF QUESTIONING

(See Shea, 1998, 2004)

The clinician should ask questions that pull for specific facts, sequential behavioral details and that elicit the patient's train of thoughts and perceived thwarted needs. Assess for the presence of perceived burdensomeness, perceived absence of social supports (feeling of social marginalization) and prior high-risk self-injurious behaviors. (Joiner, 2008). Ask the patient, and where indicated, significant others to recreate the step-by-step suicide attempt. For example, the clinician should be able to assess the detailed nature of the suicidal attempt. The clinician should also include questions that assess for the presence of protective factors or "buffers" to suicide.

What method of suicide was contemplated and what was implemented?

How close did the patient come to completing suicide: For example:

How many pills did you take?

Did you put the razor blade to your wrist?

Tell me what happened next?

How serious were the actions taken?

How serious were the patient's intentions?

Did the patient tell anyone of the attempt?

Did the patient tell anyone beforehand?

Did the patient make the attempt in an isolated area or in a place where he or she was likely to be found?

Did the patient engage in preparatory steps (e.g., write a suicide note, say goodbye to significant others, give away prized possessions, take other steps?)

Was the patient's attempt well planned or an impulsive one?

How long did the patient think about this suicidal plan?

What other ways has the patient thought of killing oneself?

Did alcohol or drugs play a role in the attempt?

Were interpersonal factors a major role in the attempt?

Did a specific stressor or set of stressors prompt (trigger) the suicide attempt?

At the time of the attempt, how hopeless did the patient feel?

Why did the attempt fail? How was the patient found, and how did the patient finally get help?

How does the patient feel about the fact that the attempt was not completed?

*What are some of your thoughts and feelings about the fact you are still alive?
Are you sorry your suicide attempt failed?
Can anyone be of help?*

The clinician should assess for previous suicidal attempts.

*What is the most serious past suicide attempt?
Does the patient view the current stressors and options in the same light as during the past attempts?
Are the current triggers and this patient's current emotional state similar to when the most serious attempts have been made?
How many previous suicide attempts has the patient engaged in? Has the patient exhausted all hope?*

Assess for Current Safety Plan

The clinician can ask:

*What would you do later tonight or tomorrow if you begin to have suicidal thoughts again?
Right now, are you having any thoughts about wanting to kill yourself?
Do you still have the gun (pills) in the house?
Have you ever gotten the gun out with the intention of killing yourself?
In the past, what stopped you from pulling the trigger?*

Assess for Protective Factors or "Buffers" to Suicide

The clinician can select from the following questions.

*Help me understand the reasons for hurting yourself or killing yourself?
What problem(s) are you trying to solve?
What would you tell a close friend who was in the same circumstances (situation)?
How else could you reasonably view your situation?
What steps can you take to begin to change your life, rather than kill yourself?
How might you make your life better in the future?
How can you reinvest in life?
What do you like best about yourself?
What happened recently that made you feel good?
What do you like better, your eyes or your hair?
The one thing that would help me no longer be suicidal would be ____ ?
Is suicide the best way for you to cope or change the situation?
Who are 3 people you will call if you are feeling like hurting yourself? (Get specific names and contact numbers). Which one would you be most comfortable in calling?
Promise me, that if you feel suicidal you will call ____ (not just leave a message) about*

how you are feeling before you try to hurt or kill yourself?

DOCUMENT THE RECORD

“If it was not recorded and documented, it is assumed it did not occur. Rather, think out loud for the record.”

Bongar and Stolberg (2009) propose that good record keeping is paramount and should include the following:

1. A systematic and thorough assessment of suicidal risk (present and past), and how this was determined by the therapist (Enumerate any measures that were used, the interview questions that were covered and the answers given).
2. Indicate the information that alerted the clinician to the suicidal risk.
3. List the risk and protective factors and actions taken (e.g., Include a copy of the Safety Plan, the Treatment plan and compliance data, for example with regard to psychotropic medication).
4. Document ongoing risk assessment and consultation efforts.
5. See Meichenbaum (2005) for a listing of the risk and protective factors that should be systematically assessed and documented when working with a suicidal client. Also see www.melissainstitute.org. For a **DETAILED HANDOUT** in assessing and treating suicidal patients (children, adolescents and adults). (Go to the Melissa Institute and Check Author Index. Scroll to Meichenbaum and call up paper entitled “*35 Years of Working with Suicidal Patients: Lessons Learned*”)

Topics covered in The Handout include:

- 1. Incidence of suicide and clinical practice: Implications**
- 2. The Suicidal Mind: A Constructive Narrative Perspective (Treatment Implications)**
- 3. Assessment Strategies: Interview Questions for Children, Youth and Adult Assessment Tools (Ongoing Risk Assessment)**
- 4. Clinical Interventions with Depressed and Suicidal Youth**
- 5. How to Implement Core Tasks of Psychotherapy**
 - a) Addressing issues of comorbid disorders**
 - b) Incorporating relapse prevention procedures**
 - c) Ensuring safety throughout**

d) Using a Patient Checklist: A “Take home” Toolkit for Suicidal Patients

TREATMENT RESEARCH EFFECTS

(See reviews by Compton et al., 2006; Jacobs & Brewer, 2004; Kelly, 2010; McCarty & Weisz, 2007; Neil & Christenson, 2009; Weersing & Brent, 2006; Weisz, McCarty & Valeri, 2006)

1. Overview of Research Findings
2. Nurturing a Therapeutic Alliance
3. Developmental Considerations: Changes in the Adolescent’s Brain Development (Treatment Implications)
4. Continuum of Care: Intervention Strategies
 - Primary (Universal)
 - Secondary (Selected)
 - Tertiary (Indicated)
5. Consideration of Various Forms of Treatment for Depressed and Suicidal Youth
 - a. Cognitive-behavior therapies (The discussion of Coping with Depression Course, ACTION, PASCET, TADS teenage depression study)
 - b. Dialectical Behavior Therapy
 - c. Interpersonal Therapy
 - d. Family-based Interventions
 - e. List of Treatment Manuals
 - f. Pharmacological Intervention
 - g. Synergistic (Combined) Treatment Approaches
 - h. Internet Resources and Interventions

1. OVERVIEW OF RESEARCH FINDINGS

(See comprehensive Reference List for Additional Resources)

There are more than 550 child and adolescent psychotherapies in use. Psychotherapy with youth has been found to be better than no treatment and youth psychotherapy appears somewhat less effective than adult psychotherapy.

Meta-analyses of evidence-based (EBT) psychotherapy with youth, compared to Treatments as Usual (TAU) yielded an Effect Size (ES=.34), and this ES decreased at a one year follow-up, indicating no lasting treatment effects. When EBT youth treatments were compared with bona-fide (stronger comparison groups), the ES decreased to .24 (Kelley et al., 2010).

A meta-analysis by Weisz et al. (2006) on the effects of psychotherapy for depression in youngsters revealed that treatment methods for depression are less effective than for other adolescent disorders.

In fact, the comparison literature with youth is quite “limited,” with only some 16 studies that meet randomized control standards.

Different youth psychotherapies have been found to be similarly effective.

Treatment dropout rates by youth from psychotherapy ranges from 28% to 85%. Youth engagement procedures such as the use of Motivational Interviewing is a critical component of treatment.

Research indicates that the quality of the therapeutic alliance is the most critical feature predicting treatment outcome with youth (Karver et al., 2005; Shirk & Karver, 2003; Spielman et al., 2007).

“The best overall risk management strategy remains a sensitive and caring therapeutic alliance within the context of the best possible clinical care” (Bongar & Stolberg, 2009, p. 10).

The efforts in developing a therapeutic alliance must be culturally sensitive and appropriate (See review by Anderson and Mays, 2010 on how race and ethnicity impact internalizing disorders in youth and Cardemil et al., 2010, on how depression prevention programs need to be culturally appropriate. You can also visit the Melissa Institute Website www.melissainstitute.org and download the papers to the 13th Annual Conference on cross-cultural interventions).

The therapeutic alliance with the parent is also critical in determining youth participation in treatment.

Such factors as the provision of a clear engaging treatment rationale, collaborative treatment planning, goal clarification with regard to outcome expectations, and a therapeutic “bonding” or support-building (perceived helpfulness, trust, and communication) and the development of hope were found to be predictive of treatment outcome.

Hope is a way of thinking about goals: a wish or desire for something accompanied by the expectation of obtaining it. Hope is the ability to produce pathways to attain goals (pathway thinking) and move on the path toward these goals (agency thinking). Hope and positive outcome expectations are interdependent processes (Snyder, 2005; Kelley et al. 2010).

Providing ongoing feedback such as parent ratings of the youth’s symptoms (Youth Outcome Questionnaire- YOQ Burlingam et al. 1996) and related feedback measures on a session-by-session basis has been found to enhance treatment outcomes (Kelley et al. 201), (See <http://www.talkingcure.com> of Scott Miller for examples of these measures and for examples of Bickman’s feedback measures see <http://peabodyvanderbilt.edu/ptpb>). Such data-based treatment decision-making enhances treatment outcomes.

In summary, the results of several studies (TADS, TORDIA and YPIC) are encouraging, especially if the quality of therapeutic alliance and treatment (session-by-session) feedback to both the patient and the therapist informs clinical decision-making. As Weisz et al. (2006) observe:

“For those who seek an alternative to antidepressants, psychotherapy offers a reasonable option, generating a small to medium Effect Size (ES =.34) that generalizes to comorbid anxiety symptoms and shows substantial holding power for some months after treatment ends.” (Weisz et al. 2006, p. 144).

The meta-analysis showed that treatments for youth depression have had beneficial, but modest effects on average. When steps were taken to better match the comparison of the designated treatment versus practising clinicians who provided treatment as usual (TAU) in clinical settings, the ES was reduced to .24. A number of evidence-based treatments failed to outperform usual care.

In two large multi-site randomly controlled studies, the combination of cognitive behavior therapy (CBT) and anti-depressant medication has been more beneficial than either treatment alone for adolescents with Major Depressive Disorder (MDD) (TADS,2007), and superior to medication alone for adolescents with treatment-resistant MDD (Brent et al. 2008).

These conclusions about the efficacy are consistent with CBT interventions with adults who evidence suicidal behaviors (Brown et al., 2005; Salkovskis et al. 1996; Wenzel et al. 2009) and consistent with the conclusions offered by Miller et al. (2007, p.33).

“The results of controlled studies as a whole indicate that outpatient psychosocial treatments targeting suicidal behaviors directly, particularly CBT interventions, are effective in reducing the risk of future such behaviors in individuals identified as at high risk for them. In contrast, there is no data suggesting that inpatient treatments are effective at reducing suicidal behaviors.”

These CBT approaches included self-monitoring of depressive symptoms, pleasant activity scheduling and behavioral activation, cognitive restructuring and social skills training. The social skills training component included ways to initiate a conversation, appropriate conversation topics, proper eye contact and facial expressions and assertiveness training. The training protocol also included family-based treatment modules. Youth and parents are taught about the connections between feelings, thoughts and behaviors and how this “negative” spiral can be interrupted in more adaptive ways. The psychoeducation should include a discussion about recurrence and risk factors, role of possible treatment barriers like stigma, warning signs, coping strategies, and benefits from treatment. Also, discuss adherence issues to medication and psychotherapy. Given the high reoccurrence of depressive episodes, especially when there has been evidence of internalizing problems before age 14, there is a need to educate about recognizing recurrence of depressive symptoms, so that treatment can be sought sooner than later.

A variety of psychotherapeutic engaging activities are used with youth. For example, Asarnow et al. (2005) use a “hot seat” game in which group members call out negative thoughts to the youth who is on the “hot seat” and who must immediately answer back with a more “positive” thought. Another group member serves as a “coach” for the youth in the “hot seat.” For younger children, CBT may include cartoon-like characters with thought bubbles above them where the child can write his or her thoughts. The therapist may use a Feelings Thermometer, a Feelings Watch,

games, role play, and even have youth make a movie where they enact their learned coping skills. These movies are shown to their parents in a multi-family group, as a means to help their parents learn how to help their children use the coping techniques at home. (Asarnow, Scott & Mintz, 2002).

There is value in reviewing regularly with parents the work done with depressed youth, so they can facilitate these interventions at home.

There is a need particularly to build into CBT active experiential learning, particularly the hands-on activities. These activities may be play-based in which youth are taught ways to “run depressive thoughts off my land,” how to engage in a “good coach-bad coach,” ways to alter self-talk; and how to use a coping Fish Card Game, Coping Cat Workbook, and the like. In short, in order to foster full engagement of youthful clients, there is a need to include age-appropriate experiential, hands on activities. These CBT clinical interventions can be supplemented by school-based interventions. The following list of Websites provide examples of screening approaches, psycho-educational and experientially-oriented coping activities.

School-based Screening and Skills-oriented Training Programs

theguide.fmhc.usf.edu/

elainet@u.washington.edu

kalafat@rci.rutgers.edu

teenscreen@childpsych.columbia.edu

beth.mcnamara@comcast.net

highschool@mentalhealthscreening.org

school-basedmentalhealthtoolkit

lafrom@stanford.org

info@livingworks.net

Ask4help@yellowribbon.org

In addition, students can be encouraged to visit various Mental Health Websites for Adolescents (Review the websites before you recommend them).

www.CopeCareDeal.org

<http://www.frozenflame.web.com/sparx.html>

www.thelowdown.co.nz

<http://au.reachout.com>

Finally, there are increasing instances of where youth have died by suicide as a result of bullying or cyber bullying. Youth who are struggling with their sexual identity are particularly vulnerable to the pernicious effects of such bullying. See the following websites as ways schools can create a school-wide bully-proof environment.

www.teachsafeschools.org (Melissa Institute Website to combat bullying)

www.prevnet.ca

2. NURTURING A THERAPEUTIC ALLIANCE

QUESTIONS THAT ARE DESIGNED TO NURTURE A COLLABORATIVE THERAPEUTIC RELATIONSHIP WITH ADOLESCENTS

(See B. Bertolino, 2003, Change-oriented therapy with adolescents and young adults. New York: Norton; See D. Meichenbaum, 2004, Treating individuals with anger-central problems and aggressive behavior. Clearwater, FL.-dhmeich@aol.com)

The following set of questions are designed to help engage adolescents and their parents in therapy. As Bertolino (2003) has highlighted, small changes in the language and “story-telling” can open new possibilities for future change. The “art of questioning” is one of the most valuable tools clinicians can use.

1. Conduct a Situational Analysis

How often does the problem typically happen?
 Where does it happen?
 When does it usually occur and how long does it last?
 When does it end?
 Who is present?
 How do they respond?
 What have you tried to do to help address this problem?

Assume future solutions through future talk

Use expression such as *yet* and *so far*
So far things have not gone right for you
 You haven't found a way to stay out of trouble yet

I would like to invite you to consider noticing any differences in the problems that brought you here and telling me about them when we meet again. For example,

Are there any changes when you get depressed?
How depressed do you become?
How long does the depression lasts?
What do you do with your depression?
Ask one question at a time.

2. Turn problem statements into goals and future actions

So you would like to see...
 So one of the things we would focus on is to find a way to change...
 So when you get the sense that..., what will be different for you?
 So when you put the trouble behind you, I wonder (I'm curious) how will your life be different?

3. Translate the client's absolutistic statements that use “all”, “nothing” or that reflect “black-white” thinking into partial statements.

Much of the time...
 In the last while...
 Always?
 Never?

Any exceptions?

4. Solicit feedback on sessions.

How was today's session?

What was helpful or unhelpful?

Did we talk about what you wanted to talk about?

Did we work on what you wanted to work on?

How was the pace of our session? Did we go too fast or too slow, or was the pace just about right?

Was there anything missing from our session that you would like to see us include in the next session?

Is there anything I should have asked that I did not ask?

Is the way we are proceeding to address your concerns fitting with the way you expect change to occur?

What ideas do you have about how I can help you with this?

I want to take the time to make sure I understand where you (or each person) are coming from. Is that okay with you?

I would like to hear your ideas about what you think should happen next in our sessions.

There are many possibilities. We could...or you could decide to...

What might make the next session a little better for you?

Are you okay with that?

I have to tell you that I am a bit confused about...

I'm still wondering if...

Correct me if I am wrong.

Are there any changes you would recommend for our future sessions?

Did you feel heard and understood?

Is there anything you would like me to do differently in future sessions?

How would you explain your experience in therapy today to others who might be curious?

What might make coming here again a little better for you?

I will be checking in with you regularly in order to find out what's been helpful to you, what's not helpful, what's working and what's not working. Is that okay with you? I want to find out what we have done together that has been of benefit to you. This way I will be able to learn from you if our working together has helped or if anything needs to change in terms of the services we provide or whether a referral to another service would be of more help.

5. Relapse Prevention Questions: Learning from setbacks (slips)

What signs were present that things were beginning to slip?

What have you learned from this setback?

What will you do differently in the future as a result of this knowledge/experience?

What can you do differently in the future if things begin to slip?

Is there anything that might come up between now and next time we meet that might pose a threat (hurdle, barrier) to the changes you have made?

Can you think of anything that might come up that would present a challenge (barrier) for you staying on track?

