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Enhancing the Developmental Appropriateness of Treatment for Depression in Youth: Integrating the Family in Treatment

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Abstract

Youth depression is an impairing and frequently recurrent and persistent disorder that impacts current and later development, resulting in high social and economic costs. Depression and interpersonal stress are frequently transactional, with depression powerfully negatively impacting relationships and relationship stress negatively impacting the course and outcome of depression. In this context, treatment models for youth depression that emphasize interpersonal functioning, particularly family relationships, may be particularly promising. This article has three objectives. It first reviews the current state of knowledge on the efficacy of psychosocial treatments for depression in youth, with an emphasis on the role of family involvement in treatment. Second, it discusses developmental factors that may impact the applicability and structure of family-focused treatment models for preadolescent and adolescent youth. Third, two family-based treatment models that are currently being evaluated in randomized clinical trials are described: one focusing on preadolescent depressed youth and the other on adolescents who have made a recent suicide attempt.

Keywords

Youth depression; Psychosocial treatment; Family; Developmental factors; Treatment Models; Randomized clinical trials

TREATMENT FOR YOUTH WITH DEPRESSIVE DISORDERS: CURRENT STATE OF THE FIELD

Pharmacologic treatments for depressive disorders in youth have been evaluated in numerous trials in recent years, with selective serotonin reuptake inhibitors (SSRIs) demonstrating efficacy for both adolescent and preadolescent youth (for review see Maalouf and Brent article in this issue). Several factors, in conjunction with data on the negative

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sequelae of youth depression, underscore the crucial need to continue to develop and evaluate psychosocial treatments:

1. Practice parameters and guidelines for youth depression emphasize an initial trial of psychosocial treatment before commencing medication intervention.¹
2. Clinical observation and recent data indicate reluctance among adolescents and their parents to pursue medication treatments for depression and a preference for psychosocial modalities,^{2,3} and this reluctance is likely to be greater among younger children.
3. Evidence of possible suicidal risk associated with SSRIs in the treatment of youth depression has led to a U.S. Food and Drug Administration (FDA) “black box” warning on all antidepressant medications, which has precipitated a reduction in prescription rates.^{4,5}

Tables 1 and 2 summarize findings of current clinical trials examining psychosocial treatments for depressive disorders in youth. Table 1 focuses on studies conducted primarily with adolescents and Table 2 focuses on studies completed with preadolescent youth. Although a number of studies have evaluated preventive interventions for youth at risk for depression (for more details please see the article by Beardslee and colleagues elsewhere in this issue), this review is limited to those examining treatments for youth currently suffering from depression.

As evidenced in Table 1, recent years have witnessed significant advances in the treatment of adolescent depression. Results from large multisite trials and smaller single-site trials document the efficacy of some psychosocial and medication treatments, as well as combined treatments.^{6–15} Examination of findings from these studies highlights the efficacy of cognitive–behavioral and interpersonal strategies in both reducing symptoms and enhancing functioning. Further, recent effectiveness trials have demonstrated improved depression, quality-of-life, and functioning outcomes when these evidence-based depression treatments are provided to adolescents in usual care settings.^{2,7,16,17} Although most clinicians agree on the importance of family involvement in comprehensive intervention for youth depression, research has not provided clear answers regarding the optimal nature and extent of family involvement. Some family treatment sessions have been included in many of the large trials evaluating depression cognitive–behavioral therapy (CBT) for adolescents (eg, Treatment for Adolescents with Depression Study [TADS], Treatment of SSRI-Resistant Depression in Adolescents [TORDIA]), and this may have contributed to the efficacy of the CBT. Underscoring the importance accorded family involvement, Brent and colleagues,⁶ in a large clinical trial comparing cognitive–behavioral, supportive, and family systemic therapies, included a few family psychoeducational sessions to enhance therapeutic engagement for all participants. However, the more extensive family systemic therapy had a remission rate of approximately 38%, similar to that of nondirective supportive treatment (39%) and significantly lower than that of CBT (60%). In other clinical trials examining CBT for adolescent depression, augmentation of a parent group did not add significantly to the adolescent-only treatment.⁸ However, more recently, Diamond and colleagues have examined a family-based treatment model focused on repairing and enhancing the attachment between the youth and his or her parents. In their initial clinical trial with

depressed adolescents,¹⁸ 81% of those who participated in this attached-based family therapy (ABFT) showed remission from their depression, as opposed to 47% of those on a waitlist. In a randomized controlled trial (RCT) with suicidal adolescents,¹⁹ 87% of those who participated in ABFT met criteria for clinical recovery in terms of suicidal ideation as compared to 52% receiving enhanced usual care. Thus, although a number of issues remain in understanding the most appropriate treatments for adolescents with depression, including the role of family involvement in treatment, there are currently several efficacious strategies for this condition.

In contrast, as illustrated in Table 2, there are relatively few RCTs of treatments for depression in childhood. Despite the morbidity of childhood-onset depression and the emphasis in current guidelines on initial psychosocial treatment, there are currently no published RCTs of psychosocial interventions exclusively for preadolescent youth with diagnosed depressive disorders (see Table 2), although two are currently ongoing. The few published studies with preadolescent samples have focused on children with high depressive symptoms rather than those with diagnosable disorders. Two clinical trials have included children 12 years of age and younger with depressive diagnoses in their samples,^{20,21} but neither included separate analyses allowing examination of treatment effects in younger children. One study included only eight prepubertal subjects,²¹ and the other included six 12-year-old participants and 13 participants younger than the age of 12 years (Vostanis P, personal communication, February 2007). There have been some treatment development studies with diagnosed school-aged youth, including our own,^{22–26} but RCTs are needed to evaluate treatment efficacy. In most of these treatments, parents are included in parallel sessions^{27,28} or in groups.^{29,30}

Despite the limitations in the literature on psychosocial treatments for childhood-onset depression, recent meta-analysis suggests similar effect sizes for child and adolescent treatment. Weisz and colleagues³¹ found an average effect size of 0.34 for depression treatments across ages. Excluding trials with mixed child and adolescent samples, the effect size for studies of youth younger than age 13 was not significantly different from the effect size for treatment of adolescents (0.41 for children vs 0.33 for adolescents). However, the effect-size estimate for younger children (vs adolescents) was based on a very small number of trials ($n = 7$), all of which selected subjects based on depressive symptoms (as opposed to formal diagnosis as proposed here), which likely led to less severe depression in the child samples (see Table 2). In addition, the overall effect size for depression treatments was lower (0.34) than that for nondepressive problems, including aggression, disruptive behavior, attention-deficit/hyperactivity, and fears (0.69), and when the experimental treatment was compared to an active control condition (rather than a waitlist or no treatment condition), the effect size was even smaller (0.24). Thus, not only is there a striking absence of “gold standard” RCTs of interventions for child (vs adolescent) depressive disorders, but also relatively small effect sizes point to the need for additional treatment development and research targeted to more severe cases.

DEVELOPMENTAL FACTORS IMPACTING YOUTH DEPRESSION AND DEPRESSION TREATMENT

As emphasized in multiple papers throughout this issue, depression is associated with a host of negative correlates and sequelae. Depressed adolescents are at increased risk for suicidal behavior,³² substance use,³³ academic failure,³⁴ and depression in adulthood.^{35–39}

Adolescent depression is frequently accompanied by high levels of family conflict, control,⁴⁰ negative interactional patterns,⁴¹ major life stressors,⁴² daily hassles,⁴³ bullying, and negative peer interactions.⁴⁴ Depressed adolescents often report low levels of social support⁴⁵ and low family cohesion.⁴⁶ Recent conceptualizations of depression generally and adolescent depression specifically⁴⁷ emphasize the role of the interpersonal context in the perpetuation of symptoms. In a bidirectional fashion, stressful events and interpersonal interactions may contribute to the development and maintenance of depression, and depressive symptoms may contribute to an increase in interpersonal stress—a process referred to as stress generation.⁴⁸ Hence, targeting the interpersonal context in the treatment of depression may be particularly germane in adolescence.

Although rarer than adolescent depression, childhood-onset depression is associated with significant morbidity, high risk of relapse, and high levels of dysfunction due to its early onset and interference with negotiation of developmental tasks. The research literature indicates that depression in children is frequently chronic and severe,^{49–51} associated with the risk of high relapse and continuing impairment^{49,50,52–54} as well as bipolar outcome.⁵³ Child depression also correlates with increased risk of drug and alcohol abuse, suicide, and other significant public health problems^{55–57} and is accompanied by substantial social impairments, both during and after resolution of depressive episodes.^{58,59} When untreated or ineffectively treated, child depression is predictive of chronic problems during adolescence as well as adult depression.^{39,60,61}

Although depression occurs in both adolescent and preadolescent youth, there are a number of important differences:

First, **depression is more common in adolescents.** Epidemiologic studies suggest that depression may impact up to 20% of adolescents by age 18,^{1,62} whereas extant data indicate 1% to 2% of school-aged youth suffer from major depressive disorder (MDD) and another 0.6% to 1.7% from dysthymic disorder (DD).¹

Second, **different risk models may underlie adolescent and preadolescent forms of depression.** For example, the cognitive vulnerability model of depression⁶³ may apply more readily to adolescent youth because, before adolescence, youth may not have well-developed negative schema for processing stress-relevant information.⁶⁴

Although forms of depression may differ across development, there are also clear differences in the developmental context and tasks between adolescent and preadolescent youth. Adolescents are developing autonomy from parents and expanding their social worlds, while still needing to maintain adaptive parent–adolescent relationships. Successful relationship functioning in adolescence includes maintaining ongoing connectedness and yet

increasing independence in family relationships, establishing strong and dependable friendships with similar-age peers, and managing emerging romantic desires and experiences. In contrast, during middle to late childhood, there is greater dependence on parents and other adult figures for negotiating social interactions as children focus on developing social abilities and academic skills. Compared to adults and adolescents, preadolescents are strongly embedded in their family context. Parents provide support and feedback throughout this period, and children are more dependent on their parents' abilities to interface with the community, support their development, and model/teach coping and other key life skills than are older adolescents or adults. In addition, the rapidly changing cognitive capacity during this developmental phase makes it unlikely that adult treatments can simply be extended downward.

These differences in both depression and developmental tasks point to a need for developmentally informed treatments during both childhood and adolescence. As a result, family-focused interventions, in which parents can help provide support, model new behavior, and help generalize skills to the home and other context, are likely to be particularly beneficial during childhood. In contrast, traditional cognitive therapies, which rest on the assumption that negative/maladaptive ways of attending to, processing, and remembering render an individual vulnerable to depression, eg,^{65,66} may be a better fit for adolescents. Interventions need to be designed with development in mind and should be tailored to address the different cognitive levels and psychosocial contexts of adolescent and preadolescent youth.

DESIGNING FAMILY-CENTERED INTERVENTIONS FOR YOUTH DEPRESSION

Data documenting the efficacy of family-based interventions for adults with mood disorders and showing promise with adolescents, in conjunction with treatment development work and data suggesting the important role of family factors in childhood depression, indicate that family approaches may be a particularly promising modality for depression both in children and adolescents (for review,^{67,68}). Specifically, a family-focused approach has potential for addressing depression across multiple family members. The high rate of depressive disorders found among parents of depressed youth underscores the fact that both depressed children and adolescents are likely to be living with depressed parents, particularly mothers.⁶⁹ For instance, in our data, the lifetime rate of major depression in mothers and fathers of children with depressive disorders (MDD or DD) was 0.63 and 0.33 respectively.⁶⁹ A family-based intervention, which can address disorders in multiple family members and enhance family functioning, may decrease risk of depressive episodes in the family as a whole. This is particularly important because depressions tend to be temporally linked across family members, with depressions in one family member seeming to be triggered by stress associated with another family member's depression.⁷⁰

A family-focused approach can also target specific family processes and stresses that are associated with poor depression outcomes (for review, see Ref.⁷¹). In our prior work, for example, parental expressed emotion (EE), an index of criticism and emotional over involvement in the home, was a strong predictor of outcome for 7- to 14-year old child

psychiatric inpatients with MDD or DD.⁷² Whereas 100% of children returning to homes with high-EE parents relapsed or showed continuing depression 1 year after hospital discharge, only 20% of children discharged to low-EE homes showed continuing depression or relapsed within that first year. Among a wide range of clinical and demographic variables, only two additional factors were found to be negatively associated with outcome: presence of a comorbid disruptive behavior disorder (attention deficit/hyperactivity, conduct, and oppositional disorders) and chronicity (>1 year of previous illness). However, even after controlling for these factors, EE remained a potent predictor of outcome. With this in mind, we developed a family-based treatment designed to specifically address the developmental needs of school-aged children and their parents through an emphasis on fostering positive and supportive parent-child interactions that scaffold the development of a positive self. This treatment appreciates the multidimensional nature of depression and addresses it systemically by helping parents provide their child additional positive feedback on his or her developmentally appropriate achievements and enhancing family and child coping.

Another advantage of family interventions is that they have greater potential, as compared to individual approaches, for addressing the range of comorbid problems typical in depressed youth. Depressed children often present with comorbid conditions, particularly anxiety and disruptive behavioral disorders.⁷³ Although family interventions may be depression focused, enhanced family coping, support, and problem solving may have broad effects on child psychopathology more generally.

Family psychoeducational approaches have been used in the treatment of mood disorders in youth,^{27,74–76} and in adults (for review, see Ref.⁶⁷). These psychoeducational approaches combine education about the disorder with skills enhancement to augment coping. In this article, we describe two intervention approaches as examples of how a family-centered approach can be used to support youth recovery: Family-Focused Treatment for Childhood Depression (FFT-CD) is a developmentally informed treatment specifically designed for preadolescent youth with depression and their families.²⁶ SAFETY is an intensive 12-week intervention designed to decrease suicide and suicide attempt risk among with a recent history of suicidal behavior.