6. Taking Credit For Change

What have you noticed that has changed?

What specifically seems to be getting better?

Who first noticed that things had changed?

When did you first notice that things had changed?

What did you notice happening?

What did you do that resulted in...?

How did you get yourself to do that?

How did you get that to happen?

How was that different than before?

How did that help you?

Where did you get the idea to do it that way?

What did you tell yourself?

What do you think made the difference?

If X were here, what would he/she say has contributed to the change you brought about?

What does it say about you that you have been able to...?

What kind of person are you that you have been able to ...?

Where did this X (courage, will-power) come from?

What kind of inner strengths do you draw on in such moments of difficulty/adversity?

What kind of inner qualities do you possess that allow you to...?

What would others say are qualities that you possess that help you when you need them?

Consider how change comes about with your parents. How can we work together so these changes continue into the future?

What have you already learned about how to make it through a day at school?

How have you managed to go so many days in a row at school without having a X?

How will you let people know when you become angry without hurting anyone else or yourself?

Who will you want to be sure to talk to this week at school?

Until we meet again next week, who can you depend upon (or call upon) when you begin to notice bad feelings (or trouble) coming on?

7. Fostering Generalization

Can you tell me a little about how things are since the last time we met?

How can we use what we learned last week to help you deal with the problem you are having with...?

Pretty tough situation. Is there anything you could do...?

I am wondering if you could...

What might happen if you...?

I am not certain you are ready for that yet.

That sounds pretty hard. Maybe, we should think of something else to do...

Why is it important to correctly guess what someone's intentions are or what they want?

What, if anything, has been different since the last time we met?

The last time we met, you mentioned that on a scale of one to ten, things were at a five.

Where would you say things are today?

Were you surprised by how you were able to...?

What did you do differently?

What did you do when you found out that...?

Do you ever find yourself out there in your day to day experiences asking yourself the questions that we ask each other, here in our meetings?

3. DEVELOPMENTAL CONSIDERATIONS: CHANGES IN THE ADOLESCENT'S BRAIN DEVELOPMENT (TREATMENT IMPLICATIONS)

“The teenage brain is a work in progress”

“Go to your room until your cerebral cortex matures”

A major concern of any treatment approach with adolescents is the need to tailor the interventions in a developmentally sensitive fashion, given the recent findings about neurological changes in the teenage years. Consider the following findings and the treatment implications.

Laurence Steinberg (2008, 2009 a,b) and Dahl and Spear (2004) have summarized the anatomical changes in the brain during adolescence.

1. There is a decrease in gray matter in prefrontal regions of the brain during adolescence, reflecting a synaptic pruning (namely, the process by which unused neuronal connections are eliminated), resulting in improved information processing and logical reasoning.
2. Changes in the dopaminergic activity involving a proliferation, reduction and redistribution of dopamine receptors in paralimbic or prefrontal cortical regions. Dopamine plays a critical role in the brain's reward system. This remoulding of dopaminergic activity can contribute to sensation seeking behaviors, given the youth's heightened salience to rewards.
3. Increase in white matter in prefrontal regions, reflective of myelination improving the efficiency of neural signalling. Whereas synaptic pruning occurs during early adolescence, the myelination process takes place toward the latter phases of adolescence and into early adulthood. This contributes to the development of executive functions, such as response inhibition, planning ahead, weighing risk and rewards and the consideration of multiple sources of information.
4. There is also an increase in brain connections among cortical areas and between cortical and subcortical regions. Such increased connectivity facilitates the development of emotional regulation and facilitates social information processing.

These structural changes and the accompanying changing patterns in brain activities contribute to the gradual development of self-management skills. As Steinberg concludes:

“Brain systems implicated in basic information processing reach adult levels of maturity by mid-adolescence. Whereas, those that are active in higher order executive functions, self-regulation and the coordination of affect and cognition do not mature until late adolescence or even early adulthood” (2009, p. 744).

Or described more poetically,

“The combination in middle adolescence of an early arousal reward system and a still immature self-regulatory system has been likened to ‘starting an engine without yet having a skilled driver.’”

From 14 to 16 (pre to mid-adolescence) impulse control, reward sensitivity, sensation seeking, risk taking, and reckless behaviors, and having an easily arousal reward system

are all prevalent. From 16 to early adulthood, such behaviors as impulse control, anticipation of future consequences, strategic planning and resistance to peer influences increase.

Steinberg's research demonstrates that the brains of teens lack the maturity to enable them to consistently control their impulses, resist peer pressure and appreciate the risks of their actions. They require "metacognitive prosthetic devices or tools" to develop self-regulatory and peer-resistant behaviors. Teens, especially in early adolescence, have reward-seeking arousal systems, but the ability to put the brakes on is still maturing.

Therapists need to adapt their interventions accordingly to meet these growing capacities. "Teenagers are less mature than we might have thought, especially, in the early stages of adolescence" (Steinberg, 2009).

TREATMENT IMPLICATIONS

1. There is a need to assess the cognitive capacity and meta-cognitive self-regulatory capacity of depressed and suicidal youth.
2. Need to provide the youth with "Meta-cognitive Prosthetic Devices" (MPDs), which may include Memory prompts, Advance organizers, Intermittent Summaries, Training in "Self-Talk" ("*What you tell your brain?*"), Problem-solving training and Ways to seek help.
3. See Melissa Institute Website www.teachsafeschools.org for examples of how to build in MPD training, Miller et al. (2007) and Treatment Manuals by Joan Asarnow and her colleagues.

4. CONTINUUM OF CARE FOR TREATMENT OF DEPRESSION IN CHILDREN AND ADOLESCENTS

Illustrative interventions

Primary (Universal)

Secondary (Selected)

Tertiary (Indicated)

Primary Interventions (Universal) - - Delivery of programs that target whole populations of youth in school settings, regardless of risk status.

1. Provide community-wide and school-wide interventions that reduce risk factors and bolster resiliency coping skills ala work of Lewisohn, Rohde, Clarke, Seligman, Reivich and those who bolster competences. (*See Melissa Institute Conferences on Resiliency training www.melissainstitute.org and Cuijpers, 1998*).
2. Provide early interventions in nurturing parent-infant attachment interventions, home-nurse visiting programs, Hawaii project. (see Chorpita et al. 1996).
3. Provide school-wide interventions. For example, see the National Association of School Psychologist's Website http://www.mentalhealthscreening.org/sos_highschool. This website describes an SOS Suicide Prevention Program that includes an educational video, workbook, a brief 7 question screening tool and an ACT program, where students are taught how to Acknowledge, Care and Tell. Another useful resource is the School-based Youth Suicide Prevention Guide.
(<http://www.fmhi.usf.edu/institute/pubs/bysubject.html>)
(<http://cfs.fmhi.usf.edu/ufsinfo/hotpubs.cfm>)
4. Following a suicide, schools often provide postvention interventions. Some cautionary observations about how to conduct such post-suicide interventions have been offered by Mazza (1997). He observes (p. 391):

Several studies showed that postvention programs have the opposite effect, that is adolescents who were at the greatest risk for suicidal behavior showed increasing levels of hopelessness, more maladaptive coping strategies, and less evaluative skills after the postvention programs were completed.

Following a student or faculty suicide, there is a need to carefully not glorify the death, to attribute the suicide to the presence of mental disorders such as depression and not attribute it to “stress” per se, to provide accurate information to curtail rumours, to provide supports. Suicide reflects a psychiatric disorder related to depression and affective disorders, rather than the cumulative effects of stressors that most youth experience. Highlight that suicide is a rare occurrence, and that help is available. See Joiner (2010) for a discussion of myths concerning suicide. Also, see Callahan (1996), Changnon et al. (2007), Cross et al. (2007), and Wyman et al. (2008) for a discussion of ways to train “gatekeepers” and the listed websites for guidelines on how school personnel can conduct postvention interventions.

Secondary Interventions (Selective Programs) - - Invite youth to participate based on a known risk factor such as parental history of depression, family conflict, exposure to violence.

1. Identify children and youth who are “at risk” for becoming depressed and suicidal and provide preventative interventions. Two examples: The ACE Program that measures the cumulative number of Adverse Childhood Experiences (www.ACEstudy.org) and program that identifies youth who are at risk because of the cumulative number of “risky” behaviors. For example, a score of 4 or more on the ACE measure raises the probability of suicide by 1220%. Or for instance Miller and Taylor (2005) found that the more problem behaviors an adolescent has, the greater his or her risk of suicidal behaviors. Problem behaviors were defined as including violent behavior, binge drinking, cigarette smoking, high risk sexual behavior, disturbed cutting behavior and illicit drug use. Compared to adolescents with zero problems, the odds of medically treated suicide attempts were 2.3 times greater than among respondents with one risk factor, 8.8 with two, 18.3 with three, 30.8 with four, 50 with five and 227 with six behavior problems. The rate of youth suicide among specific ethnic groups such as Native Americans is over 3 times the national average. Culturally sensitive interventions can be used on a preventative basis. (See La Frombosie, 1996; Witko, 2006).
2. Given the significant higher incidence of suicide among gay, lesbian and transgender youth, especially if they are bullied, there is a need for active, effective school-wide bully prevention procedures and supportive interventions for youth who are at risk. (See www.teachsafeschools.org for examples of such interventions).
3. The children of depressed parents are at particular risk to develop depression. Consider the following epidemiological data.
 - a. 50% of the offspring of parents with MDD will develop a psychiatric disorder by adolescence and they are 4x more likely to develop an affective disorder than children of non-ill parents.
 - b. Children who are depressed are more likely to be living with parents who are depressed. Depressive episodes in children are linked to depressive episodes in parents.
 - c. If one parent has MDD, the child has a 15% increased risk of developing DD and this rate increases to 40% if the parent had an early onset or if the parent had multiple recurrences.
 - d. If both parents have MDD, the child’s chances of developing MDD increases to 40%. Children of depressed parents are 3x more likely to have a lifetime average episode of MDD and an earlier onset (12-13 years) than the average 16-17 years onset and evidence more comorbid disorders. The heritability of liability to major depression is approximately 40%.
 - e. There is evidence of dysfunctional interactions between depressed mothers and their infants, toddlers. For example, clinically depressed mothers show less responsiveness, higher dysphoric affect, are less contingent, less rewarding and more irritable with

their children. As research by Goodman, Gotlib and Hammen all highlight, this interactional pattern contributes to insecure attachment and is a forerunner of adolescent depression (Gotlib & Hammen, 2002). A meta-analysis of the association between parenting and childhood depression indicates that parenting only explains 8% of variation in childhood depression. Parental rejection and hostility were most strongly related to child depression. This contrasts with genetic influences that account for 36-60% of the variance of childhood depression (McLeod et al., 2007).

- f. These research findings underscore both a genetic heritability and environmental vulnerability contributing to the development of MDD. It has been estimated that genetic factors contribute 50% of the variance in the transmission of mood disorders. For instance, MZ (identical) twins are 3x more likely to develop DD than are DZ (fraternal) twins. MZ twins show about a 65% concordance rate for affective disorders versus 14% for DZ twins.
 - g. This data highlights the need to provide preventative interventions with children of depressed parents. Work by Beardlee, Clark and their group have indicated the potential of such preventative efforts. (See Clarke et al. 2001, 2002, Young et al., 2006).
4. Youth who are brought into emergency rooms for violent behavior and comorbid depression and those youth who come into Primary Care offices provide an opportunity for interventions. See work by Asarnow, Jaycox and Kruesi.

The work of Kruesi et al. (1999) highlights the value of parent education in emergency departments. The emergency room is a major contact point for at-risk youth and their families. Some 77% of such youth do not attend recommended follow-up sessions. See work by Joan Asarnow on ways to alter this pattern. Also see Brent et al. (2000) for description of how to have parents of suicidal youth remove guns from the home.

5. Provision of School-based interventions (See Coping With Depression Course by Lewisohn and Rhode- description below and www.kpchr.org/acwd/acwd.html)

Tertiary Interventions (Indicated Programs) - - Invite youth to participate based upon elevated symptom levels that may require more intensive, clinical referral wrap-around-services.

1. Skills-based interventions
 - a) Cognitive-behavioral therapies ala TADS, YPIC, TORDIA studies
 - b) Dialectical behavior therapy ala work of Miller, Rathus and Linehan
 - c) Problem-solving and communication skills training ala work of Stark, Wolfe
 - d) Interpersonal therapy ala work of Mufson and colleagues
2. Family-based interventions (work by Brent, Rotheram, Piacentini)
3. Pharmacologically-based interventions. (*See discussion below*)

EXAMPLES OF COGNITIVE-BEHAVIORAL INTERVENTION PROGRAMS: SCHOOL and CLINICALLY-BASED TREATMENT APPROACHES

School-based Coping With Depression Course

(See Clarke et al., 2001, Clarke & Debar, 2010; Lewisohn et al., 1990, 1993 1999)

Classroom presentation- use with grade school and high school students. Use group exercises 6 to 10 adolescents (16 twice weekly 2-hour sessions over a period of 8 weeks) and parallel parent groups (3 informational meetings).

- a) Use mood monitoring- identification and association of mood states, activities, cognitions
- b) Social skills training and experiential learning- use self-modeling in which children repeatedly observe videotapes of themselves engaging in non depressive and desirable behaviors
- c) Increase pleasant activities
- d) Relaxation skills
- e) Constructive thinking-test dysfunctional cognitions
- f) Communication skills training and conflict reduction techniques
- g) Negotiation and problem-solving skills
- h) Use role playing- Participants are told that not every skill or technique will be equally useful for all participants, but that at least some group members will find each new skill helpful. Ask all participants to try each new skill and not reject it out of hand before trying.

Skills taught include mood monitoring, ways to increase pleasant activities, relaxation and social skills training, problem-solving constructive thinking and goal-setting, including writing a contract with themselves. The course also includes learning how to recognize if depression recurs and how to create a personal depression prevention plan and what to do in an emergency. They are encouraged to take an active role in their recovery. The final session reviews progress since the beginning, identifies areas of competence and areas still needing work, sharing feelings about the group ending and what adolescents can do to replace the support that the group has provided. In short, “how to become their own therapist or coach.”

The typical group session has the following sequence:

1. review of the agenda for the day's session

2. review of homework, including catch-up for those who did not complete it
3. presentation of the new skills
4. active practice with feedback
5. problem-solve solutions to possible barriers to implementing new skills
6. new homework assignment

Parents are informed about general topics discussed, skills taught and how to be supportive. The parents' own depression was not directly discussed in the parent meetings. Focus is on ways parents can reinforce and promote positive changes in their children.

The **Coping with Depression Course** has been translated into multiple languages and copies of the therapist manual and adolescent workbook and other material are available at

www.kpchr.org/acwd/acwd.html

Recovery rate of 60% with Coping With Depression Course. Approximately one-third of youths entering the group may not fully recover and will require monthly group booster sessions. Brief, 10-minute therapist telephone calls may be placed periodically after acute treatment to check for depression recurrence and case management to address emergent life events.

Overall Median Effect Size with CBT for depression with children is .64 to .67. CBT led to remission in 65% of cases, a higher rate than either supportive therapy or family therapy (Brent et al., 1997).

The CBT program may also be combined with SSRI anti-depressant medication. (*See Section on Pharmacology*)

THE ACTION TREATMENT PROGRAM FOR GIRLS (See Stark et al. 2010).

Treatment Format

1. This cognitive-behavioral therapy (CBT) consists of 20 group meetings and two individual meetings that are conducted in schools in small groups of 2 to 5 girls ranging from 45-75 minutes. Tailored to both the developmental level of the participants and the practical aspects of the school program.
2. It also has been tailored to the treatment of depressed boys (See Stark, 1990). It is a manualized multicomponent gender-specific intervention.
3. A parent training component includes positive behavior management, family problem-solving, communication skills training, conflict resolution and supportive behaviors. To encourage parent participation, transportation, day care and dinner or snacks are provided. Parents were seen in small group sessions. The combination of CBT & PT and

CBT were equally effective, but the combination treatment led to greater maintenance of treatment effects (84% vs. 73%).

Examples of Treatment Components

1. The ACTION program included:
 - a. **Affective education** - girls taught to identify their emotions by acting like “emotional detectives” learning how to check on “Three B’s”: **B**ody - - how my body is reacting; **B**rain - - what am I thinking; **B**ehavior - - how am I behaving.
 - b. **Goal setting** - collaboratively identify three treatment goals. Group brainstorm how they can help each other reach their goals. At the beginning of each session there is a “goal check-in” time where girls report progress toward goal attainment.
 - c. **Mood monitoring** – girls taught how to use a mood thermometer or rate themselves on a 1 to 10 mood monitor, both in and out of sessions. Also, learn how to keep a diary of positive events “Catch the Positive Diary.”
 - d. **Learn ACTION skills**
 1. Do something fun and distracting
 2. Do something soothing and relaxing
 3. Seek social support
 4. Do something that expends lots of energy
 5. Change your thinking. Become a “thought detective”

Help girls identify situations where it is best to use each **ACTION** skill.
 - e. **Problem-solving skills Training**
 Through directed instruction, modeling, coaching, rehearsal and feedback girls learn the “five Ps” of problem-solving.
Problem - - problem definition
Purpose - - goal definition
Plans - - solution generation
Predict and pick - - consequential thinking
Pat on the back - - self-evaluation
 - f. **Cognitive restructuring**
 Help participants learn the connections between thoughts, feelings and behaviors and conduct hypothesis testing (check the data), alternative thinking where making multiple choices- - How to catch negative thoughts and become a “thought detective.”
 Use STOP
S - - Recognize what I am feeling
T - - Ask myself, What are my thoughts? What am I thinking?
O - - What are other thoughts or things I can do?
P - - Praise myself for working on my goals.