FFT-CD

Our FFT (formerly referred to as FFI²⁶) has roots in family psychoeducational approaches, family-focused treatments developed for adults and adolescents, and cognitive-behavioral interventions. It has also been strongly influenced by interpersonal theories of depression,⁷⁷ which emphasize the role of interpersonal stress and functioning as both risk and maintaining factors. Indeed, recent research underscores the bidirectional association between depression and stress, particularly increased interpersonal conflicts and stressors; it emphasizes how depression leads to “stress-generating” interpersonal interactions that then further fuel depression. Thus, the FFT approach conceptualizes depression in youth as a biopsychosocial phenomenon. Biological and environmental factors contribute to depression onset, and cognitive, behavioral, emotional, and biological processes as well as stress impact course and outcome, leading to a downward spiral of escalating symptoms, interactions, and

stressors.⁷⁸ FFT is designed to reverse the downward spiral of depression and negative interpersonal interactions and provide enhanced support in combating feelings and maladaptive cognitive, behavioral, and emotion regulation processes that are associated with depression.

In creating a family-centered approach that would address the unique developmental needs of depressed preadolescent children, we integrated family systems and cognitive-behavioral models to provide expanded psychoeducation and skills-building within a family context. Specific FFT interventions focus on understanding the family's unique interactional processes while increasing adaptive and decreasing maladaptive interactional sequences. Using the concept of emotional spirals, families are introduced to the idea that interpersonal processes are related to mood states, providing a rationale for intervening in these processes. Two individual sessions, one with the parent(s) and one with the child, are conducted at the outset to facilitate the alliance, address questions, and provide psychoeducation at an appropriate developmental level. All other sessions are conducted with the child and parent(s) together, with siblings and others (eg, grandparents) incorporated as judged to be appropriate.

The FFT consists of five modules:

1. Rapport-building and education about depression, including introduction of an interpersonal model
2. Communication training
3. Fun activities scheduling
4. Problem solving
5. Termination.

This treatment was designed to be flexible in the face of the diverse challenges families bring to treatment. Although modules typically proceed in order, modules 2 through 4 are sometimes reordered depending on the needs of particular families.

Careful attention was paid to constructing a developmentally appropriate and informed intervention that could support durable behavioral change and generalization across multiple settings. Four specific features of the intervention are noted in this regard.

First, because school-aged youths may be uncomfortable talking about family problems, ideas are presented slowly. Handouts are used to describe concepts, and families are provided with numerous hypothetical examples; once they become comfortable with the concepts, they are asked to come up with examples from their own family.

Second, exercises are presented as “games” initially to make them more palatable to school-aged youth, increase the likelihood that these “games” could become “family tools” for combating depression after treatment is over, and create a fun/engaging “behavioral activation” exercise within the session. For example, giving positive feedback is initially presented as a game in which participants draw cards with positive statements written on them from a “hat” and have to give others the (sometimes silly) feedback. In previous work

implementing a cognitive behaviorally focused family intervention,²⁷ depressed school-aged youth preferred the behavioral aspects of CBT over its cognitive aspects, and thus we were careful to emphasize active, behavioral strategies in this family-based model.

Third, because of limits on cognitive development, school-aged children are generally more concrete than adolescents and adults. Therefore, we expanded on Rotheram-Borus and colleagues'⁷⁹ approach of using tokens to facilitate positive communication within the family. These tokens, referred to as “thanks chips,” are used throughout the treatment; the therapist models using the thanks chips to express appreciation to the child and parents and to give positive feedback. In-session “thanks chips” exercises/games are also used to help youths and parents express positive feelings/appreciation and give positive feedback to one other. In addition, between sessions, “homework” is used to promote generalization and practice of positive communication patterns. Family members are each given a number of thanks chips to take home each week with the goal of “giving all of them away” to other family members before the next session.

Fourth, session handouts use simple language, and skills are broken down into small components that can be mastered in a stepwise fashion. For example, giving positive feedback consists of identifying positive behavior (“catching upward spirals”) and giving feedback (“keeping upward spirals going”).

Family-Focused Treatment Modules

MODULE 1 includes three psychoeducational sessions:

1. One with the child
2. One with his/her parent(s)
3. One joint session.

Parent session goals include:

1. Providing psychoeducation about depression
2. Supporting parents' roles as models and change agents for their children
3. Emphasizing the role of “stress” in perpetuating family difficulties and child problems/symptoms
4. Refocusing the problem from one of “fixing” the child to one of helping the family to cope with stress and promoting the child's recovery.

Depressed children are often coping with multiple stressors, and teaching new ways of coping with these stressors is meant to enhance parental efficacy. The first session with the parents begins by providing feedback on the diagnostic evaluation, including diagnoses, a brief case conceptualization (emphasizing the role of stress), and treatment recommendations. Although each conceptualization differs depending on life circumstances, comorbidity, and other factors, each includes a description of the symptoms that were apparent, a review of some of the stressors that might be contributing to the symptoms, and a biopsychosocial model for how the symptoms developed and how they could be ameliorated through treatment. The therapist normalizes the frustration and, often,

helplessness that parents may feel. Given the fact that depression in children is frequently characterized by irritability as well as the research underscoring the negative interaction qualities of depressed children,⁸⁰ we are careful to underscore the bidirectional nature of depression and stress in families; stress can fuel depression and depression can fuel negative family interactions. For example, a child who is dysphoric in facing a negative life event (eg, losing a much loved pet) or an ongoing life stressor (eg, severe bullying at school) may become more anhedonic and negative when interacting with parents, increasing the likelihood of conflicts and impacting his or her ability to access parental support. Parents can become frustrated as their attempts to provide assistance may be unsuccessful. Therapy is presented as an opportunity to learn skills for overcoming depression and for the parents to mobilize family resources and parenting strategies to support the child's recovery.

Module 1 then proceeds to an individual session with the child, in which the therapist engages the child in a discussion of "happy," "sad," and "angry" feelings. The child is then presented a model demonstrating how the behavior of others and the behavior of self and moods are all connected. As with the parent session, the bidirectional association between moods and interpersonal relationships is emphasized. The idea of upward and downward interactional spirals is presented and the child is encouraged to provide examples. Throughout, negative interactions are normalized and their role in perpetuating depression is emphasized.

In the final Module 1 session, the therapist reviews the interactional depression model and the rationale for FFT with the parents and child together. The therapist establishes the family as the unit of treatment by reframing the problem as an interactional one in which, working together, parents and children can help combat depression and create ways of responding within the family that protect the child from some of the negative sequelae of stress. Children and their families are provided information about the ways in which family and other social interactions affect mood, using the concept of emotional spirals (illustrated on handouts). As illustrated in Fig. 1, in downward emotional spirals, negative interpersonal communication contributes to negative emotions that further contribute to negative communication and so on. In upward emotional spirals (Fig. 2), positive interpersonal interactions contribute to positive emotions that further fuel positive interpersonal interactions. Good family communication and problem solving can be used to turn downward spirals into upward spirals, and all families need to work on these skills, practicing ways to work together effectively. Families are shown pictorial examples of escalating cycles of both positive and negative family communication and are asked to identify similar patterns within their families. Normalizing is used to remind families that all families experience negative and positive spirals, thus disrupting the tendency to blame. The session focus is to identify the understandable patterns that families get into when someone is depressed or confronting high levels of stress and to engender hope that family members can have a positive and effective impact on the depressed individual. The rationale of the treatment is clearly laid out: "to stop downward spirals and to start upward spirals so that everyone feels better."

MODULE 2—“Families Talking to One Another”—takes three or four sessions, includes the child and parent(s), and focuses on communication training. The goals of these sessions are to:

1. Increase the child’s assertiveness skills
2. Decrease depressive withdrawal and irritability
3. Engage the family members
4. Encourage the development of empathy.

Specific skills include giving positive feedback to other family members, listening actively, making positive requests for behavioral change, and giving negative feedback. Handouts describe each of the skills to be learned. Role-playing, behavioral rehearsal, and homework assignments are used to help shape these behaviors. The therapist actively models, directs, and provides verbal reinforcement to family members during this learning process. We have created a number of games to reinforce learning. For example, in practicing active listening, players draw a card on which instructions are written for specific self-disclosure (eg, “Describe a time when you felt really afraid”). One player engages in the self-disclosure, another is the “active listener,” while other family members have the job of making sure the listener is implementing all the skills listed on the active listening handout. To make it less anxiety provoking for children, this game starts with items that focus on listening for content (eg, “Describe how to make a peanut butter-and-jelly sandwich”), moves to listening for emotion about a third party (eg, “Bob just found out he failed a test, describe how he would feel”), and finally moves to listening to personal emotional self-disclosure (eg, “Describe a time when you felt really angry”). Again, normalization is frequently used, conveying to family members that although these skills are important, it is natural and understandable for all families to need to practice them.

MODULE 3—“Things we do affect how we feel”—takes two or three sessions, includes the child and parents(s), and is based on pleasant activity scheduling strategies. The goals of these sessions are to:

1. Increase positive reinforcers in the child’s environment
2. Increase positive family interactions.

Each member specifies several activities that make him or her “feel better after a rough day.” The therapist uses this discussion to normalize stress, to emphasize measures that can be taken to reduce its impact, and to encourage communication of needs between family members. Family members use communication exercises to ask others family members to engage in activities. Families are then encouraged to plan and implement several fun activities together as homework. Care is taken to help them select “do-able” activities that require limited resources and time (eg, walking the dog, playing a game, reading a book, or watching a family movie together).

MODULE 4—“We can solve problems together”—takes three or four sessions and includes two sections: problem identification and problem solving. These sessions include the child and parent(s), and at times also include a sibling or siblings, particularly if

problems with siblings were contributing to the perpetuation of downward spirals in the family. The goals of the first section of this module, problem identification, are to:

1. Have family members develop problem identification skills
2. Practice self-monitoring of emotional states
3. Reframe problems as choices and opportunities to problem solve.

The goals of the second section of this module, problem solving, are to:

1. Practice conflict resolution skills
2. Empower the family to solve and become more flexible in approaching problems.

Children and their parents are taught to brainstorm possible solutions, to decide upon the optimal solution(s), and to effectively implement the solution(s). The therapist actively presents the family with the steps of problem solving, aids in defining the problem and evaluating the solutions, and reviews the success of the implemented solution(s). Throughout this process, therapists lower family expectations by normalizing problems, framing problem solutions as experiments to be tested, and by emphasizing the need to adjust problem solutions over time.

MODULE 5—“Saying goodbye”—takes one or two sessions. The child is given a colorful notebook including all the handouts that were used in treatment and is provided the opportunity to decorate the cover in order to more take ownership of the material. The therapist, child, and parent(s) look through the handouts together, remembering and reviewing the material. A problem-solving exercise is conducted to solve the problem of how to “keep your new skills going” after termination. The goals of these sessions are to:

1. Provide additional practice in problem solving
2. Encourage generalization of skills
3. Establish a regular family meeting time.

During these sessions, the family members are praised for their hard work, progress is acknowledged, and further work planned as necessary. See Family-Focused Treatment Case Vignette and Fig. 3 for details on FFT in practice.

Our experience to date with FFT for depressed children demonstrates that, first, the intervention is safe, feasible, and acceptable. There were no adverse events associated with FFT; it can be effectively implemented with a wide range of families; and families are interested in such a treatment, seldom dropping out once treatment is initiated. Second, this FFT can positively impact the course of depression.²⁶ Finally, children report improved family functioning after treatment. Currently a two-site clinical trial (Boston University and UCLA) is being conducted to examine the efficacy of FFT compared to an individual supportive treatment modeled after usual care. In addition to evaluating efficacy, this trial will allow examination of potential moderators (parental EE, severity/chronicity of depression, externalizing comorbidity) and mediators (reduction in parental depression, reduction in family conflict) of treatment impact.

SAFETY TREATMENT FOR ADOLESCENT SUICIDE ATTEMPTERS

The SAFETY treatment was developed as a 12-week intervention designed to be incorporated in emergency mental health services for youths presenting with suicide attempts. SAFETY stands for Safe Alternatives for Teens and Youths, with the program name intended as a reminder to youths and parents that the goal of the program is to enhance SAFETY and identify safe and healthy alternatives to suicidal behavior when problems and stress appear insurmountable. Although this trial is still in progress, and results are not yet available, we offer this description as an illustration of another approach to family treatment that has been developed for adolescents versus younger children.

Our treatment development approach involved a community partnership model in which community providers and service organizations were included from the start, the approach was piloted in community settings early in the treatment development process, and feedback/discussions between the community partners and the research team helped shape the developing treatment strategy. The SAFETY treatment is rooted in cognitive-behavioral and family systems models; builds directly on our work on emergency department (ED) interventions for suicidal youths^{81,82} and the “first-generation” Specialized Emergency Room intervention on which the Family Intervention for Suicide Prevention (FISP) was based⁸³; and draws on strategies from CBT, dialectical behavior therapy (DBT),^{84,85} and multisystemic therapy (MST).^{86,87} The target age range for the SAFETY program is 12 through 18 years, primarily because suicide attempt rates are lower before adolescence. A team of two therapists delivers the treatment: one therapist identifies primarily as the child’s therapist and the other primarily as the parent(s)’ therapist. Sessions generally include an “individual component” with youth and parents seen by their respective therapists and a family component in which youths and parents are brought together to practice or reinforce skills emphasized in the individual session components.

Treatment is conceptualized as involving three phases, although issues addressed in one phase often reemerge in other phases.

1. Phase 1 emphasizes maximizing safety by developing an initial “cognitive-behavioral fit analysis” (CBFA; Fig. 4) that describes the risk and protective factors for reattempts and highlights the most important targets for intervention. This CBFA is developed collaboratively with the youth and family and forms the basis for the development of a collaborative treatment plan.
2. Phase 2 emphasizes work on specific skills or areas identified in the CBFT.
3. Phase 3 focuses on consolidation of gains/skill learning and relapse prevention.

Consistent with the MST approach, sessions and phone contacts are scheduled based on youth and parental need. Sessions generally occur on a weekly basis. At the early phases of treatment when attempt risk is high, a more frequent treatment dose is often used to promote learning and strengthen safe coping behavior. Each of these phases is described in greater detail in the text that follows.

The initial phase 1 goal of maximizing youth safety is addressed through an initial in-home session, unless the family is unwilling to have the treatment team visit the home. As in the FISP^{81,82} and specialized Emergency Room intervention,⁸³ this session is conceptualized as a therapeutic intervention and “imminent risk assessment” that focuses on four major tasks.⁸³ Youths or families who cannot address these tasks are viewed as high-risk and possibly requiring more intensive evaluation and a more restrictive/intensive treatment (eg, hospitalization).