Learn how to “change my tune.” Girls may use a Thought-feeling watch with 12, 3, 6 and 9 o’clock corresponding to “mad, sad, worried, happy.” Like the time on a watch, one’s feelings also change.

Muck Monster

Talking back to the “Muck Monster” to change one’s thinking, instead of being “stuck in the negative muck.” “It is the Muck Monster that is filling them with negative thoughts,” learning to talk back to your brain. “Muck Monster” is not used with adolescents. Instead, they are asked to give the source of their depression a “name” or refer to “your depression talking to you.” Can use the “empty chair” procedure with the patient sitting in the “Hot Seat” talking back to the “Muck Monster.” Also, see below for Asarnow et al use of a Hot Seat procedure.

Use of a Coping Kit with cue card reminders

If I feel bad and I don’t know why, I can use my coping skills.

If I feel bad and I can change the situation, I can use my problem-solving skills.

If I feel bad and it is due to my negative thoughts, I can change my thinking.

Build Positive Sense of Self

Create a self-map- identify relevant strengths and signs of resilience. Parents, teachers, peers and group participants are engaged to help complete the self-map.

Build in generalization guidelines

Ensure participants take credit for changes, plan for ways to identify and cope with possible lapses, and be put in a “consultative mode” where they can teach others what they have learned.

PRIMARY AND SECONDARY CONTROL ENHANCEMENT TRAINING (PASCET)

(See Bearman et al. 2010; Weisz et al. 1997, 2008)

1. The PASCET program helps 8-14 youngsters cope with depression by developing skills in achieving primary control (changing objective conditions) and secondary control

(adapting to objective conditions) so as to control their subjective emotional impact by changing cognitions.

2. PASCET can be conducted on an individual and in group format.
3. PASCET uses the acronyms **ACT** and **THINK** to present core coping skills.

ACT SKILLS

Activities that solve problems and boost moods such as engaging in pleasant activities

Calming response-relaxation, focused breathing, imagery procedures

Turn on my positive self-practice and implement positive self-presentation

THINK SKILLS

Think positive- - generating realistic, helpful thoughts to replace distorted or unhelpful cognitions.

Help from a friend - - finding social support.

Identify the silver lining- - finding something positive that is made by otherwise negative conditions.

No replaying of bad thoughts- - using distracting activities to minimize unproductive rumination.

Keep on using the ACT and THINK skills- - persevering despite setbacks and failures. Using my backup plans.

4. Throughout the treatment exercises, use behavior rehearsal, role play, mood booster reminders, workbooks, rewards, self-monitoring using a “feelings” thermometer and the use of activities as a means of changing feelings and accompanying thoughts.
5. In the final sessions, the youth completes an end-of-treatment project (e.g., a booklet telling “my story,” a poster showing his or her favourite skills) designed to represent the skills the youth has learned. They can also become “teachers” or “demonstrators” of PASCET skills.
6. Weisz and his colleagues are now working on a school-friendly video-guided program of PASCET skills using youth actors to demonstrate the coping-skills in video segments. The PASCET program has also been adapted to include a parent training program. The protocol includes practice in child-caregiver special time; praise; contingent reinforcement of positive mood and behavior; positive communication training and family problem-solving. (Bearman et al. 2010).
7. PASCET has also been adapted for physically ill children (inflammatory bowel disorder (IBD), Crohn’s disease and ulcerative colitis) (Szigethy et al. 2007).

8. These innovative efforts can be used in mental health clinics, schools, and pediatric care settings. They are designed to improve upon the modest treatment effects of cognitive-behavioral interventions.

FEATURES OF THE TREATMENT OF ADOLESCENTS WITH DEPRESSION STUDY (TADS)

(See Journal of American Medical Association: JAMA, 2004, 292, 807-820 and Cognitive and Behavioral Practice, 2005, Vol. 12, Number 2)

1. Treatment study was conducted across 13 different sites using random assignment of 439 moderately to severely depressed adolescents (Ages 12-17, Mean age 14.6). The youth met the diagnostic criteria of Major Depressive Disorder- MDD on the Children's Depression Rating Scale- Revised. (Mean Group score of 60, reflecting moderate to severe depression, Poznanski & Moknos, 1995).
2. 80% of the subjects were experiencing their first episode of depression. Medium length of depression was 42 weeks and the average length of depression was 71 weeks.
3. One-third of the adolescents had past suicidal behavior, experienced current suicidal ideation and/or parasuicidal behaviors such as cutting. Other high risk behaviors included drugs use, promiscuity, runaway behavior, school refusal, and dangerous Internet use (e.g., arranging meetings with people who were met on-line).
4. 50% of the adolescents had comorbid psychiatric disorders, (27% had anxiety disorders and 10% had social phobias which contributed to the maintenance of their depression). Although learning disabilities were not specifically assessed, 6% of the sample was enrolled in special education classes, 15% had a history of repeating a grade. Such learning problems in children who are depressed are common. 23% were diagnosed with comorbid Disruptive Disorders and Oppositional Behavior Disorders (negative, hostile, defiant). 14% met the criteria of ADHD.
5. Race- 74% were Caucasian; 12% Black/African American; 4.8% Latino.
6. Exclusion Criteria- Adolescents with very problematic comorbidities of serious conduct disorder and substance abuse were excluded. Adolescents with high risk of suicidal behavior as defined as suicide attempts that required hospitalization within the previous 3 months were also excluded. They also excluded teens who missed more than 25% of school days in the preceding 2 months. If school absences were deemed to be depression-related then this exclusion criterion could be overruled (this occurred in 6% of the cases).
7. Adolescent subjects were randomly assigned to one of four individualized treatment conditions.

Combined Treatment of Antidepressant Medication (Fluoxetine 10- 40 mg/day) with CBT

CBT alone

Fluoxetine alone

Placebo pill equivalent

8. Treatment Format- Three Phases (Flexible Application of Manualized Treatment)

Phase I- Acute Treatment- 12 weekly sessions that involve individual sessions with depressed adolescent and parent involvement (2 psychoeducational sessions and 1 conjoint family session).

Phase II - Continuation Treatment – 6 weeks

- weekly sessions for partial responders where additional new skills training sessions are conducted
- bi-weekly sessions for full responders (consolidation of skills)
- last session for both full and partial responders focusing on relapse prevention

Phase III – Maintenance Treatment – 18 weeks

Visits every 6 weeks where the focus is on skills consolidation, maintenance of treatment goals and relapse prevention.

Therapy sessions are moderately structured, especially during the first 6 sessions of acute treatment where core skills are taught. Each session is divided into 3 sections of approximately 20 minutes.

First Section is a check-in with the adolescent about concerns, issues, and current condition regarding depressive symptoms since the last session.

Second Section learn and practice new skills. Relate to personal concerns and life experiences. Use didactic instruction, modeling, role playing and Socratic questioning. *(Build in treatment guidelines for generalization)*

Third Section- Plan “homework” to be conducted before the next session. *(Follow guidelines on how to conduct “homework”)*

The therapist used a Treatment Manual to guide the teaching of the 8 required skills and the therapist in collaboration with the youth and his/her parents can choose from 5 additional skills. The skills to be addressed were as follows:

COMPONENTS OF CBT WITH ADOLESCENTS WITH MAJOR DEPRESSION (TADS STUDY)

8 - - REQUIRED SKILLS

1. Establish a Working Therapeutic Alliance with adolescent and parent, united on common treatment goals and conducting psychoeducation about depression and about the Treatment Model with both the adolescent and his/her parents
2. Systematic Mood Monitoring
3. Collaborative Goal-Setting
4. Increasing Pleasant Mood-enhancing Activities
5. Improving Problem-Solving Skills
6. Recognizing and Modifying Automatic Thoughts, Cognitive Distortions and Underlying Negative Assumptions (Implicit “if-then” propositions)
7. Formulating Helpful (more adaptive) Counter-thoughts and Combating Core Beliefs concerning a Negative View of Self, the World and the Future
8. Taking Stock of what has been helpful as a result of the Acute Treatment (Stage I, 12 weeks of treatment) and what skills would likely be of help in the upcoming period.

5 - - OPTIONAL SKILLS

1. Improving Social Interactions
2. Nurturing Assertive Skills
3. Training Communication, Negotiation and Compromise Skills, especially around issues of Autonomy
4. Training Relaxation Skills
5. Teaching Affect Regulation skills

**INCLUSION OF CONTINUATION AND MAINTENANCE
TREATMENT SESSIONS****MAJOR FINDING**

Based on a rating on the Clinical Global Impression Measure where adolescents were judged as being “much improved” or “very much improved” at the end of the 12 week acute treatment phase, the following results emerged.

	<u>Degree of Improvement</u>
Combined Treatment	71%
Medication Alone	61%
CBT Alone	43%
Pill Placebo	35%

As Kratchwill et al. (2005, p. 162) observe:

“Initial results from TADS (TADS, 2004) indicate that following acute treatment (12 weeks) Fluoxetine combined with CBT was better than either Fluoxetine alone or CBT alone. Comparison also showed that Fluoxetine alone outperformed CBT, which in turn was statistically indistinguishable from placebo group, with clinically significant suicidal ideation dropping most in the combination treatment group.”

COGNITIVE-BEHAVIORAL SAFETY PROGRAM - - SAFE ALTERNATIVES FOR TEENS AND YOUTH

Asarnow and her colleagues (1999a, 2006, 2007, 2010) have developed a variety of interventions which are time-limited (e.g., 12-16 sessions within three months) that are individually tailored and that specifically target suicide and risk reduction. The intervention programs typically include:

- (1) family and community-based interventions (schools, peers, community) to support youth safety and adaptive behaviors;
- (2) cognitive-behavioral interventions and the development of a SAFETY Plan;
- (3) care linkage strategies, linking youth to needed active follow-up care. There is a need to create a “Circle of Support.” (Keep in mind that a previous suicide attempt increases the risk of a reattempt by 30 fold).

DIALECTICAL BEHAVIOR THERAPY *(See Linehan, 1993; Miller et al., 2007)*

1. Dialectical Behavior Therapy (DBT) employs multiple treatment features - - concurrent skills training with teens, individual therapy, multifamily training groups, family therapy as

needed, between session telephone consultations (with both teens and parents) and consultation to therapists. The DBT has varied from 16 weeks to one year in length.

2. The treatment focus includes increasing a client's motivation with special attention to therapy-interfering behaviors, skill acquisition and generalization, providing support and ensuring safety throughout.
3. DBT employs a target hierarchy with treatment structured to target behaviors according to their priority.
4. Skills training Modules with accompanying client workbooks have been developed in the following areas: (See Acronyms)

Core Mindfulness Skills

Use "wise mind" skills - - use acceptance, observation, non-judgmental skills

Emotional Regulation Skills

Reduce vulnerability to emotions

Increase positive emotions and acting opposite to current emotions

"Turning down the volume" (emotional volume)

Interpersonal Effectiveness Skills

DEAR MAN (Describe, Express, Assert, Reinforce, stay Mindful, Appear confident, Negotiate)

GIVE (be Gentle, act Interested, Validate, use an Easy manner)

FAST (be Fair, no Apologies, Stick to values, be Truthful)

Distress Tolerance Skills

Distract with "wisemind **ACCEPTS**" (Activities, Contributing, Comparisons, Emotions, Pushing away, Thoughts, Sensations)

Self-soothing activities

IMPROVE the moment (Imagery, Meaning, Prayer, Relaxation, One thing in the moment, Vacation, Encouragement)

See Miller et al., (2007) for examples of patient handouts. They also discuss a number of practical implementation strategies.

TREATING ADOLESCENT DEPRESSION USING INTERPERSONAL PSYCHOTHERAPY

(See Jacobson & Mufson, 2010; Mufson, 2004; Young et al. 2006)

Common features of adolescent depression are interpersonal conflicts and losses such as loss of friendships, breakup of romantic relationship, family conflict, parental divorce, low family cohesion, high levels of expressed emotions, physical illness, and having to deal with transitions. Such situations may be both a precipitant and consequence of depression.

Interpersonal Therapy with Adolescents- IPT-A

1. IPT-A focuses on four problem areas: interpersonal role disputes, role transitions, interpersonal deficits and grief. It is usually delivered over the course of 12 weeks (12-15 sessions) to 12 to 18 year olds on a group or individual basis in school-based health clinics. In order to prevent relapse and recurrence monthly maintenance sessions are recommended.
2. While IPT-A has been employed with depressed youth who have comorbid disorders, it is not recommended for adolescents who are actively suicidal, psychotic, have bipolar disorders, are mentally challenged or actively abusing substances.
3. Three primary treatment components are education, affect identification and interpersonal skills building.
4. As part of the psychoeducation process with the adolescent and his/her parents, the IPT-A therapist explains that depression is similar to an illness such as pneumonia and requires time to recover. (See Jacobson and Mufson, 2010, p. 144).
5. Adolescents are asked to conduct a social support network analysis using a “closeness circle.” “Teen Tip” sheets are provided to help adolescents communicate more effectively (See Jacobson and Mufson, 2010, p. 148).
6. Problem-solving and role playing are used as ways to consolidate their learning. They develop a “work-at-home” plan with specific goals for each social situation.
7. The termination phase of treatment is designed to nurture a sense of competence. They discuss their feelings about the conclusion of treatment, review skills learned and goals accomplished, discuss warning signs of depression and potential future challenges, and consider how coping strategies can be employed and ideas about how treatment gains can be maintained. A similar discussion can be held with the adolescent’s parents in the presence of the youth.
8. This IPT-A has been adapted to Puerto Rican depressed youth by Bernal. (See www.melissainstitute.org for a description of cultural adaptations. IPT-A has also been adapted for pediatric primary care clinics).

FAMILY-BASED INTERVENTIONS

Restifo and Bogels (2009) examine the family processes that contribute to the development and maintenance of youth depression. They identify risk factors that include parental rearing style, family environment, marital conflict and psychopathology, family abuse and neglect. The

relationships between youth depression and these family factors are both reciprocal (bi-directional) and transactional (behaviors that engender responses). They discuss the need for family-based psychotherapeutic interventions with depressed children and youth, given the limited effectiveness of cognitive therapy and the success of such family-oriented treatments with youth with externalizing disorders, substance abuse and eating disorders (Diamond and Josephson, 2005). For example, dysfunctional cognitive styles in children and youth have been associated with negative parenting practices such as the level of criticism and the lack of parental involvement (i.e., high Expressed Emotion) and the ways that adolescents establish autonomy (Asarnow et al. 1994; Robin & Foster, 1989). Depressed youth report less pride in their families, trust, respect, cohesion, loyalty and view their families as less adaptable when under stress, and more enmeshed and isolated.

It is important to recognize that while parent depression is a risk factor for offspring depression, it is also linked to the development of other forms of psychopathology such as anxiety and substance abuse disorders. Some 10 studies have tested the effects of treating maternal depression on child depression (Gunlicks & Weissman, 2008). Other treatment approaches have focused on parent-child relationship factors such as conflict resolution, improving communication and parental support. The potential value of developing interventions that target parent-youth interactional patterns has been highlighted by McLeod et al. (2007), Robin and Foster (1989) and Sander and McCarthy (2005). Negative parenting behaviors (rejection, hostility, criticism, absence of warmth) may contribute to, but also may be a reaction to, children who are depressed). This reciprocal, escalating pattern can become highly interwoven and stronger over time.

A number of treatment approaches have included a parent component (Cognitive Therapy, Behavioral Activation, Coping with Depression Course, Interpersonal Therapy, Attachment-based Family Treatment, Systemic Behavior Family Therapy, Family Psychoeducation). (See Dowell, 2010, and Restifo and Bogels 2009, for a review).

These varied treatment programs include such components as:

- a) Collaborative goal-setting following family assessment and feedback;
- b) Education about depression, role of risk and protective factors, and increased sensitivity to developmental issues;
- c) Safety planning and recognition of warning signs and ways to reduce the risk of relapse and suicide;
- d) Attempts to change dysfunctional family interactional patterns;
- e) Family problem-solving skills training;
- f) Family communication skills training;

- g) Improving parenting skills and the use of behavioral contingency schedules and positive reinforcement and reduction of High Expressed Emotions behaviors;
- h) Fostering of positive parent-adolescent attachment behaviors (family cohesion resiliency-building activities);
- i) Whenever indicated, provide separate interventions to address parent psychopathology and marital conflict;

The Treatment for Adolescent Depression (TADS) study which was described, demonstrates the feasibility of targeting multiple family risk factors using flexible treatment modules that can be integrated into a cognitive-behavioral therapy approach.