- The first task of the in-home session is to strengthen family support and healthy communication by assisting the youth and parent(s) in identifying positive attributes in the youth and the family as a whole.
- Second, an “emotional thermometer,” a hierarchy of “suicide-triggering situations,” is identified and youths are supported in identifying feelings, triggers, and associated physiologic signals, thoughts, and behaviors.
- Third, this information is used to develop and practice using a “safety plan” that youths can use to reduce their “emotional temperature” when it is getting too hot and risk for uncontrolled, dangerous, or suicidal behavior is elevated. Diverse coping strategies are encouraged, including behavioral, self-soothing strategies (ie, putting a cool wash cloth on the forehead, listening to comforting music, relaxation, distraction, seeking support from parents), cognitive strategies (“helpful” thoughts), and the development of a “Hope Box” or “Emergency Kit” filled with reminders of reasons for living and cues/facilitators of the safety plan (coping cards, CDs, telephone numbers of people to call for support).
- Fourth, the therapist works to obtain a commitment from the youth to use the SAFETY plan if he or she feels suicidal rather than attempting suicide and a SAFETY plan card is developed to serve as a concrete support that youth can keep and use at times of acute stress/suicide attempt risk to cue him or her to use adaptive coping strategies.

These treatment tasks can be conducted individually with the youth and parent or with the family together; therapists make this choice based on their assessments of which format will prove most effective. However, parents and youths are brought together to finalize the safety plan and share the positive characteristics they each identified in the youth and family. The safety plan always includes telling the youth and parents to page the therapist in the event of concerns about increasing risk and to call 911 or go to the nearest emergency room in a suicidal crisis. Safety plans are used in a wide range of treatments for suicidal youths. The model used here is rooted in that developed by Rotheram-Borus and colleagues⁸³ and emphasizes identifying specific skills and strategies that youths can use to down-regulate their emotional temperatures and decrease the risk of suicidal behavior.

The initial session also includes psychoeducation regarding the importance of continuing treatment and restricting access to dangerous suicide attempt methods. Indeed, this session is held in the home partly to evaluate potentially dangerous suicide attempt means in the home environment and to facilitate engineering of the environment to reduce suicide attempt risk. The parent therapist meets with the parent(s) individually to identify potentially dangerous

suicide attempt (SA) methods in the house, lock up or remove any medications or other dangerous potential SA means, find a strategy for eliminating access to loaded guns if they are present in the home, and address any other major safety issues (eg, on home visits we have discovered balconies that could be used to jump and have arranged for doors to these upper floor balconies to be locked). A metaphor used in this work is to ask the parents to imagine that they are on a diet and their refrigerator is full of your favorite ice cream; we want to change the environment to create as many obstacles as possible to SAs just like they would not want to have the ice cream right there if they had the urge to eat ice cream. Families are taught that as time passes, the more likely it is that the “suicide attempt urge” will pass, something may interrupt the process, or some other protective factor may emerge. The youth therapist meets with the youth individually at this time and asks to see his or her room and any other key features of the environment (eg, a favorite spot in the yard). The therapist works with the youth to restrict access to potentially dangerous SA methods, create cues for using the SAFETY plan in the home (eg, arranging the location of the HOPE Box, coping resources, reminders of reasons for living), and uses any remaining time to get to know the youth better, strengthen the relationship, and reinforce the work completed in session. The therapist also introduces the mood diary as a “practice” between sessions, with youths charting their mood daily as well as any thoughts of deliberate self-injury/suicide attempts and any suicidal or self-injurious behavior. The mood diary is continued as a standard practice throughout treatment.

The second and third sessions during phase 1 focus on developing the CB fit analysis and to identify risk and protective factors at the individual, family, peer, and community level. A chain analysis of the target SA is conducted with the youth and parent(s) in individual sessions to understand the sequence of events, feelings, thoughts, behaviors, and reactions leading up to, during, and after the SA.^{84,85} This information is combined with a broader assessment of risk and protective factors to develop the CBFT and collaborative treatment plan. The concept of a SAFETY pyramid is used in the development of the treatment plan.

1. **SAFE settings** form the base of the pyramid, with the importance of restricting access to dangerous SA methods and providing protective supervision and monitoring emphasized.
2. **SAFE people** are emphasized at the next level; the importance of working to increase the likelihood that the youth will turn to the parents and other responsible adults and youths as safe people at times of SA risk is discussed. Because of the increasing focus on peer support during the adolescent years, this is challenging for many families and the structure of the SAFETY program is designed to explicitly promote and practice turning to parents/parent figures instead of self-harm behavior at times of acute risk.
3. **SAFE activities** are promoted, through an analysis of the ways in which youths spend their time, the effect of activities on mood and SA risk, and the development of strategies for increasing time spent in activities that build “a life worth living.”⁸⁴
4. **SAFE thoughts** are emphasized at this next level of the pyramid, with an emphasis on finding realistic but helpful ways of thinking that allow individuals to accept

what they cannot change and to think about problems in helpful as opposed to hopeless/unhelpful ways.

5. **SAFE stress reactions** form the tip of the pyramid, with an emphasis on the need to develop strategies for managing stress without turning to SA or self-harm.

As in all phases of the intervention, the mood diary is reviewed at the start of each youth session and skills are introduced to facilitate using skills as opposed to resorting to self-harm in high-risk moments. The Hope Box, filled with reminders of reasons for living and cues/resources for using the SAFETY plan (as described earlier) and coping skills is developed and expanded on during phase 1. Because of the high rate of depression among youths attempting suicide (79% reported severe depressive symptoms in our prior study,⁸¹ CBT strategies, such as activity scheduling and developing helpful ways of thinking, are often introduced during phase 1, in addition to the concept of reversing downward spirals into depression and hopelessness through trying different activities and ways of thinking about events. Activity monitoring also provides information regarding the youth's life situation and context, and this is helpful for developing the CBFA. In parent sessions, a safety plan is developed with the parent(s) that focuses on how the parent(s) can identify signs that the youth is moving into a "high-risk temperature zone," how they can regulate their own emotional temperature, and ways they can respond to help their child down-regulate his or her emotional temperature and cope in a safe manner (without suicidality or self-harm).

Across all treatment phases, family sessions follow a standard format and begin with a round of "thanks notes," sticky notes on which family members write something they appreciate about someone else in the family. Family members give these notes to one another to say "thank you" and express appreciation for things done during the week. This is intended to encourage family members to notice and attend to things they appreciate about each other, strengthen their tendencies to tell one another what they like and appreciate, build a more supportive home environment, and increase the likelihood that youths will turn to parents in the event that SA risk should reappear. Therapists generally join this exercise to model the skill and reinforce progress in youths and parents. To promote consolidation and generalization of the individual work to the family environment, each team (youth and parents) then presents a capsule summary of the work they did in session, designed to encourage optimism regarding the work and changes being accomplished. If appropriate, an aspect of one of the skills is introduced in the session. For instance, if the youth has done mood and activity monitoring as part of the session, he or she could introduce this to the parents and have them practice the skill during the next week. Conversely, if parents have worked on active listening during the individual session component, during the family session the parents could share that they are working on being better listeners and introduce the active listening skills and an active listening practice activity/game during the session. The session ends with a practice assignment for the next week that always includes "thanks notes," and therapists may conclude the session with another round of "thanks notes." Some families have opted to send text messages as "thanks notes," which has appeal for many youths and parents who are more technologically inclined.