At this point, there is no comparative outcome data that provides a profile matching between the mode of intervention options and risk factors (see McCarty & Weisz, 2007). Involving families and providing them with support does lead to improved retention levels that correlates with treatment outcomes. See the following Manualized Family Therapy Protocols for treating depressed youth.

Attachment-based Family Therapy	Diamond et al, 2002
TADS Family Modules	Wells & Albano, 2005
Systemic Behavioral Family Therapy	Brent et al, 1997
Coping with Depression Course	Lewishon et al, 1990
Dialectical Behavior Therapy	Miller et al, 2007
Multisystemic Family Therapy (MFT)	Henggeler et al. 2002; Huey et al. 2004. Also see Littell, 2005, 2006 for a critique of MFT
Safety Program and Stress Busters Emergency Department Family Intervention Manual Youth Partners in Care Stress and Your Mood	Asarnow et al, 1999 a,b, 2002
Emergency Room Psychoeducation for Parents	Brent et al, 2000; Kruesi et al, 1999

PHARMACOLOGICAL TREATMENT

- In the last decade, the prescription rate of antidepressants for children, youth and young adults has tripled.

- Approximately 11 million antidepressant prescriptions were written for children and adolescents in the U.S.
- It is unclear if antidepressants are safe or effective in children under 5 years of age.
- Only 23% - 30% of depressed youth receive treatment.
- SSRI are the pharmacological treatment of choice with adolescent depressions. They have a higher response rate, greater tolerability than TCA's and limited side-effects. (See Weller & Weller, 2000). But overall, the outcome literature compared to adults is quite limited.
- The rate of relapse with older children is around 40% in the first 6 to 12 months after withdrawal from pharmacological treatment. Need to consider maintenance dosage.
- 60% of youth with MDD show a positive placebo response.
- For a description of treatment guidelines and promising results see Emslie et al. (1997) and Hughes et al. (1999).
- ***“The evidence for the effectiveness of SSRIs compared with placebo in the treatment of depression disorders in children and adolescents is far from compelling.” (Cochrane, 2007 Review of SSRIs and Child and Adolescent Depression)***

Meta-analysis from 17 blind clinical trials comparing fluoxetine with tricyclic antidepressants and placebo showed no significant reductions in suicidal acts as a result of taking antidepressants (Beasley et al. 1992)

The FDA has issued a Black Box warning that antidepressants increase the risk of suicidal thinking and behavior in children and adolescents with major depressive and psychiatric disorders. But this is controversial. Fewer than 20% of adolescents who commit suicide in the U.S. each year are or have ever taken antidepressants.

There is often a synergistic effect between pharmacotherapy and CBT interventions. This is illustrated by the recent TORDIA study.

A study of Treatment of Resistant Depression in Adolescents (TORDIA) was conducted with 334 adolescents diagnosed with MDD who had failed a previous trial of an SSRI. (See Asarnow et al. 2009; Brent et al. 2008; Spiroto et al. 2008). They were enrolled in one of four conditions:

- 1) switch to a second different SSRI (paroxetine, citalopram, fluoxetine)
- 2) switch to a different SSRI plus CBT
- 3) switch to venlafaxine
- 4) switch to venlafaxine plus CBT

The youth had been depressed for at least 2 years before the study entry and they had 17 weeks of previous SSRI treatment and 8 weeks of prior psychotherapy. A high proportion (56%) reported significant suicidality.

Overall, the results support the value of the combination of CBT and medication switch.

“After 12 weeks of care, 55% of youths who received CBT and a new antidepressant showed a substantial clinical response compared to medication switch alone; there were no significant differences in response between classes of medication”
(Weersing & Brent, 2010, p. 134)

Combination treatment showed most superiority over medication monotherapy with depressed adolescents with comorbid disorders (Asarnow et al. 2009; Brent et al., 1997). (See the Services for Teens at Risk- - STAR Program at the Western Psychiatric Institute and Clinic WPIC at the University of Pittsburgh Medical School. Treatment Manuals are available from Dr. David Brent, WPIC, 3811 O’Hara Street, Pittsburgh, PA, 15213).

PREVENTING DEPRESSION AMONG ADOLESCENTS

(See illustrative programs by Arnett, 2000, 2007; Cardemil et al., 2005; Garber, 2006; Gillham et al., 2000; Horowitz & Garber, 2006; Merry et al., 2004a, 2004b; Merry & Spence, 2007; Rapee et al., 2006; Schochet et al., 1997, 2005; Spence et al., 2003, 2005; Weisz et al., 2005; Wolfe et al., 2008; Zimmerman & Brenner, 2010)

1. Prevention programs for adolescent depression have been conducted successfully at the universal level (school-wide) and for targeted youth who are at particular risk of developing depression. Although the selected and indicated programs provide more logistical challenges than universal interventions, their effectiveness (Effect Size) tend to be larger. But, prescreening and case finding procedures can be expensive and time consuming.
2. These prevention programs are conducted on a group basis, usually in gender-specific classes. A special focus has been with adolescent girls (see programs by Stark and Wolfe and their colleagues). In adolescence, the rate of depression in girls is double to triple that of boys. These specific prevention programs for girls focus on such specific topics as body image concerns, sexual pressures, dating violence, mood problems, substance abuse and other high risk behaviors.
3. The target group is usually Grade 9 girls who will receive 8 to 11 sessions of manualized treatment such as the Resourceful Adolescent Program (RAP) (Schochet et al. 2001; Wolfe et al. 2008). These cognitive-behavioral programs include activation, stress recognition, affect regulation skills training, positive thinking, building social support networks, perspective taking, interpersonal problem-solving, and ways to bolster self-

esteem. Wolfe et al. (2008) provides a session-by-session overview of the RAP program and discusses ways to implement such programs in schools.

4. Some illustrative RAP interventions include:
 - a) Having participants build group rapport by having participants play a “get to know you game.” Participants tell one untrue and four true things about themselves and other students have to guess which statements are true and which one is untrue.
 - b) Ask students to identify personal strengths in a variety of domains (creativity, sports, academics, family, etc). Engage in collaborative goal-setting.
 - c) Learning personal bodily clues of distress. “My stress indicators are...”
 - d) Use of handouts, behavior rehearsal, imagery training, role playing and group peer support.
 - e) Use of a “Thought Court,” whereby participants role play examples of negative self-talk. Fellow students select cards that challenge such negative self-talk such as “What is the evidence for...? Any other ways to view that”?
 - f) Use of relaxation response and development of interpersonal problem-solving skills (conflict resolution skills), use of humor and network analysis.
 - g) Ways to deescalate social situations, ways of anticipating possible barriers.
 - h) Have participants create “homework” assignments of what they have learned, (posters, videos), engage in group discussions and teach others.
 - i) Space out treatment and include booster sessions and use reminders of coping skills (see Ogden et al., 1996) and employ Internet follow-up activities.
5. It is critical that such depressive prevention programs should be culturally sensitive and appropriate (Anderson & Mayes, 2010; Bernal, 2009; Cardemil et al., 2010).
6. Prevention programs should include interventions designed to bolster resilience in youth and adults (Goldstein and Brooks, 2005; Reich et al., 2010; Reivich & Schatte, 2002).
7. Although many theorists assumed that adolescence and early adulthood (18-25) was a transition developmental period of “stress and strain,” the evidence indicates that most emerging adults are highly contented, experience increasing well being and feel optimistic about their futures. (Arnett, 2000, 2007). (See www.melissainstitute.org for papers on resilience).

WORKING TOGETHER TO REDUCE ADOLESCENT SUICIDE: A “TO DO” LIST

Donald Meichenbaum, Ph.D.

The following list enumerates a variety of Core Tasks or a “**TO DO**” interventions list designed to reduce adolescent suicide. They are organized by settings: School, Medical, Clinical and Special Needs. How many Core Tasks do you engage in? In which area would you consider yourself an “**EXPERT**”? By the designation of “**EXPERT**,” this means that you know how to conduct this Core Task, can demonstrate or teach others, and have others come to you for consultation. In contrast, which Core Tasks would you consider to be a “**Budding Skill**” for which you would like more information? Which Core Tasks do not apply to your work and you do not want more information, at this time?

A PROPOSAL- - now imagine a Website that you could (1) access or download to your I-Phone, I-Pod; (2) then you could scroll down on an “as-needed basis,” and (3) click that Core Task and obtain information and a video demonstration on how to implement each Core Task designed to reduce Adolescent Suicide. Moreover, consider how such a Website could be Interactive, whereby you can submit to the Website your specific suggestions on how to implement that Core Task, so it can be shared with others.

What additional Core Tasks would you add to this list? Please email suggestions to Don Meichenbaum (dmeich@aol.com).

The Melissa Institute is looking for individuals or organizations to support the development of such a Training Website. **Any supporters out there?**

A “TO DO” LIST OF WAYS TO REDUCE ADOLESCENT SUICIDE

Consider your level of “expertise” in regard to each Core Task. Next to each **TASK** that applies to your setting indicate **E = Expert, BS = Budding Skill, and NA = Not Applicable**.

SCHOOL SETTINGS

- _____ 1. Identify “high risk” students for developing depression and suicidal behaviors.
- _____ 2. Use Screening Self-Report Measures and other indicators.
- _____ 3. Have a referral system in place for identified students.
- _____ 4. Provide school-wide resilience-building activities.
- _____ 5. Provide evidence-based coping with depression course and build in generalization guidelines.
- _____ 6. Educate teachers and other “gate-keepers” about warning signs, referral procedures and myths concerning depression and suicide. Educate them about the adolescents’ “developing brain” and implications.
- _____ 7. Provide students with information about depression and suicide. Raise awareness and train them on how to be of assistance. (*For example, how to ask questions! “I am concerned about you. Are you thinking of hurting yourself? Are you thinking of suicide?”*)
- _____ 8. Incorporate discussion of suicide (facts, myths, Art of questioning, specific information about referral sources). Use role-playing and practice. Use class discussion, drama groups and demonstrations. Focus on Middle-School aged students (Grades 7 and 8).
- _____ 9. Have a drop-in center for students in need.
- _____ 10. Give out pens, have posters with Crisis Hotline numbers, Websites and Internet resources. Use bilingual posters and other information.
- _____ 11. Teach computer literacy skills and responsibility. Combat cyber-bullying and how to avoid Websites that encourage suicidal acts.
- _____ 12. Implement a bully-proof school-wide program, especially be sensitive to sexual orientation issues since gay, lesbian and transgender youth are most high-risk for victimization and suicide.
- _____ 13. Implement an explicit school-wide program to enhance school-connectedness.
- _____ 14. Identify, monitor, and when indicated, refer “high-risk” students to mental health agencies. For example, repeat suicides, students of parents who committed suicide,

victimized students, (PTSD with comorbid problems), students who come from homes of marital conflict, homeless youth, runaways, students who are returning to school after a suicide attempt. Designate a staff member to identify and track such at-risk students and to co-ordinate secondary intervention programs and wrap-around services.

- _____ 15. Establish and maintain a good working relationship with local mental health center.
- _____ 16. Provide mental health services in school such as CBITS- - Cognitive behavior intervention training in schools.
- _____ 17. Include parents in any planned intervention programs. Have a Parent Night on “Meeting Student’s Mental Health Needs.” Indicate on School Website and Newsletter available services and how these can be accessed.
- _____ 18. When a student suicide occurs, be careful about possible contagion effects. Conduct a network analysis of the suicidal student and identify other potential “high-risk” students.
- _____ 19. Following a student or faculty suicide be cautious in how you conduct postventions. (Provide information and combat rumours; do not sensationalize the death; attribute suicide to the presence of a psychiatric disorder such as depression and not to cumulative stress that many students experience; consider how best to honor the suicidal individual). (*See **FMHI Youth Suicide Prevention School-based guide***)
- _____ 20. Provide support to students and staff who were most impacted by the loss (See work on treatment of complicated grief reactions).
- _____ 21. Provide training and resources for staff on ways to address needs of depressed and suicidal students. Educate them about Social media Internet resources. Include a Professional Developmental Training on “Meeting the Mental Health Needs of Our Students.”
- _____ 22. Work with the media on how they should cover the story of a suicide in your school.
- _____ 23. Work with the School District to collect data on student mental health needs and collect and report data on the effectiveness of these interventions. School Superintendent should collect data on the degree of “Expertise” for each school. How many of Core Tasks are available in each school?
- _____ 24. What other Core Tasks should be added to this List for School Settings?
- a) _____
- b) _____

(Please e-mail suggestions to dhmeich@aol.com)

MEDICAL SETTINGS

- _____ 25. Train Primary Doctors and other gate-keepers on the warning signs, Screening Questions, assessment tools, Motivational Interviewing Questions for working with adolescents who are depressed and evidence suicidal potential. Include a discussion of epidemiological data, comorbid disorders, referral information, value of synergistic treatment approaches of psychotropic medication and psychotherapy, myths concerning suicide, the research on the adolescent's "developing brain" and the treatment implications.
- _____ 26. Provide detailed referral resources and ensure follow up and follow-through. (Most students in need never receive treatment and evidence non-adherence to medication).
- _____ 27. When prescribing antidepressant medication conduct adherence counselling procedures, involve parents, monitor side-effects and conduct follow-up assessments.
- _____ 28. In the Emergency Room, the medical team should conduct interventions with suicidal youth and their parents. Educate and engage parents in ways to implement a Safety Plan (remove guns, pills, monitor warning signs, use referral sources).
- _____ 29. When indicated, hospitalize suicidal youth and implement a collaborative treatment program. Ensure safety, while hospitalized and when discharged.
- _____ 30. Provide psychotherapeutic interventions, such as CBT, to depressed youth who have chronic physical illnesses.
- _____ 31. What other Core Tasks should be added to this list of Medical Settings?
- a) _____
- b) _____

(Please e-mail suggestions to dhmeich@aol.com)

CLINICAL SETTINGS

- _____ 32. With referred youth use a multigating assessment approach and a Comprehensive Case Conceptualization Model with accompanying feedback procedures.
- _____ 33. Assess explicitly for suicidality and the presence of comorbid disorders.
- _____ 34. Use treatment engagement strategies and Motivational Interviewing procedures with both referred youth and their parents.
- _____ 35. Engage in Collaborative treatment goal-setting and monitor progress.
- _____ 36. Use evidence-based treatments (Individual, Group, Family, Home-based psychotherapeutic approaches).

- ___ 37. Build in session-by-session feedback from youth and parents for both the client and the therapist to inform treatment decision-making.
- ___ 38. Conduct treatment in a culturally and gender-sensitive fashion. Consider sexual orientation issues.
- ___ 39. Be sensitive to developmental issues such as changes to youth's "developing brain."
- ___ 40. Conduct adherence counselling, if medication is prescribed.
- ___ 41. Be sure to include parent education, participation, and where indicated, refer parents who are "in need."
- ___ 42. Connect back with the school and help with student transition, especially after a suicide attempt.
- ___ 43. How many of the following clinical skills do you feel "Expert" at implementing and for which do you want further skills training? (**E = Expert, BS = Budding Skill**)
- ___ 1. Develop, monitor, and repair "ruptures" in therapeutic alliance with youth and their parents.
 - ___ 2. Use treatment engagement strategies and motivational interviewing techniques.
 - ___ 3. Conduct suicide assessment, and where indicated, crisis management.
 - ___ 4. Assess for comorbid disorders. Conduct a developmental behavior chain analysis.
 - ___ 5. Assess for strengths and potential barriers.
 - ___ 6. Use a Case Conceptualization Model and provide feedback.
 - ___ 7. Use Time Lines and Collaborative Goal-setting as ways to nurture hope. Use a Hope Kit.
 - ___ 8. Use a Safety Plan, Informed Consent, (Do not use Behavioral Contracts to not harm oneself).
 - ___ 9. Assess for possible parent involvement in terms of psychoeducation, parent participation in treatment and family therapy.
 - ___ 10. Provide psychoeducation to youth and parents about the interconnections between feelings, thoughts and behaviors.
 - ___ 11. Use Pleasant Activity Scheduling and Behavioral Activation Procedures.
 - ___ 12. Teach skills in a gender, developmental and culturally-sensitive manner. Note the variety of skills to be addressed such as emotion-regulation, distress tolerance, problem-solving, social and communication skills, parent conflict resolution, and the like.
 - ___ 13. Build in Generalization Guidelines to increase the likelihood of transfer and maintenance of treatment efforts. Provide home-based interventions.
 - ___ 14. Conduct Cognitive Restructuring Procedures. Use of Coping Cards and related procedures.
 - ___ 15. Ensure training occurs in an experiential and engaging manner (e.g. "Hot Seat," Metaphor, role-playing, movie-making, etc.).

- ___ 16. Treat the presence of comorbid disorders in an integrated fashion (e.g., PTSD, Substance Abuse, Anxiety Disorder, Conduct Disorder, Borderline Personality Disorder, Serious Mental Disorders like Bipolar and Schizophrenia).
- ___ 17. Conduct Relapse Prevention procedures.
- ___ 18. Provide ongoing telephone consultation and follow-through.
- ___ 19. Provide support and consultation to therapists who work with depressed and suicidal patients.
- ___ 20. Use Additional Resources
(See Websites and Reference Section for Treatment Manuals)

- ___ 44. What other Core Tasks should be added to this list of Clinical Settings?
- a) _____
- b) _____

(Please e-mail suggestions to dhmeich@aol.com)

SPECIAL NEEDS SETTINGS

- ___ 45. Juvenile Justice Setting. Screen for depression, suicidality and comorbid disorders. Monitor carefully for safety and ongoing risk assessment. Refer for evidence-based Treatments.
- ___ 46. Overlooked Populations- Latino youth, homeless youth, run-away youth. Implement an active out-reach program. Use peer-based interventions.
- ___ 47. Native American Populations- - work with cultural groups and use cultural traditions and heritage. Use American Indian Life Skills Training Curriculum.
- ___ 48. What other Core Tasks should be added to this list of Special Needs Settings?
- a) _____
- b) _____

(Please e-mail suggestions to dhmeich@aol.com)

TEST YOUR KNOWLEDGE ABOUT ADOLESCENCE

Answer each question by circling True (T) or False (F)

- T. F.** 1. Normal adolescent development is a tumultuous period of “storm and stress”
- T. F.** 2. Puberty is a negative event for most adolescents.
- T.F.** 3. The adolescent’s brain is fully developed.
- T.F.** 4. Adolescent thought is childlike.
- T. F.** 5. The vast majority of adolescents have negative feelings toward their parents.
- T.F.** 6. The majority of adolescents evidence mental health problems.
- T.F.** 7. One cannot trust the accuracy, nor the reliability of adolescent’s self-report.
- T.F.** 8. Adolescents prefer to share personal information with their parents, rather than self-disclose this material to their peers.
- T.F.** 9. Adolescence is a uniform developmental process from ages 11 to 18.
- T.F.** 10. Psychotherapy with youth has proven ineffective.

(See the end of the Reference Section for Correct Answers)

References

- AACAP (1998). Practice parameters for the assessment and treatment of children and adolescents with depressive disorders. Journal of American Academy of Child and Adolescent Psychiatry, 37, Suppl: 63-83.
- Abela, J.R., & Hankin, B.L. (Eds.), (2008). Handbook of depression in children and adolescents. New York: Guilford Press.
- Ackerson, J., Scogin, F., McKendrea-Smith, N., & Lyman, R. D. (1998). Cognitive bibliotherapy for mild and moderate adolescent depressive symptomatology. Journal of Consulting and Clinical Psychology, 66, 685-690.
- American Association of Child and Adolescent Psychiatry (AACAP). (1998). Practice parameters for the assessment and treatment of children and adolescents with depressive disorder. Journal of the American Academy of Child and Adolescent Psychiatry, 37, 63-83.
- American Medical Association (2003). Major depressive disorder in primary care. (For copies contact Dr. Mark Evans, AMA, 515 N. State St., Chicago, IL 60610).
- Anderson, E.R., & Mayes, L.C. (2010). Race/ethnicity and internalizing disorders in youth: A Review. Clinical Psychology Review, 30, 338-348.
- Angold, S., Costello, E. J., Messer, S. C., et al. (1995). Development of a short questionnaire for use in epidemiological studies of depression in children and adolescents. International Journal of Methods of Psychiatric Research, 5, 237-249.
- Appleby, L., Shaw, J., et al., (1991). Suicide within 12 months of contact with mental health services: National clinical survey. British Medical Journal, 318, 1235-1239.
- Arnett, J.J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. American Psychologist, 55, 469-480.
- Arnett, J.J. (2007). Suffering, selfish, slackers? Myths and reality about emerging adults. Journal of Youth and Adolescence, 55, 469-480.
- Asarnow, J.R., Berk, M., Navarro, M.D., & Huey, S. (2006). The Safety Program: Ecological cognitive-behavioral intervention for adolescent suicide attempters. Los Angeles; CA: UCLA School of Medicine.
- Asarnow, J.R., Berk, M., Sudolath, R. & Huey, S. (2010). The SAFETY Program: A crisis intervention program for adolescent suicide attempters. Unpublished Treatment Manual. UCLA.
- Asarnow, J. R., Carlson, G.A., Shuster, M. et al. (1999a). Youth partners in care: A guide for primary care providers and care managers. Santa Monica, CA: Rand.
- Asarnow, J. R., & Carlson, G. A. (1985). Depression self-rating scale: Utility with child psychiatric inpatients. Journal of Consulting and Clinical Psychology, 53, 491-499.
- Asarnow, J., Carlson, G., Schuster, M. et al. (2007). Youth Partners in Care: Clinician Guide to Depression Assessment and Management among Youth in Primary Care Settings: UCLA.
- Asarnow, J. R., Clarke, G., Hops, H., Jaycox, L., Levisohn, P., & Rhode, P. (1999b). Stress and your mood: A manual for groups. Los Angeles: UCLA Neuropsychiatric Institute.
- Asarnow, J.R., Emslie, G.J., Clarke, et al. (2009). Treatment of SSRI-Resistant Depression in Adolescents (TORDIA): Predictors and moderators of treatment response. Journal of the American Academy of Child and Adolescent Psychiatry, 48, 330-335.
- Asarnow, J. R., Goldstein, M. J., et al. (1993). One-year outcomes of depressive disorder in child psychiatric inpatients: Evaluation of the prognostic power of a brief measure of

- expressed emotion. Journal of Child Psychology and Psychiatry, 34, 129-137.
- Asarnow, J.R., Jaycox, L.H. et al. (2005a). Effectiveness of quality improvement intervention for adolescent depression in primary care clinics. A randomized controlled trial. Journal of the American Medical Association, 293, 311-319.
- Asarnow, J.R., Jaycox, L.H. et al. (2005b). Long-term benefits of short-term quality improvement interventions for depressed youths in primary care. American Journal of Psychiatry, 466, 1002-1010.
- Asarnow, J. R., Jaycox, L. H., & Tompson, M. C. (2001). Depression in youth: Psychosocial interventions. Journal of Clinical Child Psychology, 30, 33-47.
- Asarnow, J.R., Scott, C.W., & Mintz, J. (2002). A combined cognitive-behavioral family education intervention for depressed children: A treatment development study. Cognitive Therapy and Research, 26, 221-229.
- Asarnow, J. R., Tompson, M. et al. (1994). Family expressed emotion, childhood-onset depression and childhood-onset schizophrenia spectrum disorders. Journal of Abnormal Child Psychology, 22, 129-146.
- Bagge, C.L. & Sher, K.J. (2008). Adolescent alcohol involvement and suicide attempts: Toward the development of a conceptual framework. Clinical Psychology Review, 28, 1283-1296.
- Barrett, P.M., Farrell, L.J. et al. (2006). Long-term outcomes of an Australian universal prevention trial of anxiety and depression symptoms in children and youth: An evaluation of the friends program. Journal of Clinical Child and Adolescent Psychology, 35, 403-411.
- Bearman, S.K., Ugeto, A., Alleyne, A., & Weiz, J.R. (2010). Adapting cognitive-behavioral therapy for depression to pit diverse youths and contexts. Applying the Deployment-focused Model of treatment development and testing. In J.R. Weisz & A.E. Kazden (Eds.), Evidence-based psychotherapies for children and adolescents. (pp. 466-481). New York: Guilford Press.
- Beasley, C.M., Dornseif, B.E. et al. (1992). Fluoxetine and suicide: A meta-analysis of controlled trials of treatment for depression. International Clinical Psychopharmacology, 6, 35-57.
- Belsher, G. & Wilkes, T. C. (1994). Ten key principles of adolescent cognitive therapy. In T. C. Wilkes, G. Belsher, A. J. Rush & E. Frank (Eds.), Cognitive therapy for depressed adolescents. (pp. 22-44). New York: Guilford Press.
- Berk, M.S., Henriques, G.R. et al. (2004). A cognitive therapy intervention for suicide attempters: An overview of treatment and case examples. Cognitive and Behavioral Practice, 11, 265-277.
- Berman, A.L., Jobes, D.A. & Silverman, M.M. (2005). Adolescent Suicide: Assessment and intervention. Washington, DC: APA.
- Berrman, L. (2010). I know this much is true. Independent Practitioner, 30, 15-17.
- Bernal, G. (2009). Treatment Manual for Depressed Puerto Rican Youth. (<http://ipsi.uprrp.edu/recursos.html>)
- Bertolino, B. (2003). Change-oriented therapy with adolescents and young adults. New York: W. W. Norton.
- Birmaher, B. & Brent, B. (1998). Practice parameters for the assessment and treatment of children and adolescents with depressive disorder. Journal of American Academy of Children and Adolescent Psychiatry, 37, 63-83.
- Birmaher, B., Brent, D. A. & Benson, R. S. (1998). Summary of the practice parameters for the

- assessment and treatment of children and adolescents with depressive disorders. Journal of the American Academy of Child and Adolescent Psychiatry, *37*, 1234-1238. (*See also www.acap.org/clinical/depress*)
- Birmaher, B., Ryan, N. D., Williamson, D. et al. (1996). Childhood and adolescent depression: A review of the past 10 years. Journal of American Academy of Child and Adolescent Psychiatry, *35*, 1427-1439.
- Bongar, B., & Stolberg, R. (2009). Risk management with the suicidal patient. The Register Report, *35*, 10-17.
- Bradley, J., & Rotheram-Borus, M. J. (1990). Evaluation of imminent danger for suicide. Oklahoma City, OK: National Resource Center for Youth Services.
- Braswell, L., Kendall, P. C. et al. (1985). "Involvement" in cognitive-behavior therapy with children: Processes and its relationship to outcome. Cognitive Therapy and Research, *9*, 6-11.
- Brent, D. A., Baugher, M., Birmaher, B. et al. (2000). Compliance with recommendations to remove firearms in families participating in a clinical trial for adolescent depression. Journal of American Academy of Clinical and Adolescent Psychiatry, *39*, 1220-1226.
- Brent, D.A., Emslie, G., Clarke, G. et al., (2008). Switching to another SSRI or to venlafaxine with or without cognitive behaviour therapy for adolescents with SSRI-resistant depression: The TORDIA randomized controlled trial. Journal of the American Medical Association, *299*, 901-913.
- Brent, D. A., Holder, D., Kolko, D. et al. (1997). A clinical psychotherapy trial for adolescent depression comparing cognitive, family and supportive therapy. Archives of General Psychiatry, *54*, 877-885.
- Brent, D. A., & Perper, J. A. (1995). Research in adolescent suicide: Implications for training, service delivery, and public policy. Suicide and Life-Threatening Behavior, *25*, 222-230.
- Brown, G.K., Have, T.T., Henriques, G.R. et al., (2005). Cognitive therapy for the prevention of suicide attempts: A randomized controlled trial. Journal of American Medical Association, *294*, 563-570.
- Brown, J.S., Meadows, S.O., & Elder, Y.H. Jr. (2007). Race-ethnic inequality and psychological distress: Depressive symptoms from adolescence to young adulthood. Developmental Psychology, *43*, 1295-1311.
- Brown, R. T., & Sammons, M. (2002). Pediatric psychopharmacology: A review of new developments and recent research. Professional Psychology, *33*, 135-14
- Burlingam, G.M., Wells, M.G., & Lambert, M.J. (1996). They Youth Outcome Questionnaire, Stevenson, MD: American Professional Credentialing Service.
- Burns, B.J., Fisher, S.K., Ganju, V. at al. (2008). A guide for selecting and adopting evidence-based practices for children and adolescents with disruptive behavior disorder. Rockville, MD: SAMHSA.
- Callahan, J. (1996). Negative effects of a school suicide postvention program: A case example. Crisis, *17*, 5-12.
- Cardemil, E.V., Kim, S., Pinedo, I.M., & Miller, D.W. (2005). Developing a culturally appropriate depression prevention program. The Family Coping Skills Program. Cultural Diversity and Ethnic Minority Psychology, *11*, 99-112.
- Cardemil, E.V., Kim, S., et al., (2010). Developing culturally appropriate depression prevention

- program: Opportunities and challenges. Cognitive and Behavioral Practice, *17*, 188-197.
- Carlson, G. A. (1994). Adolescent bipolar disorder: Phenomenology and treatment implications. In W. M. Reynolds, & H. F. Johnston (Eds.), Handbook of depression in children and adolescents. (pp. 41-60). New York: Plenum Press.
- Carlson, G. A. (2000). The challenge of diagnosing depression in childhood and adolescence. Journal of Affective Disorders, *61*, 3-8.
- Caspi, A., Sugden, K. et al., (2003). Influences of life stress on depression: Moderation by polymorphism on the 5-HTT gene. Science, *301*, 386-388.
- Chagnon, F., Houle, J., Marcoux, J., & Renaud, J. (2007). Control-group study of an intervention training program for youth suicide prevention. Suicide and Life-threatening Behavior, *37*, 135-144.
- Chorpita, B.F., Daleiden, E., & Weisz, J.R. (2005). Modularity in the design and application of interventions. Applied and Preventive Psychology, *11*, 141-156.
- Chorpita, B.F., Yim, L.M. et al. (2002). Toward large-scale implementation of empirically supported treatments for children: A review and observation by the Hawaii Empirical Basis to Service Task Force: Clinical Psychology: Science and Practice, *9*, 165-190.
- Choquet, M., & Menke, H. (1989). Suicidal thoughts during early adolescence: Prevalence, associated troubles and help-seeking behavior. Acta Psychiatrica Scandinavica, *81*, 170-77.
- Chu, B.C., Colognori, D., Weissman, A.S. & Banner, K. (2009). An initial description and pilot of group Behavioral Activation theory for anxious and depressed youth. Cognitive and Behavioral Practice, *16*, 408-419.
- Cicchetti, D., & Toth, S. L. (1998). The development of depression in children and adolescents. American Psychologist, *53*, 221-241.
- Clarke, G.N. & Debar, L.L. (2010). Group cognitive-behavioral treatment for adolescent depression. In J.R. Weisz, & A.E. Kazdin (Eds.), Evidence-based psychotherapies for children and adolescents. (pp. 110-125). New York: Guilford Press.
- Clarke, G. N., Hops, H., Lewishohn, P. M., Andrews, J., Seeley, J. R. & Williams, J. (1992). Cognitive-behavioral group treatment of adolescent depression: Prediction of outcome. Behavior Therapy, *23*, 341-354.
- Clarke, G. N., Hornbrook, M., Lynch, F. et al. (2001). A randomized trial of a group cognitive intervention for preventing depression in adolescent offsprings of depressed parents. Archives of General Psychiatry, *58*, 1127-1134.
- Clarke, G.N., Hornbrook, M., Lynch, F. et al., (2002). Group cognitive-behavioral treatment for depressed adolescent offspring of depressed in health maintenance organization. Journal of the American Academy of Child and Adolescent Psychiatry, *41*, 305-313.
- Clarke, G.N., Lewishohn, P.M., Hops, H. & Seeley, H. (1990). Adolescent coping with depression course. Eugene, OR: Castalia Press.
- Cohen, J., & Campbell, S. (1992). Influence of maternal depression on infant affect regulation. In D. Cicchetti & S. L. Toth (Eds.), Developmental perspectives on depression. (Vol. 4, pp. 103-130). Rochester: University of Rochester Press.
- Compas, B. E. (1997). Depression in children and adolescents. In E. J. Mash & L. G. Terdal (Eds.), Assessment of childhood disorders. (3rd ed., pp. 190-229). New York: Guilford Press.
- Compas, B. E., & Oppedisano, G. (2000). Mixed anxiety/depression in childhood and adolescence. In A. J. Sameroff, M. Lewis, & S. M. Miller (Eds.), Handbook of

- developmental psychopathology. New York: Kluwer Academic/Plenum Publishers. (pp. 467-490).
- Compton, S.N., March, J., Brent, D. et al. (2004). Cognitive-behavioral psychotherapy for anxiety and depressive disorders in children and adolescents: An evidence-based medicine review. Journal of American Academy of Child and Adolescent Psychiatry, *43*, 930-989.
- Conner, J. (2009). Predicting adolescent suicidality: Comparing multiple informants and assessment techniques. Journal of Adolescence, *32*, 619-631.
- Cooper, J., Kapur, N., et al (2005). Suicide after deliberate self-harm: A 4-year cohort study. American Journal of Psychiatry, *162*, 279-303.
- Cotgrove, A., Zirinsky, L., Black, D., & Wesson, D. (1995). Secondary prevention of attempted suicide in adolescence. Journal of Adolescence, *18*, 569-577.
- Cross, W., Matthieu, M., Cerel, J., & Knox, K. (2007). Proximate outcomes of gatekeeper training for suicide prevention in the workplace. Suicide and Life-threatening Behavior, *37*, 659-670.
- Cuijpers, P. (1998). A psychoeducational approach to treatment of depression: A meta-analysis of Lewinsohn's "Coping with depression" course. Behavior Therapy, *29*, 521-523.
- Curry, J.F., Wells, K.C., Brent, D.A., & TADS Team (2000). Treatment for Adolescents with Depression Study (TADS): Cognitive Behavioral Therapy Manual. Duke University Medical School.
http://trialweb.dcri.duke.edu/tads/tad/manual/TADS_CBT.pdf
- Dahl, R.E., & Spear, L.P. (Eds.) (2004). Adolescent brain development: Vulnerabilities and opportunities. New York: New York Academy of Sciences.
- Dennis, M., Godley, S.H. et al. (2004). The Cannabis Youth Treatment (CYT) Study: Main findings from two randomized trials. Journal of Substance Abuse Treatment, *27*, 197-213.
- Depression Guideline Panel. (1993). Clinical practice guideline, Number 5. Depression in primary care. Volume 2. Treatment of major depression. AHCPR Publication No. 93-0551. Rockville: USHSA.
- Diamond, G., & Josephson, A. (2005). Family-based treatment research: A 10 year update. Journal of American Academy of Child and Adolescent Psychiatry, *44*, 872-890.
- Diamond, G.S., Reis, B.F. et al. (2002). Attachment-based family therapy for depressed adolescents: A treatment development study. Journal of the American Academy of Child and Adolescent Psychiatry, *41*, 1190-1196.
- Dierker, L. C., Albano, A. M., Clarke, G. N. et al. (2001). Screening for anxiety and depression in early adolescence. Journal of American Academy of Child and Adolescent Psychiatry, *40*, 929-936.
- Doan, J., Roggenbaum, S., & Lazear, K. (2003). Youth Suicide Prevention School-based Guide. University of South Florida.
- Dodge, K. A. (1993). Social-cognitive mechanisms in the development of conduct disorder and disorder. Annual Review of Psychology, *44*, 559-584.
- Dowell, K.A. (2010). The effects of parent participation on child psychotherapy outcome: A meta-analytic review. Journal of Clinical Child and Adolescent Psychology, *39*, 151-162.
- Downey, G., & Coyne, J. C. (1990). Children of depressed parents: An integrative review. Psychological Bulletin, *108*, 50-76.