Given the heterogeneity among youths who attempt suicide and their environmental circumstances, the CBFA varies across youths. However, several common themes emerge in

phase 2 of treatment. As noted previously, much of the work done individually with youths focuses on CBT and DBT strategies; they are asked to monitor their moods, self-harm thoughts, and behavior between sessions using the mood diary and skills are frequently introduced as part of the card as a reminder that the goal is to use the “skills” versus self-injurious behavior to cope with stress/“unbearable” emotions and to obtain data on the effects of skill use/practice. We have found that in almost every case we have done some work on activities, thoughts, emotion regulation, and communication/problem solving. With parents, we have found that active listening is consistently a key target, as many parents rush to problem solve or give advice when the youth is in need of understanding and validation before effective problem solving can occur. Because depression and suicidal tendencies can run in families, and having a child attempt suicide is very stressful for any parent, a focus on parental emotional needs is important; in some instances the CBFT or parent reactions to the SA and sequelae of the SA dictate a need to focus on strategies for addressing parental depression, anxiety, distress, or even suicidality, including referral for treatment (medication or individual). Regardless of the treatment plan and specific skills emphasized during phase 2 (based on the CBFT), a consistent theme across families has been to develop and practice strategies for youths to be able to turn to their parents for support at times of emerging suicidal impulses/SA-risk, and for parents to develop strategies for responding that facilitate youths down-regulating their emotional temperatures and returning to safer affective states. This frequently involves helping parents listen and support youths in using distress tolerance skills such as distraction (ie, validating the youths emotional reactions/stress and shifting the focus to activities like making cookies, taking the dog for a walk) to help youths regain a sense of emotional control so that they can get through the stressful moment and address the stressor with greater emotional strength and skill. Based on the CBFT and treatment plan, other responsible adults may be brought into the treatment or introduced as another resource to which youths can turn. This could include other relatives, providers (ie, primary care, therapists, school counselors), or adults in their school or community.

Phase 3 emphasizes relapse prevention. Strategies that have proven helpful to the youth and family over the course of treatment are reviewed and the youth is asked to engage in a relapse prevention task.^{88,89} This task is introduced as an opportunity for the youth to review the chain of events leading to the index SA and to replay the events using the new skills developed during treatment. The youth is also asked to consider potential new stresses that might have previously triggered self-harm/SA impulses and how he or she could use skills to respond to these stresses in safe ways without resorting to self-harm. A guided imagery approach is used to help the youth capture the emotions associated with the initial SA chain to assess the youth’s ability to reexperience intense distress, tolerate these emotions, and use skills instead of self-harm behavior/SAs. A similar approach is used with parents to help them to consolidate skills for supporting their youths in times of high SA risk. Throughout phase 3, skill practice is emphasized to further strengthen the abilities of youths to use skills instead of SA/self-harm behavior and the increase the parental ability to support youths in tolerating stress and distress and using skills to down-regulate their child’s emotional response. This often involves continuing work with parents on practicing skills to down-regulate their own emotional reactions so that they can provide effective support to their children and feel more confident and less stressed. Although youths and parents know

that the treatment is time limited from the start, phase 3 also emphasizes termination and links youths and families to additional treatment resources as needed. A goal of phase 3 is to have youths and families connected to other providers at the end of the SAFETY treatment for additional mental health treatment and, when needed, to primary care, school, or other services. Because of the barriers to mental health care, both real and perceived (ie, stigma and the desire of youths and parents to feel that they have developed new and effective strategies for addressing stress, intense emotions, and self-harm tendencies), we consistently emphasize primary care as a resource for mental health as well as health monitoring and care.^{2,27,81}

DEVELOPMENTAL ISSUES

These two approaches—FFT for childhood depression and the SAFETY program for adolescent suicide prevention—highlight a number of ways in which interventions are tailored to meet the developmental levels and needs of youths. Some of these are noted below.

First, we have found that cognitive and emotional differences across development have influenced how quickly we can address issues within families. With younger children, we have found that “warm-up” activities, like games and practice focused on problems not specific to the child, are often helpful in engaging the child in a nonblaming atmosphere. Thus, in working with families of younger children, we take a slow approach, gradually addressing family-specific problems as children gain skills and become more comfortable in the family therapy setting. In contrast, when working with adolescents, we continue to use “games” to practice skills and begin with examples that are not likely to trigger intense emotions, yet we are able to move to emotionally charged issues more quickly and focus communication and problem-solving exercises on issues that are specifically relevant to individual adolescents and their families (ie, curfews, tensions in the home).

Second, developmental factors influence the degree to which family members are seen in conjoint versus individual sessions and how other family members might be integrated in the treatment model. Younger children are strongly embedded within the family context and, often, dependent on parents for support in solving problems both within the family context and the larger social environment. When parents demonstrate good listening skills and support, younger children generally welcome their input in solving problems with peers, providing an opportunity for the therapist to underscore the role of parents as potential helping agents. Thus, we have found it useful to include both the child and parent in most family sessions. When individual sessions are needed, they usually are briefer, involve parents alone, and focus on implementation of behavior management techniques/strategies and or marital/family stressors that impact parenting. In addition, younger children often benefit from the inclusion of siblings in some sessions, particularly those focused on problem solving. In working with families of younger children, several specific family problems regularly emerge, including cleaning up around the house, doing homework, TV/computer time, and, regularly, conflicts with siblings. Thus, problem-solving sessions focused on developing strategies for improving sibling relationships can reduce stress for all family members. In contrast, given the tendencies for adolescents to shift their focus to peers

and outside/nonfamily activities as they mature, we have found that it is often useful to have more individual time with adolescents to address issues that they may not be able to discuss with their parents present (ie, romantic breakups that are often precipitants of depression and suicidal behavior, bullying, and risky behavior or situations). Conversely, individual time with parents provides opportunities to address sensitive issues openly, without the potential of adverse youth reactions (ie, parent depression, marital tensions, parental concerns about youth friends or behavior). By combining the individual time with youths and parents, we have found that we are able to effectively address individual issues, gain information that would not emerge in family sessions, prepare youths and parents to come together in “new ways,” disrupt negative family interactional sequences/scripts, enhance skills for working together as a family to reduce SA risk in the youth, and promote healthy functioning. This approach is similar to those employed by Beardslee and colleagues⁹⁰ in their preventive interventions and Diamond and colleagues⁹¹ in attachment-based family therapy.

SUMMARY

In sum, brief family psychoeducation has been used to improve treatment engagement⁷⁴ and is considered a standard of care.¹ Evidence is emerging that more intensive family interventions may be efficacious in the prevention^{92,93} and treatment of youth depression^{24,90} and suicidality.¹⁹

In this article we have reviewed the literature on family treatments for youth depression and described and illustrated two family-based treatment models that specifically incorporate developmental factors. We expect that the next few years will demonstrate more conclusively that increased inclusion of families in the treatment of depression and suicide may broaden social support, help skill generalization, and enhance treatment efficacy.