- Dujovnic, V. F., Barnard, M. U., & Rapoff, M. A. (1995). Pharmacological and cognitive-behavioral approaches in the treatment of childhood depression: A review and critique. Clinical Psychology Review, *7*, 589-611.
- Ellis, T.E. & Newman, L.F. (1996). Choosing to live: How to detect suicide through cognitive therapy. Oakland, CA: New Harbinger.
- Emslie, G. J., Heiligenstein, J. H., Wagner, K. D. et al. (2002). Fluoxetine for acute treatment of depression in children and adolescents: A placebo-controlled randomized clinical trial. Journal of American Academy of Child and Adolescent Psychiatry, *41*, 1205-1215.
- Emslie, G. S., Rush, A. J., Weinberg, W. A. et al. (1997). A double-blind randomized, placebo-controlled trial of fluoxetine in children and adolescents with depression. Archives of General Psychiatry, *54*, 1031-1037.
- Farrell, L.J. & Barrett, P.M. (2007). Prevention of childhood emotional disorders. Reducing the burden of suffering associated with anxiety and depression. Child and Adolescent Mental Health, *12*, 58-65.
- Ferguson, D. M., Horwood, L. J., & Beautrais, A. L. (1999). Is sexual orientation related to mental health problems and suicidality in young people? Archives of General Psychiatry, *56*, 612-622.
- Ferguson, D.M., & Woodward, L.J. (2002). Mental health education and social role outcomes of adolescents with depression. Archives of general Psychiatry, *59*, 225-231.
- Field, T. (2002). Infants of depressed mothers. Development and Psychopathology, *4*, 49-66.
- Flannery-Schroeder, E.C. (2006). Reducing anxiety to prevent depression. American Journal of Prevention Medicine, *31*, 136-142.
- Fleming, J. E., & Offord, D. R. (1990). Epidemiology of childhood depressive disorders: A critical review. Journal of American Academy of Child and Adolescent Psychiatry, *29*, 571-580.
- Friedberg, R.R., & McClure, J.M. (2002). Clinical practice of cognitive therapy with children and adolescents. New York: Guilford Press.
- Fristad, M., & Shaver, A. E. (2001). Psychosocial intervention for suicidal children and adolescents. Depression and Anxiety, *14*, 192-197.
- Garber, J. (2000). Development and depression. In A. J. Sameroff, M. Lewis, & S. M. Miller (Eds.), Handbook of developmental psychopathology. New York: Kluwer Academic/Plenum Publishers. (pp. 467-490).
- Garber, J. (2006). Depression in children and adolescents: Linking risk research and prevention. American Journal of Preventive Medicine, *31*, 104-125.
- Garber, J., & Hilsman, R. (1992). Cognitions, stress, and depression in children and adolescents. Child and Adolescent Psychiatric Clinics of North America, *1*, 129-167.
- Geller, B., & Luby, J. (1997). Child and adolescent bipolar disorder: A review of the past 10 years. Journal of American Academy of Child and Adolescent Psychiatry, *36*, 1168-1176.
- Geller, B., Reising, D., Leonard, H. L. et al. (1999). Critical review of tricyclic antidepressant use in children and adolescents. Journal of American Academy of Child and Adolescent Psychiatry, *38*, 513-576.
- Gillham, J. E., Shatte, H. J., Freres, D. R. (2000). Preventing depression: A review of cognitive-behavioral and family interventions. Applied and Preventative Psychology, *9*, 63-88.
- Gladstone, T. R., & Kaslow, N. J. (1995). Depression and attributions in children and adolescents: A meta-analytic review. Journal of Abnormal Child Psychology, *23*, 597-606.

- Godley, S.H., Meyers, R.J. et al. (2001). The adolescent community reinforcement approach for adolescent cannabis users. Cannabis youth treatment (CYT) Vol. 4. DHHS Pub. No. (SMA) 07-3864. Rockville, MD. Center for Substance Abuse.
- Goldstein, D.B., Moloch, S.D. et al. (2008). Cultural considerations in adolescent suicide and psychosocial treatment. American Psychologist, *63*, 14-31.
- Goldstein, S., Brooks, R. (Eds.) (2005). Handbook of resilience in children. New York: Kluwer Academic/Plenum Press.
- Goodman, S., & Gotlib, I. (1999). Risk for psychopathology in the children of depressed mothers: A developmental model for understanding mechanics of transmission. Psychology Review, *106*, 458-490.
- Gotlib, I. H., & Hammen, C. L. (1992). Psychological aspects of depression: Toward a cognitive-interpersonal integration. Chichester, UK: Wiley.
- Gottlib, I.H., & Hammen, C.L. (Eds.) (2002). Handbook of depression. New York: Guilford Press.
- Gould, M. S., & Kramer, R. A. (2001). Youth suicide prevention. Suicide Life-Threatening Behavior, *31*, 6-31.
- Greco, L. A., & Eifert, G. H. (2004). Treating parent-adolescent conflict: Is acceptance the missing link of the integrative family therapy? Cognitive and Behavioral Practice, *11*, 305-314.
- Gruttadaro, D., Burns, B., Duckworth, K., & Cruda, D. (2007). Choosing the right treatment: What families need to know about evidence-based practices. Arlington, VA: National Alliance on Mental Illness.
- Gunlicks, M.L. & Weissman, M.M. (2008). Change in child psychopathology with improvement in parental depression: A systemic review. Journal of American Academy of Child and Adolescent Psychiatry, *47*, 379-389.
- Hains, A.A. & Ellmann, S.W. (1994). Stress inoculation training as a preventative intervention for high school youths. Journal of Cognitive Psychotherapy, *8*, 219-232.
- Hains, A.A., & Szyjakowski, M. (1990). A cognitive stress reduction intervention program for adolescents. Journal of Counselling Psychology, *37*, 79-84.
- Hammen, C. L. (1991). Depression runs in families: The social context of risk and resilience in children of depressed mothers. New York: Springer-Verlag.
- Hammen, C. L. (1992). Cognitive, life stress, and interpersonal approaches to a developmental psychopathology model of depression. Development and Psychopathology, *4*, 189-206.
- Hammer, C., Burge, D., & Adrian, C. (1991). Timing of mother and child depression in a longitudinal study of children at risk. Journal of Consulting and Clinical Psychology, *59*, 291-298.
- Harrington, R., Whitaker, J., & Shoebridge, P. (1998). Psychological treatment of depression in children and adolescents. British Journal of Psychiatry, *173*, 291-298.
- Henggeler, S.W., Schoenwald, S.K., & Rowland, M.D. (2002). Multisystemic treatment of children and adolescents with serious emotional disturbance. New York: Guilford Press.
- Hicks, B. A. (1990). Youth suicide: A comprehensive manual for prevention and intervention. Bloomington, IN: National Educational Service.
- Hodges, K. (2000). Child and adolescent functional assessment scale (2nd ed.). Ypsilanti: Eastern Michigan University.
- Horowitz, J.L., & Garber, J. (2000). The prevention of depression symptoms in children and adolescents. A meta-analytic review. Journal of Consulting and Clinical Psychology, *74*, 401-415.
- Huey, S.J., Henggeler, S.W. et al. (2004). Multisystemic-therapy effects on attempted suicide by

- youths presenting psychiatric emergencies. Journal of the American Academy of Child and Adolescent Psychiatry, 43, 183-190.
- Hughes, C. W., Emslie, G. J. et al. (1999). Texas Children's Medication Algorithm Project: Treatment of childhood major depressive disorder. Journal of American Academy of Child and Adolescent Psychiatry, 38, 1442-1454.
- Jacobs, D., & Brewer, M. (2004). APA guidelines provides recommendations for assessing and treating patients with suicidal behaviors. Psychiatric Annals, 34, 373-380.
- Jacobson, A. et al., (1994). Interviewing prepubertal children about suicidal ideation and behaviour. Journal of The American Academy of Child and Adolescent Psychiatry, 33, 439-451.
- Jacobson, C.M., & Mufson, L. (2010). Treating adolescent depression using interpersonal psychotherapy. In J.R. Weisz & A.E. Kazden (Eds.), Evidence-based psychotherapies for children and adolescents. (pp. 140-158). New York: Guilford Press.
- Jaycox, L. (2004). Cognitive behavioral intervention for trauma in schools. Longmont, CO: Sopris West Educational Service.
- Jayson, D., Wood, A., Kroll, L. et al. (1998). Which depressed patients respond to cognitive-behavioral treatment? Journal of the American Academy of Child and Adolescent Psychiatry, 37, 35-39.
- Jensen, P.S., Hoagwood, K.E. (Eds.) (2008). Improving children's mental health through parent empowerment. New York: Oxford University Press.
- Jobes, D.A. (2006). Managing suicidal risk: A collaborative approach. New York: Guilford Press.
- Johnson, J. G., Harris, E. S., Spitzer, R. L., & Williams, J. B. (2002). The Patient Health Questionnaire for Adolescents. Journal of Adolescent Health, 30, 196-204. (Also see www.depression-primarycare.org/clinicians/other_resources)
- Joiner, T.E. (2005). Why people die by suicide. Cambridge, MA: Harvard University Press.
- Joiner, T.E. (2010). Myths about suicide. Cambridge, MA: Harvard University Press.
- Joiner, T. E., & Wagner, K. D. (1995). Attributional style and depression in children and adolescents: A meta-analytic review. Clinical Psychology Review, 15, 777-798.
- Karver, M.S., Handelsmen, J.B., Fields, S., & Bickman, L. (2005). A theoretical model of common process factors in youth and family therapy. Mental Health Services Research, 17, 35-51.
- Kaslow, N. J., Adamson, L. B., & Collins, M. H. (2000). A developmental psychopathology perspective on the cognitive components of child and adolescent depression. In A. J. Sameroff, M. Lewis, & S. M. Miller (Eds.), Handbook of developmental psychopathology. New York: Kluwer Academic/Plenum Publishers. (pp. 491-510)
- Kaslow, N. J. & Thompson, M. P. (1998). Applying the criteria for empirically supported treatments to studies of psychosocial interventions for child and adolescent depression. Journal of Clinical Child Psychology, 27, 146-155.
- Kaufman, J., Yang, B.Z. et al., (2004). Social support and serotonin transport gene moderate depression in maltreated children. Proceedings of the National Academy of Science USA, 101, 17316-17321.
- Kazak, A.E., Hoagwood, K., Weisz, J.R., Hood, K., Kratchwill, T.R., Vargas, L.A., Banez, G.S. (2010). A meta-systems approach to Evidence-based Practice for children and adolescents. American Psychologist, 65, 85-97.
- Kazdin, A. E. (1990). Childhood depression. Journal of Child Psychology and Psychiatry, 31, 121-160.

- Kazdin, A. E., Rodgers, A., Colbus, D. (1986). The Hopelessness Scale for Children: Psychometric characteristics and concurrent validity. Journal of Consulting and Clinical Psychology, 54, 242-245.
- Kellam, S. G. (1990). Developmental epidemiological framework for family research on depression and aggression. In G. R. Patterson (Ed.), Depression and aggression in family interaction. Hillsdale, NJ: Erlbaum.
- Kellam, S. G., Anthony, J. C. et al. (1989). Prevention research on early risk behaviors in cross-cultural studies. In M. H. Schmidt & H. Renschmidt (Eds.), Needs and prospects of child and adolescent psychiatry. Hogrefe & Huber: Toronto.
- Kelley, I. D., Bickman, L., & Norwood, E. (2009). Evidence-based treatments and common factors in youth psychotherapy. In B.L. Wampold & M.A. Hubble (eds.), The heart and soul of change. (2nd Ed.). (pp. 325-358). Washington, DC: American Psychological Association.
- Kendall, P. C., Stark, K. D., & Adam, T. (1990). Cognitive deficit or cognitive distortion in childhood depression. Journal of Abnormal Psychology, 18, 255-270.
- Kendler, K.S., Kuhn, J.W. et al., (2005). The integration of stressful life events and a serotonin transporter polymorphism in the prediction of episodes of major depression. A replication. Archives of General Psychiatry, 62, 529-535.
- Kleespies, P. M., Dileppo, J. D. et al. (1999). Managing suicidal emergencies: Recommendations for the practitioner. Professional Psychology, 30, 454-463.
- King, C. A. (1997). Suicidal behavior in adolescence. In R. Maris, M. Silverman, & S. Canetto. (Eds.), Review of suicidology. (pp. 61-95). New York: Guilford Press.
- Kiselica, M.S., Baker, S.B. et al. (1999). Effects of stress inoculation training on anxiety, stress and academic performance among adolescents. Journal of Counseling Psychology, 41, 335-342.
- Kleespies, P. (1998). Emergencies in mental health practice: Evaluation and management. New York: Guilford.
- Klimes-Dougan, B. (1998). Screening for suicidal ideation in children and adolescents: Methodological considerations. Journal of Adolescence, 21, 1-10.
- Klomek, A.B., Sourander, A. et al. (2009). Childhood bullying behaviors as a risk for suicide attempts and completed suicides: A population-based birth cohort study. Journal of American Child and Adolescent Psychiatry, 48, 237-239.
- Kovacs, M. (1986). A developmental perspective on methods and measures in the assessment of depressive disorders. In M. Rutter, C. Izard, & P. Read (Eds.), Depression in young people. New York: Guilford Press. (pp. 435-465).
- Kovacs, M. (1997). Depressive disorders in childhood: An impressionistic landscape. Journal of Child Psychology and Psychiatry, 38, 287-298.
- Kovacs, M., & Feinberg, T L., et al. (1984a). Depressive disorders in childhood. I: A longitudinal prospective study of characteristics and recovery. Archives of General Psychiatry, 41, 229-237.
- Kovacs, M., Feinberg, T. L. et al. (1984b). Depressive disorders in childhood. II A longitudinal study of the risk for a subsequent major depression. Archives of General Psychiatry, 41, 633-649.
- Kruesi, M.J., Grossman, J. et al. (1999). Suicide and violence prevention. Parent education in emergency department. Journal of the American Academy of Child and Adolescent Psychiatry, 38, 250-255.

- Kulkin, H. S., Chaivin, E. A., & Percle, G. A. (2000). Suicide among gay and lesbian adolescents and young adults: A review of the literature. Journal of Homosexuality, 40, 1-29.
- LaFromboise, T.D. (1996). American Indian life skills development curriculum. Madison, WI: University of Wisconsin.
- Lee, L. C., & Rebok, G. W. (2002). Anxiety and depression in children: A test of the positive-negative affect model. Journal of American Academy of Child and Adolescent Psychiatry, 41, 419-425.
- Leenaars, A. A., & Wenckstern, S. (1990). Suicide postvention in school systems. In J. D. Morgan (Ed.), The dying and bereaved teenager. (pp. 140-159). Philadelphia: The Charles Press.
- Lerner, R., Steinberg, L. (Eds) (2005). Handbook of adolescent psychology. (3rd Ed). New York: Wiley.
- Lewisohn, P. M., & Clarke, G. N. (1999). Psychosocial treatment for adolescent depression. Clinical Psychology Review, 19, 329-342.
- Lewisohn, P. M., Clarke, G. N, Hops, H. & Andrews, J. (1990). Cognitive-behavioral treatment for depressed adolescents. Behavior Therapy, 21, 385-401.
- Lewisohn, P. M., & Rohde, P. (1993). The cognitive-behavioral treatment of depression in adolescents: research and suggestions. The Clinical Psychologist, 46, 177-183.
- Lewisohn, P. M., Rohde, P., & Seeley, J. R. (1998). Major depressive disorder in older adolescents: Prevalence, risk factors and clinical implications. Clinical Psychology in Review, 18, 765-794.
- Linehan, M.M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.
- Lissman, T. L., Boehnlein, J. K. (2001). A critical review of Internet information about depression. Psychiatric Services, 52, 1046-1050.
- Littell, J.H. (2005). Lessons learned from a systematic review of multisystemic therapy. Children and Youth Services Review, 27, 445-463.
- Littell, J.H. (2006). The case for multisystemic therapy: Evidence or orthodoxy. Children and Youth Services Review, 28, 458-472.
- Littell, J.H., Popa, M., & Forsythe, B. (2005). Multisystemic therapy for social, emotional and behavioral problems in youth age 10-17. Cochrane Library, Issue 3. Chichester, UK: John Wiley & Sons.
- Mahler, J. (2004). Teenagers and the antidepressant dilemma. New York Times Magazine, Nov. 21, p. 58.
- Masser, J., & Fremour, W.J. (2008). A critical review of explanatory models for self-mutilating behaviours in adolescents. Clinical Psychology Review, 28, 162-178.
- Mazza, J. J. (1997). School –based suicide prevention program: Are they effective? School Psychology Review, 26, 382-396.
- McBride, H. E., & Siegel, L. S. (1997). Learning disabilities and adolescent suicide. Journal of Learning Disabilities, 30, 652-659.
- McCarty, C.A., & Weisz, J.R. (2007). Effects of psychotherapy for depression in children and adolescents: When we can (and can't) learn from meta-analysis and component profiling. Journal of American Academy of Child and Adolescent Psychiatry, 46, 879-886.

- McClure, E. B., Kubiszyn, T. & Kaslow, N. J. (2002). Advances in the diagnosis and treatment of childhood mood disorders. Professional Psychology, *33*, 125-134.
- McDaniel, J. S., Purcell, D., & Augelli, A. R. (2001). The relationship between sexual orientation and risk for suicide research findings and future directions for research and prevention. Suicide Life-Threatening Behavior, *31*, 84-105.
- McIntosh, J. L. (2000). Epidemiology of adolescent suicide in the United States. In R. W. Maris, S. S. Canetto, J. L. McIntosh, & M. M. Silverman (Eds.). Review of suicidology, New York, NY: Guilford Press (pp. 3-33).
- McKnight, P.E., & Kashdan, T.B. (2009). The importance of functional impairment to mental health outcomes: A case for reassessing our goals in depression treatment research. Clinical Psychology Review, *29*, 243-259.
- McLeod, B.D., Weisz, J.R., & Wood, J.J. (2007). Examining the association between parenting and childhood depression. Clinical Psychology Review, *27*, 986-1003.
- Meichenbaum, D. (1997). Treating adults with PTSD. Clearwater, FL: Institute Press.
- Meichenbaum, D. (2002). Treating individuals with anger-control problems and aggressive behaviors. Clearwater, FL: Institute Press.
- Meichenbaum, D. (2005). 35 years of working with suicidal patients: Lessons learned. Canadian Psychologist, *46*, 64-72.
- Meichenbaum, D. (2006). Trauma and suicide. In T. Ellis (Ed.), Cognition and suicide (pp. 333-354). Washington, DC: American Psychological Association.
- Meichenbaum, D. (2006a). Resilience and posttraumatic growth: A constructive narrative perspective. In L. Calhoun & R. Tedeschi (eds.), Handbook of posttraumatic growth: Research and practice. Mahwah, NJ: Erlbaum Associates.
- Meichenbaum, D. (2008). Bolstering resilience: Benefiting from lessons learned. In D. Brom, P. Horenczyk & E. Ford. Treating traumatized children: Risk, resilience and recovery. New York: Routledge.
- Merkin, D. (2009). A long journey in the dark: My life with chronic depression. The New York Times Magazine. May 10, 30-37.
- Merry, S.N., McDowell, H. et al., (2004). A randomized placebo-controlled trial of a school-based depression prevention program. Journal of the American Academy of Child and Adolescent Psychiatry, *43*, 538-547.
- Merry, S., McDowell, H. et al., (2004). Psychological and/or educational interventions for the prevention of depression in children and adolescents. The Cochrane Database of Systematic Reviews. Issue 2, CD003380.
- Merry, S.N., & Spence, S.H. (2007). Attempting to prevent depression in youth: A systematic review of the evidence. Early Intervention in Psychiatry, *1*, 128-137.
- Meyer, G.J., Finn, S.E., Eyde, L.D., et al. (2001). Psychological testing and psychological assessment: A review of evidence and issues. American Psychologist, *56*, 128-165.
- Michael, K. D. & Crowley, S. L. (2002). How effective are treatments for child and adolescent depression? A meta-analytic review. Clinical Psychology Review, *22*, 247-270.
- Miller, A., & Glinski, J. (2002). Youth suicidal behavior: Assessment and intervention. Journal of Clinical Psychology, *56*, 1131-1152.
- Miller, A.L., Rathus, J.H. & Linehan, M.M. (2007). Dialectical Behavior Therapy with Suicidal Adolescents. New York: Guilford Press.
- Miller, S., Rotheram-Borus et al. (1992). Successful Negotiating Acting Positively: A brief Cognitive Behavioral Family Therapy Manual for Adolescent Suicide Attempters and

- Their Families. Columbia University. New York.
- Miller, T.B., & Taylor, D.M. (2005). Adolescent suicidality. Who will ideate, who will act? Suicide and Life-Threatening Behavior, *35*, 425-435.
- Morrison, L. L., & Heureux, J. L. (2001). Suicide and gay/lesbian/bisexual youth: Implications for clinicians. Journal of Adolescence, *24*, 39-49.
- Mufson, L., Dorta, K.P., Moreau, D., & Weisman, M.M. (2004). Interpersonal psychotherapy for depressed adolescents (2nd ed.). New York: Guilford Press.
- Mufson, L., & Fairbank, J. (1996). Interpersonal psychotherapy for depressed adolescents: A one-year naturalistic follow-up study. Journal of the Academy of Child and Adolescent Psychiatry, *35*, 1145-1155.
- Mufson, L., Gallagher, T., Dorta, K.P., & Young, J. (2004). A group adaptation of interpersonal psychotherapy for depressed adolescents. American Journal of Psychotherapy, *58*, 220-238.
- Mufson, L., Morreau, D., Weissman, M. M., & Klerman, G. L. (1993). Interpersonal psychotherapy for depressed adolescents. New York: Guilford Press.
- Mufson, L., Weisman, M. M., Moreau, D. et al. (1999). Efficacy in interpersonal psychotherapy for depressed adolescents. Archives of General Psychiatry, *56*, 573-579.
- Neil, A.L. & Christenson, H. (2009). Efficacy and effectiveness of school-based prevention and early intervention programs for anxiety. Clinical Psychology Review, *29*, 208-215.
- Nock, M.K., Borges, G., Bromet, E.J. et al. (2008). Suicide and suicidal behavior. Epidemiological Research, *30*, 133-154.
- Nolen-Hoeksema, S., Wisco, B.E., & Lyubomirsky, S. (2008). Rethinking rumination. Perspectives on Psychological Science, *3*, 400-424.
- Ogden, A., Shepherd, M., & Smith, W.A. (1996). The Prevention Marketing Initiative: Applying prevention marketing. Atlanta: Center for Disease Control and Prevention.
- Oquenda, M.A. & Mann, J.J. (Eds.) (2008). Suicidal behavior: A developmental perspective. Psychiatric Clinics of North America, *31*, 157-362.
- Osman, A., Bagge, C. L. et al. (2001). The suicidal behaviors questionnaire – revised (SBQ-R). Assessment, *8*, 443-454.
- Osman, A., Downs, W. T. et al. (1998). The Reason for Living Inventory for Adolescents (RFL-A): Development and psychometric properties. Journal of Clinical Psychology, *54*, 1063-1078.
- Overholser, J., Evans, S., & Spirito, A. (1990). Sex differences and their relevance to primary prevention of adolescent suicide. Death Studies, *14*, 391-402.
- Park, R. J., & Goodyear, I. M. (2000). Clinical guidelines for depressive disorders in childhood and adolescence. European Child and Adolescent Psychiatry, *9*, 147-161.
- Pfeffer, C. R., Ying, H., & Kakum, T. (2000). Child adolescent suicidal potential index (CASPI): A screen for risk for early onset suicidal behavior. Psychological Assessment, *12*, 304-318.
- Pattison, C., & Lynd-Stevenson, R.M. (2001). The prevention of depressive symptoms in children: The immediate and longitudinal outcomes of a school-based program. Behavior Change, *18*, 92-102.
- Ramey, H.L., Busseri, M.A., & Khanne, N. (2010). Youth engagement and suicide risk. Journal of Youth and Adolescence, *39*, 243-258.
- Rapee, R.M., Wignall, A., et al., Adolescents reactions to universal and indicated prevention programs for depression, perceived stigma and consumer satisfaction. Prevention Science, *7*, 167-177.

- Rehm, L. & Sharp, R. N. (1996). Strategies for childhood depression. In M. A. Reinecke, F. M. Dattillio, & A. Freeman (Eds.), Cognitive therapy with children and adolescents. New York: Guilford (pp. 103-123).
- Reich, J.W., Zautra, A.J., & Hall, J.S. (2010). Handbook of adult resilience. New York: Guilford Press.
- Reinecke, M. A., Ryan, N. E., & Dubois, D. L. (1998). Cognitive-behavioral therapy of depression and depression symptoms during adolescence: A review and meta-analysis. Journal of American Academy of Child and Adolescent Psychiatry, *37*, 26-34.
- Reivich, K., Gillham, J.E., Chaplin, I.M., & Seligman, M.E. (2005). From helplessness to optimism: The role of resilience in treating and preventing depression in youth. In S. Goldstein & R.B. Brooks (Eds.) Handbook of resilience in children. (pp. 223-237). New York: Kluwer Academic/Plenum Publisher
- Reivich, K. & Shatte, A. (2002). The resilience factor. New York: Broadway Books.
- Restifo, K., & Bogels, S. (2009). Family processes in the development of youth depression: Translating the evidence to treatment. Clinical Psychology Review, *129*, 294-316.
- Reynolds, C. R., & Richmond, B. O. (1985). Revised Children's Manifest Anxiety Scale (RCMAS) Manual. Los Angeles: Western Psychological Services.
- Roberts, R. E., Levisohn, P. M., & Seeley, J. R. (1991). Screening for adolescent depression: A comparison of depression scales. Journal of the American Academy of Child and Adolescent Psychiatry, *30*, 58-65.
- Robin, A.L., & Foster, S.L. (1989). Negotiating parent-adolescent conflict. New York: Guilford Press.
- Rood, L., Roelofs, J. et al. (2009). The influence of emotion-focused rumination and distraction on depressive symptoms in non-clinical youth: A meta-analytic review. Clinical Psychology Review, *29*, 607-616.
- Rosello, J., Bernal, G. (2005). New developments in cognitive-behavioral and interpersonal treatments for depressed Puerto Rican adolescents. In E.D. Hibbs & P.S. Jensen (Eds.) Psychosocial treatments for child and adolescent disorders: Empirically-based strategies for clinical practice (2nd ed.) (pp. 187-217). Washington, DC: American Psychological Association.
- Rotherman, F., Morling, B., & Rusk, N. (2009). How goals and beliefs lead people in and out of depression. Review of General Psychology, *13*, 302-314.
- Rotheram, M. J. (1987). Evaluation of imminent danger for suicide among youth. American Journal of Orthopsychiatry, *57*, 102-110.
- Rudd, A.D., Joiner, T.E., & Rajab, M.H. (2004). Treating suicidal behavior: An effective time-limited approach. (2nd Ed.). New York: Guilford Press.
- Rudd, M.D., Joiner, T., Brown, G.K., Cukrowicz, K., Jobes, D.A., & Silverman, M. (2009). Informed consent with suicidal patients: Rethinking risks in (and out of) treatment. Psychotherapy: Theory, Research, Practice, Training. *46*, 459-468.
- Salkovskis, P.M., Atha, C., & Storer, D. (1980). Cognitive-behavioral problem-solving in the treatment of patients who repeatedly attempt suicide: A controlled trial. British Journal of Psychiatry, *157*, 871-876.
- Sanchez, H. G. (2001). Risk factor model for suicide assessment and intervention. Professional Psychology, *32*, 351-358.
- Sander, J.B. & McCarty, C.A. (2005). Youth depression in the family context: Familial risk factors and

- models of treatment. Clinical Child and Family Psychology Review, 8, 203-219.
- Schulberg, H. C., Katon, W., et al. (1998). Treating major depression in primary care practice: An update of AHCPR. Archives of General Psychiatry, 55, 1121-1127.
- Sexson, S. B., Glanville, D. N., & Kaslow, N. J. (2001). Attachment and depression: Implications for family therapy. Child and Adolescent Psychiatric Clinics of North America, 10, 465-486.
- Shaffer, D., & Craft, L. (1999). Methods of adolescent suicide prevention. Journal of Clinical Psychiatry, 60, 70-76.
- Shea, S.C. (1998). The chronological assessment of suicide events: A practical interviewing strategy for clinicians of suicidal ideation. Journal of Clinical Psychiatry, 59, 55-72.
- Shea, S.C. (2004). The delicate art of eliciting suicidal ideation. Psychiatric Annals, 34, 385-400.
- Sheffield, J.V. Spence, S.H. et al. (2006). Evaluation of universal, indicated, and combined cognitive-behavioral approaches to the prevention of depression among adolescents. Journal of Consulting and Clinical Psychology, 74, 66-79.
- Shirk, S.R., & Karver, M. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: A meta-analytic review. Journal of Consulting and Clinical Psychology, 71, 452-462.
- Shneidman, E.S. (1996). The suicidal mind. New York: Oxford University Press.
- Snyder, C.R., Hoza, B. et al., (1997). The development and validating the Children's Hope Scale. Journal of Pediatric Psychology, 22, 399-421.
- Snyder, R. (2002). Hope theory: Painters on the mind. Psychological Inquiry, 13, 249-275.
- Sommers-Flanagan, J., & Sommers-Flanagan, R. (1995). Intake interviewing with suicidal patients: A systemic approach. Professional Psychology: Research and Practice, 26, 41-47.
- Spence, S., Sheffield, J., & Donovan, C. (2001). Long-term outcome of a school-based universal approach to prevention of depression in adolescents. Journal of Consulting and Clinical Psychology, 73, 160-167.
- Spence, S., Sheffield, J. & Donovan, C. (2003). Preventing adolescent depression: An evaluation of the Problem Solving for Life Program. Journal of Consulting and Clinical Psychology, 71, 3-13.
- Spence, S.H., & Shortt, A.L. (2007). Research review: Can we justify the widespread dissemination of universal, school-based interventions for the prevention of depression in children and adolescents? Journal of Child Psychology and Psychiatry, 48, 526-542.
- Spielman, G.I., Pasek, L.F., & McFall, J.P. (2007). What are the active ingredients in cognitive and behavioral psychotherapy for anxious and depressed children? A meta-analytic review. Clinical Psychology Review, 27, 642-654.
- Spirito, A., Brent, D., Emslie, G., et al., (2009). Site differences and their possible sources in the outcomes of a multi-site clinical trial: The TORDIA study. Journal of Consulting and Clinical Psychology, 77, 439-450.
- Stark, K. D. (1990). Childhood depression: School-based intervention. New York: Guilford Press.
- Stark, K.D. (2008). Experiences implementing the ACTION treatment program. Implications for preventative interventions. Health Psychology, 15, 342-345.
- Stark, K.D., Hargrave, J., Hersh, B., et al., (2008). Treatment of childhood depression: The ACTION program. In J.R. Abela & B.L. Hankin (Eds.), Handbook of depression in children and adolescents. (pp. 224-227). New York: Guilford Press.
- Stark, K., & Kendall, P.C. (1996), Treating depressed children: Therapist Manual for "Taking