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Family-Focused Treatment Case Vignette

“Emily” was a 9 1/2-year-old girl with dysthymic disorder. She was the middle of three children in an intact family with an older sister and a younger brother. At treatment outset she reported depressed, and frequently “grumpy” and “frustrated,” mood most of the day. Emily had good school performance and relationships with peers, but tended to isolate from others when sad. Her mother and father reported intense temperament, perfectionism, and high rejection sensitivity. She had frequent verbal and sometimes physical altercations with her siblings and mother and reported feeling that she was “not part of the family.” Her mother believed that Emily hated her, felt hopeless about improving the relationship, and described frequent interactions in which Emily demanded attention but seemed to reject it when it was offered.

Early Treatment

Emily and her mother attended 12 sessions of FFT, and her father joined in when his travel schedule allowed. The first two sessions focused on psychoeducation and engaging the family. Despite the mother’s initial expressions of frustration and indications they she had “tried everything,” she was quickly engaged. The child initially displayed limited affect, but was able to engage in role plays readily. Initial sessions focusing on enhancing positive interactions resulted in more warmth between the mother and daughter during sessions and reports of more shared enjoyment at home. Thus, positive feedback and active listening exercises and fun activities scheduling were used to strengthen the relationship between Emily and her mother, as well as to enhance the bond with her father, whose frequent travel schedule limited their time together.

Middle Phases of Treatment

The next phase of treatment focused on identifying downward spirals in the family and using communication and problem-solving exercises to address these spirals. Using the FFT model, we were quickly able to identify a downward spiral that recurred with some frequency in which Emily felt sad and wished for support from her mother; however, she did not communicate this wish. In the absence of direct communication, Emily’s mother did not recognize her wish and respond as desired, leading Emily to become angry and resentful and push her mother away. This cycle fueled Emily’s continuing feelings of increasing isolation, sadness, and anger. Fig. 3 illustrates this downward spiral.

At session 5, Emily became increasingly withdrawn from treatment and expressed a desire to discontinue. With much support and active listening on the part of the therapist and her mother, she was able to articulate her concerns— the timing of sessions interfered with some valued school activities. The therapist was able to use this problem to illustrate the downward spiral in the therapy, underscore its similarity to the downward spiral that frequently occurred with her mother, and model the use of both direct communication and problem solving. This represented a turning point in treatment. Communication training was utilized to help Emily to express her needs and desires to her mother and help her mother to listen actively. Problem-solving training focused on ways in which Emily and her mother could work more effectively together when intense feelings were aroused.

Final Phase of Treatment

During the final treatment sessions, gains were extended and consolidated and plans were made for the future. A sibling session was conducted to identify the “downward spirals” associated with the sibling conflicts (particularly the quick escalation of teasing behavior) and to problem solve potential solutions. This session was lighthearted and Emily enjoyed seeing her siblings “on the hot seat.” Problem solving led to the use of a “stop” signal that siblings could employ when teasing interactions felt overwhelming to anyone; this solution appeared to decrease downward spirals at home. The family reported frequently using their skills at home and posting the Communication Training handouts on the refrigerator as a reminder. At the final session, which occurred before the beginning of the new school year, a booklet of handouts from the treatment was provided for Emily, and she was given the opportunity to decorate the cover. The book was used with the family to review the content of the previous 11 sessions. Time was spent anticipating potential problems, including school stress, that might derail progress, and plans were made to confront this stress as a family.

Emily and both her mother and father reported improvements in her mood and in their family interactions by treatment end. These improvements were maintained at the 9-month follow-up and, indeed, continued to be reported by her mother 2 years later.

Safety Case Vignette

“Jane” was a 15-year-old girl who lived with her single mother. She presented to the emergency department (ED) after a suicide attempt by overdose. As illustrated in the initial cognitive-behavioral fit analysis below, Jane’s suicide attempt was triggered by a conflict with her mother that developed when Jane refused to go to school and her mother insisted. At school, Jane was rejected by peers, had academic difficulties, and had few positive experiences. She disliked school, frequently faked illness to avoid going to school, and felt hopeless and helpless to change her life situation. Her mother worked hard to support them and could not stay home with Jane because of fear of losing her job. Jane was aware of that, which made her feel guilt and shame and intensified her emotional distress. When asked about what happened before the suicide attempt, Jane stated: “I couldn’t stand it. Nothing helps. I hate school. I can’t get along with my mother. I just wanted to die, make all of the bad feelings go away, when I saw the pills I just took all of the pills in the bottle. I was done with it.” Jane had a history of one prior suicide attempt by overdose.

Phase 1 (Sessions 1–3): Development of CBFA and Intervention Plan

Session 1 was conducted in the home and represented an expansion on our ED intervention.^{81,82} The session began by working with Jane to notice her strengths and positive characteristics and help Jane and her mother notice strengths and positive characteristics in their family. Using standard procedures from our ED intervention, a feeling thermometer was used to assist Jane in identifying high-risk situations for suicidal behavior and her reactions to these situations, with the goal of identifying feelings, thoughts, and physiologic and behavioral warning signs that her temperature was reaching a high-risk zone.

Based on these data, an initial SAFETY plan was developed that emphasized strategies that Jane could use to “reduce her temperature” (regulate her emotion and enhance distress tolerance), such as putting a cold cloth on her head and focusing on the way this felt, watching a funny video, reading a series of coping self-statements (eg, Just take things one step at a time), and going to her mother and asking her to engage in an activity with her without talking about anything except the activity. Jane and her mother enjoyed each other when engaged in an activity (eg, baking cookies), but unstructured conversation frequently led to escalating tension and feelings of shame and guilt. Jane appeared enthusiastic about treatment. She agreed to use the SAFETY plan if she felt her temperature rising and contracted to tell her mother if she felt she could not control a suicidal impulse. Emergency telephone numbers were given to Jane and her mother and they agreed to contact the therapist in an emergency. To restrict access to potentially dangerous suicide attempt methods, all medications, razor blades, and other potentially dangerous means of self-harm were removed/locked up (SAFE SETTINGS/ENVIRONMENT). Standard practices/homework were assigned, including the mood diary for Jane and thanks notes for Jane and her mother.

In **Session 2**, the individual work with Jane began with a check on the week’s practice/mood diary and thanks notes, her safety, how the coping strategies listed in her SAFETY

plan had worked, and to conduct an expanded fit analysis aimed at obtaining a chain analysis of the events leading up to the suicide attempt and consequences of the attempt. The session ended with the “hope box” task, with Jane creating a box in which she placed cues and “tools” to facilitate and cue the use of SAFE coping strategies (eg, a washcloth, favorite video, pictures of good times in her life and places she wanted to go, cookie recipes she wanted to try, and a “relaxation CD” given to her by the therapist). She called this box “Kelly,” as she thought “hope box” was “weird.” In addition to the mood diary, her practice for the week also involved trying out “Kelly” during the week and creating a “mini-Kelly” that she could take to school with her to help her get through the day. The session with the mother similarly involved practice review (thanks notes); review of SAFETY and incidents during the week; a chain analysis of the suicide attempt; introduction of the SAFETY pyramid; and review of risk and protective factors for suicide attempts in the family, peer, school, and community systems. The family component of the session was 15 minutes and involved a round of thanks notes, capsule summaries in which Jane presented “Kelly” and the idea of developing a “mini-Kelly” to help her get through the stress of school, as well as her mother discussing the SAFETY pyramid and how she was working on being a SAFE person for Jane and creating a SAFE environment with reduced stress.