- Action". Ardmore PA: Workbook Publishing.
- Stark, K., & Kendall, P.C., McCarthy, M. et al. (1996). Taking Action: A workbook for overcoming depression. Ardmore PA: Workbook Publishing.
- Stark, K. D., Napolitano, S., et al. (1996). Issues on the treatment of depressed children. Applied and Preventative Psychology, 5, 59-83.
- Stark, K. D., Rouse, L., & Livingstone, R. (1991). Treatment of depression during childhood and adolescence: Cognitive-behavioral procedures for the individual and family. In P. C. Kendall (Ed.), Child and adolescent therapy. (pp. 165-206). New York: Guilford Press.
- Stark, K.D., Stresand, W., Krumholz, L.S., & Patel, P. (2010). Cognitive-behavioral therapy for depression: The ACTION Treatment for girls. In J.R. Weisz & A.E. Kazden (Eds), Evidence-based psychotherapies for children and adolescents. (pp. 93-109). New York: Guilford Press.
- Stochet, I., Dadds, M., et al., (2001). The efficacy of a universal school-based program to prevent adolescent depression. Journal of Clinical Child Psychology, 30, 303-315.
- Stochet, I., Holland, D., & Whitefield, K. (1997). Resourceful Adolescent Programs (RAP): Group Leader's Manual. Brisbane, Queensland, Australia: Griffith University.
- Stein, B.D., Jaycox, L.H., et al. (2003). A mental health intervention for school children exposed to violence. Journal of American Medical Association, 240, 603-611.
- Steinberg, L. (2008). A social neuroscience perception on adolescent risk taking. Developmental Review, 28, 78-106.
- Steinberg, L. (2009a). Should the science of adolescent brain development inform public policy? American Psychologist, 64, 739-750.
- Steinberg, L. (2009b). Adolescent development and juvenile justice. Annual Review of Clinical Psychology, 5, 47-73.
- Stoelb, M. & Chirabaga, J. (1998). A process for assessing the adolescent risk for suicide. Journal of Adolescence, 21, 359-370.
- Stolberg, A.L. & Mahler, J. (1994). Enhancing treatment gains in a school-based intervention for children of divorce through skill training, parental involvement and transfer procedures. Journal of Consulting and Clinical Psychology, 62, 147-156.
- Szigethy, E., Kenny, E., Carpenter, J., et al. (2007). Cognitive-behavioral therapy for adolescents with inflammatory bowel disease and subsyndromal depression. Journal of the American Academy of Child and Adolescent Psychiatry, 45, 396-400.
- Thompson, E. A., Eggert, L. L., Randell, B. P., & Pike, K. C. (2001). Evaluation of indicated suicide risk preventive approaches for potential high school dropouts. American Journal of Public Health, 91, 742-752.
- Tishler, O.L., Reiss, N.S., & Rhodes, A.R. (2007). Suicidal behavior in children younger than twelve: A diagnostic challenge for emergency department personnel. Academic Emergency Medicine, 14, 810-818.
- TORDIA Group (2001). Treatment of SSRI- Resistant Depression in Adolescents: TORDIA CBT Manuals. University of Pittsburgh, Western Psychiatric Institute. (Treating Depressed Children: Therapist Manual and Parent Component). (<http://www.workbookpublishing.com/depression.html>)
- Treatment for Adolescents with Depression Study (TADS) Team. (2004). Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression. Journal of the American Medical Association, 292, 807-820.
- Van Voorhees, B.W., Paunesku, D., et al. (2008). Protective and vulnerability factors predicting

- new onset depressive episode in a representative sample of U.S. adolescents. Journal of Adolescent Health, 42, 605-616.
- Wagner, B. M. (1997). Family risk factors for child and adolescent suicidal behavior. Psychological Bulletin, 121, 246-298.
- Weersing, V.R., & Brent, D.A. (2006). Cognitive-behavioral therapy for depression in youth. Child and Adolescent Psychiatric Clinics of North America, 15, 939-957.
- Weersing, V.R., & Brent, D.A. (2010). Treating depression in adolescents using individual cognitive-behavioral therapy. In J.R. Weisz & A.E. Kazdin (Eds.), Evidence-based psychotherapies for children and adolescents. (pp. 126-139). New York: Guilford Press.
- Weersing, V.R., Iyengar, S., et al. (2006). Effectiveness of cognitive-behavioral therapy for adolescent depression: A benchmarking investigation. Behavior Therapy, 17, 36-48.
- Weersing, V.R., & Weisz, J.R. (2002). Community clinic treatment of depressed youth: Benchmarking usual care against CBT clinical trials. Journal of Consulting and Clinical Psychology, 70, 299-210.
- Wells, K.C., & Albano, A.M. (2005). Parent involvement in CBT treatment of adolescent depression: Experiences in the treatment for adolescents with depression. Cognitive and Behavioral Practice, 12, 209-220.
- Weisz, J.R. (2004). Psychotherapy for children and adolescents: Evidence-based treatments and case examples. Cambridge, England: Cambridge University Press.
- Weisz, J.R., Gray, J.S., Bearman, S.K., & Stark, K. (2008). Therapist manual PASCET: Primary and secondary control enhancement training (3rd ed.). Cambridge, MA: Harvard University.
- Weisz, J.R., Jensen-Doss, S., Hawley, K.M. (2005). Youth psychotherapy outcome research: A review and critique of the evidence base. Annual Review of Psychology, 56, 337-363.
- Weisz, J.R., Jensen-Doss, S., Hawley, K.M. (2006). Evidence-based youth psychotherapies versus usual clinical care: A meta-analysis of direct comparisons. American Psychologist, 61, 671-689.
- Weisz, J.R., & Kazdin, A.E. (Eds). (2010). Evidence-based psychotherapies for children and adolescents. New York: Guilford Press.
- Weisz, J.R., McCarty, C.A., & Valeri, S.M. (2006). Effects of psychotherapy for depression in children and adolescents: A meta-analysis. Psychological Bulletin, 123, 132-149.
- Weisz, J.R., Sandler, I.N., Durlak, J.A., & Anton, B.S. (2005). Promoting and protecting youth mental health through evidence-based prevention and treatment. American Psychologist, 60, 628-648
- Weisz, J.R., Thurber, C., Sweeney, L., Proffitt, V.D. & LeGagnoux, G.L. (1997). Brief treatment of mild-to-moderate child depression using primary and secondary control enhancement training. Journal of Consulting and Clinical Psychology, 65, 703-707.
- Wenzel, A., Brown, G.K., & Beck, A.T. (2008). Cognitive therapy with suicidal patients: Scientific and clinical applications. Washington, D.C.: APA Books.
- Wenzel, A., Brown, G.K., & Beck, A.T. (2009). Cognitive therapy for suicidal patients: Scientific and clinical applications. Washington, DC: American Psychological Association
- Weller, E. B., & Weller, P. A. (2001). Suicide in youth. Depression and Anxiety, 14. (See entire issue.)
- Weller, E. B., & Weller, P. A. (2001). Treatment options in the management of adolescent depression. Journal of Affective Disorders, 61, 23-28.

- Wells, K. B., Kataoka, S. H., & Asarnow, J. R. (2001). Affective disorders in children and adolescents: Addressing current needs in primary care settings. Society for Behavioral Psychiatry, 49, 1111-1120.
- Wilkes, T. C., & Rush, A. J. (1988). Adaptation of cognitive therapy for depressed adolescents. Journal of American Academy of Child and Adolescent Psychiatry, 88, 381-386.
- Witko, T.M. (Eds.) (2006). Mental health care for urban Indians: Clinical insights from native practitioners. Washington, DC: American Psychological Association.
- Wolfe, V.V., Dozas, D.J., Fisman, S., & DePace, J. (2008). Preventing depression among adolescent girls. Pathways toward effective and sustainable programs. Cognitive and Behavioral Practice, 15, 36-46.
- Wood, A., Harrington, R., & Moore, A. (1996). Controlled trial of a brief cognitive-behavioral intervention in adolescent patients with depressive disorders. Journal of Child Psychology and Psychiatry, 37, 737-746.
- Whybrow, P. C., Akiskal, H. S., & McKinney, W. T. (1984). Mood disorders: Toward a new psychology. New York: Plenum.
- Wyman, P., Brown, C., Inman, J., Cross, W., Schneelk-Cone, K., et al. (2008). Randomized trial of a gatekeeper program for suicide prevention: 1-year impact on secondary school staff. Journal of Consulting and Clinical Psychology, 76, 401-115.
- Wilkes, T. C., Belsher, G., Rush, A. J., Frank, E., & Associates. (1994). Cognitive therapy for depressed adolescents. New York: Guilford.
- Wolraich, M., Felice, M. E., & Drotar, D. (Eds.) (1996). The classification of child and adolescent mental diagnosis for primary care. Elk Grove Village, IL: American Academy of Pediatrics.
- Yates, T. M. (2004). The developmental psychopathology of self-injurious behavior: Compensatory regulation in posttraumatic adaptation. Clinical Psychology Review, 24, 35-74.
- Yongstrom, E.A., Freeman, A.J., & Jenkins, M.M. (2009). The assessment of children and adolescents with bipolar disorder. Child and Adolescent Psychiatric Clinics of North America, 18, 353-390.
- Young, J.F., Mufson, L., & Davies, M. (2006). Efficacy of interpersonal psychotherapy.-Adolescent skills training: An indicated preventive intervention for depression. Journal of Child Psychology and Psychiatry, 47, 1254-1262.
- Zalsman, G., Brent, D.A., & Weersing, H.R. (@006). Depressive disorders in childhood and adolescence: An overview of epidemiology, clinical manifestations and risk factors. Child and Adolescent Psychiatric Clinics of North America, 15, 827-841.
- Zero to Three, National Center of Clinical Infant Program. (1999). Diagnostic classification of mental health and developmental disorders in infancy and early childhood: 0-3. Arlington, VA: Author.
- Zimmerman, M.A., & Brenner, A.B. (2010). Resilience in adolescence: Overcoming neighborhood disadvantage. In J.W. Reich, A.J. Zautra & J.S. Hall (Eds.) Handbook of adult resilience. (pp 283-308). New York: Guilford Press.

(Answers to Test Your Knowledge of Adolescence. All Answers are FALSE)

WEBSITES

For information on Cognitive-behavior Therapy Training in Trauma-focused Cognitive-behavior Therapy, Cognitive Processing Therapy, and related programs

www.musc.edu/tfcbt

<http://cpt.musc.edu>

www.nctsnet.org

Training in Cognitive Behavior Therapy for Substance Abuse

<http://www.drugabuse.gov/txmanuals/cbt/cbt1.html>

The Cognitive Therapy Pages

<http://www.habitsmart.com/cogtitle.html>

Cognitive Behavior Therapy

<http://cognitive-behavior-therapy.org/>

Evidence-based Interventions

APA Task Force Report on EBPP with Children and Adolescents

www.apa.org/pi/cyf/evidence.html

Bernal, G. Treatment Manual for Depressed Puerto Rican Youth

<http://ipsi.uprrp.edu/recursos.html>

Coping with Depression Course

www.kpchr.org/acwd/acwd.html

Florida Mental Health Institute School-based Youth Suicide Prevention Guide

<http://www.fmhi.usf.edu/institute/pubs/bysubject.html>

<http://cfs.fmhi.usf.edu/cfsinfo/hotpubs.cfm>

MacArthur Foundation Network on Youth Mental Health

www.childsteps.org

SAMHSA Suicide Prevention Program

<http://modelprograms.samhsa.gov>

Evidence-based Suicide Prevention Programs

www.sprc.org/feature_resources/ebjp/ebjp-factsheets.asp#type

Registry of Evidence-based Suicide Prevention Programs

www.sprc.org/featured_resources/ebpp/ebpp_factsheets.asp#type

Treatment of Adolescents with Depression Study (TADS)
http://trialweb.dcri.duke.edu/tads/tad/manuals/TAD_CBT.pdf

What Works Clearing House
www.whatworks.ed.gov/
www.effectivechildtherapy.com

For information on depression:

Dr. Ivan's Depression Central
<http://www.psycom.net/depression.central.html>

Wing of Madness
<http://www.wingofmadness.com>

Psychology Information Online: Depression
<http://www.psychologyinfo.com/depression/>

For understanding depression in children:

Are you Considering Medication for Depression?
<http://www.utexas.edu/student/cmhc/booklets/meds/meds.com>

Child & Adolescent Bipolar Foundation
<http://www.pbkids.org>

Depression in Children and Adolescents
<http://www.klis.com/chandler/pamphlet/dep/depressionpamphlet.htm>

Depression in Children and Adolescents: A Fact Sheet For Physicians
<http://www.nimh.nih.gov/publicat/depchildresfact.cfm>

Depression and Bipolar Support Alliance
<http://www.ndmda.org/>

Northern County Psychiatric Association
http://www.ncpamd.com/Depression_%20Adults_Children.htm

For medication and/or psychotherapy of mood disorders

Psychotherapy versus Medication for Depression
<http://www.apa.org/journals/anton.html>

For Additional Resources**American Association of Suicidology***<http://www.suicidology.org/>***American Foundation for Suicide Prevention***<http://www.afsp.org/>***American Psychiatric Association Practice Guidelines for the Assessment And Treatment of Patients with Suicidal Behaviors***www.psych.org/psych_pract/treat/pg/suicidalbehavior_05-15-06.pdf***Applying Best Practices***www.mentalhealth.samhsa.gov**www.effectivechildtherapy.com**www.paxis.org**www.search_institute.org**www.naspweb.org**www.colorado.edu.cspv/blueprints/***Burden of Suicide Report***www.mcw.edu/FileLibrary/Groups/InjuryResearchCenter/pdf/Bos_final_9_5.pdf***CDC's SafeUSA Guide to Preventing suicide***<http://www.cdc.gov/ncipc/pub-res/youthsui.htm>***CDC Statistics On Suicide***www.cdc.gov/ncipc/dvp/suicide***Charles E. Kubly Foundation***www.charlesekublyfoundation.org***Center for Disease Control and Prevention National Center for Injury Prevention and Control***<http://www.cdc.gov/ncipc/>***Connecting the Dots to Prevent Violence: American Medical Association****(Also call 312-464-4520)***<http://www.ama-assn.org/ama/pub/category/3242.html>***How to Report on Suicide***www.afsp.org/media*

JED Foundation: Ways to Safeguard College Students Against Suicide
www.jedfoundation.org

Joint Commission for Hospital Accreditation (JCAHO)
<http://www.jointcommission.org/PatientSafety?NationalPatientSafetyGoals>

Joint Commission National Patient Safety Goals
<http://www.jointcommission.org/PatientSafetyNationalPatientSafetyGoals>

National Organization for People of Color Against Suicide
www.nopcas.com

National Institute of Mental Health suicide Fact Sheet
<http://www.nimh.nih.gov/research/suicide.cfm>

National Institute of Mental Health (2008) Suicide in the U.S.: Statistics and Prevention
<http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention.shtml>

National Resource Center for Prevention and Aftercare
<http://thelink.org>

National Strategy for Suicide Prevention
<http://www.mentalhealth.samhsa.gov/suicideprevention/strategy.asp>

National Suicide Hotline
1-800-Suicide

National Suicide Prevention Lifeline
1-800-273-TALK

NIMH Frequently Asked Questions About Suicide
<http://www.nimh.nih.gov/research/suicidefaq.cfm>

Resource Guide for Implementing (JCAHO) 2007 Patient Safety Goals On Suicide
www.mentalhealthscreening.org/events/ndsd/JCAHO.aspx

Review of Suicide Measures for Adults
<http://www.nimh.nih.gov/research/adultsuicide.pdf>

Review of Suicide Measures for Children
<http://www.nimh.nih.gov/research/measures.pdf>

Selected Bibliographies on Suicide Research-1999
<http://www.nimh.nih.gov/research/suibib99.cfm>

Search Institute: 40 Developmental Assets

<http://www.search-institute.org>

Suicide Assessment and Clinical Interviewing

<http://www.suicideassessment.com>

Suicide Awareness Voices of Education

www.save.org

Suicide Prevention Information

<http://www.mentalhealth.org/>

Suicide Prevention Lifeline

1-800-273-TALK (Also on Facebook and Twitter)

Lifeline Website

www.suicidepreventionlifeline.org

Blog

www.crisis-centersblog.com

Lifeline Gallery

www.lifelinegallery.org

My Space

www.myspace.com/800273TALK

You Tube

www.youtube.com/800273TALK

Suicide Prevention Website

www.StopASuicide.org

1-800-273-TALK

1-800-273-8255

Suicide Statistics from CDC's National Center for Health Statistics

<http://www.cdc.gov/nchs/fastats/suicide.cfm>

The Surgeon General's Call to Action to Prevent Suicide

<http://www.surgeongeneral.gov/library/calltoaction/default.htm>

World Health Organization Statistics on Suicide

<http://www.who.int/on/>

Yellow Ribbon Organization

<http://www.yellowribbon.org/>

Call 303-429-3530

Ongoing Research**Treatment of Adolescents with Depression Study (TADS)**

(Go to Clinical Trials page of NIMH)

<http://www.nimh.nih.gov/studies/index.cfm>

National Institute of Health Clinical Trials Database

<http://www.clinicaltrials.gov/>

Supportive Agencies**Child and Adolescent Bipolar Foundation**

<http://www.pbkids.org>

Depression and Bipolar Support Alliance

<http://www.dbsalliance.org>

Psychoeducational Materials for Youth and Their Families**Adolescence Directory On-Line (ADOL)**

<http://education.indiana.edu/cas/>

Cope Care: A Mental Health Site for Teens

<http://www.copecaredeal.org/Default.aspx>

<http://www.inspire.org.au/about-us.html>

<http://au.reachout.com>

Teen Center

<http://www.wholefamily.com/aboutteensnow/dramas/>

Teen Health

<http://www.teenhealth.org/teen/index2.html>

Treating Depressed Children: Therapist Manual and Parent Component

<http://www.workbookpubling.com/depression.html>

Websites for Depressed Youth

<http://www.frozenflameweb.com/sparx.html>

<http://www.thelowdown.co.nz>

<http://www.inspire.org.au/about-us.html>

<http://au.reachout.com>

Conference Sponsored Websites**Melissa Institute for Violence Prevention***www.melissainstitute.org***Ganley Foundation***www.ganleyfoundation.org*