Session 3 built on the work of the prior sessions with the standard format. The focus was on identifying SAFETY versus RISK within multiple systemic contexts (family, peers, school, community) and at the different intervention levels (SAFETY pyramid), and developing a collaborative treatment plan. Based on the CBFA, the treatment plan emphasized the importance of maintaining a SAFE home environment (SETTING) where access to suicide attempt methods was restricted and interactions between Jane and her mother were more supportive and less tense (SAFE PEOPLE). The positive behaviors and activities that they had identified through the “thanks notes” practice were used to highlight SAFE ACTIVITIES & ACTIONS. The importance of SAFE THOUGHTS versus thoughts of hopelessness, guilt, and shame was emphasized; and the coping strategies that Jane had found most helpful were related to SAFE STRESS REACTIONS on the SAFETY pyramid and tools and reminders that Jane could keep in “Kelly” and “mini-Kelly.” Treatment options were discussed, including the possibility of considering an evaluation for possible medication treatment, which neither Jane nor her mother wanted. During the family portion of the session, there was an emphasis on reinforcing progress using the “thanks notes” to communicate things that Jane and her mother appreciated in their daily interactions.

Phase 2: Intervention Plan Implementation

Based on the CBFA, the most proximal triggers of suicidal behavior appeared to be (1) hopelessness and maladaptive depressotypic thought patterns, (2) problems with distress tolerance and emotion regulation, and (3) family tension. Therefore, building on the foundation of the initial sessions and practices that emphasized building family support (eg, family “thanks notes”), a decision was made to begin with modules designed to build hope and more hopeful and SAFE thoughts as well as teaching skills for tolerating distress and regulating intense emotions. The goal was to support Jane in using her emotion regulation and distress tolerance skills instead of engaging in non-suicidal self-

injury or suicidal behavior. With the mother, the emphasis was on strengthening family support, communication, and problem solving. Because family conflict had triggered the attempt, it was viewed as critical to enhance the mother's ability to listen to and understand Jane's experiences and reactions, communication, and conflict resolution skills. Family sessions emphasized promoting "active listening," communication, and problem solving with the goal of increasing supportive interactions and the likelihood that Jane would be able to turn to her mother rather than engaging in suicidal behavior. Throughout all sessions, there was an emphasis on reinforcing the skills presented in prior sessions (eg, when addressing family communication, ways in which different thoughts could help vs impede the communication process were discussed). A plan was developed with the school to create a more supportive school environment, with some class changes, a counselor whom Jane could go to if she had a problem, and a plan for Jane to help out at the library during lunch period (a time that Jane found particularly stressful).

Phase 3: Consolidation and Relapse Prevention

During the final 3 sessions, the problems and issues that Jane and her mother brought up were addressed using strategies introduced in previous sessions. The mother was encouraged to continue to speak with the school counselor about strategies for improving Jane's school situation. Following the relapse prevention task, a relapse prevention plan was developed that emphasized noting early warning signs, seeking help through her primary care physician (whom Jane liked and confided in), seeking support at school from the school counselor, and practicing and reinforcing strategies for coping with stress. At the intervention end point, Jane had begun weekly therapy with the school counselor and a follow-up appointment had been scheduled with the primary care physician. She had not shown any suicidal behavior during the treatment period. Although she had experienced suicidal ideation at times, she had been able to manage these thoughts with her coping strategies and "Kelly," and at the treatment end-point she reported significant improvements in suicidal ideation, hopelessness, depression, and family communication and support.

Fig. 1.
Downward spiral.

Fig. 2.
Upward spiral.

Fig. 3.
Emily's downward spiral.

Fig. 4.
Sample Cognitive-Behavioral Fit Analysis.

Table 1

Randomized clinical Intervention trials for adolescents with depression

References	Subjects	Diagnostic/Risk Assessment	Format(s)	Intervention Type(s)	Degree of Family Involvement	Post-Treatment Assessment	Impact of Treatment
Asamow et al ²	Ages 13–21 (n = 418)	Either: 1 “stem items” for MDD or DD from the CIDI-12, 1 week or more of past-month depressive symptoms, and a total CES-D score >16, or 2 CES-D score 24	Individual	1 6-month quality improvement intervention 2 Usual care	Parent consultation offered	Immediate	Intervention patients, compared with usual care patients, reported significantly higher mental health care utilization, fewer depressive symptoms, higher mental health-related quality of life, and greater satisfaction with mental health care.
Brent et al ⁶ ; Birmaher et al ⁹⁵	Ages 13–18 (n = 107)	Diagnosis of MDD based on K-SADS Interview and BDI 13	Family; Individual	1 SBFT 2 CBT 3 Supportive therapy	Extensive family involvement only in the SBFT group only	Immediate; 2 years ⁹⁵	The CBT group had faster response, less diagnosable MDD at the end of the treatment, a lower number of depressive symptoms, and were more likely to be remitted. No differences in depression between treatment groups at 2-year follow-up.
Brent et al ⁹⁶	Ages 12–18 (n = 334)	Diagnosis of MDD based on K-SADS-PL, CDRS 40, resistant to “adequate trial” of SSRIs (equivalent to 40 mg fluoxetine)	Individual	1 CBT + medication change 2 Medication change alone	Family education plus additional family sessions, focusing on decreasing conflict and improving family communication and problem solving (mean = 1; range, 0–7 family sessions)	Immediate 24 weeks 48 weeks 72 weeks	Combined CBT + medication was associated with a significantly higher rate of clinical response/improvement at the end of the acute treatment phase (12 weeks) as compared to a medication switch alone.
Clarke et al ⁸	Ages 14–18 (n = 123)	Diagnosis of MDD or DD based on the K-SADS interview	Group	1 CWD-A 2 CWD-A with nine-session parent group 3 WLC	Concurrent parent sessions plus two joint parent-adolescent groups in CWD-A plus parent group; none in other groups	Immediate; 12 months; 24 months	CBT was associated with higher depression recovery rates (66.7% vs 48.1 % in wait list condition) and greater reduction in depressive symptoms. Addition of parent group had no significant effect. Booster sessions accelerated recovery among youth still

References	Subjects	Diagnostic/Risk Assessment	Format(s)	Intervention Type(s)	Degree of Family Involvement	Post-Treatment Assessment	Impact of Treatment
Clarke et al ⁹⁷	Ages 13–18 (n = 88)	Diagnosis of DSM-III-RMDD and/or DD based on the K-SADS interview	Group	<p>1 Usual care plus group CBT program (CWD-A)</p> <p>2 Usual care</p>	A few parent psychoeducation sessions	Immediate; 12 months; 24 months	No significant differences between CBT and usual care, either for depression diagnoses, continuous depression measures, nonaffective mental health measures, or functioning outcomes.
Clarke et al ⁷	Ages 12–18 (n = 152)	Diagnoses of DSM-IV MDD based on the K-SADS-PL interview	Individual	<p>1 Brief CBT plus treatment as usual (primarily SSRI)</p> <p>2 Treatment as usual</p>	Monthly informational parent meetings offered	Immediate; 26 weeks; 52 weeks	CBT program showed advantages on the Short-Form-12 Mental Component Scale and reductions in treatment as usual outpatient visits and days' supply of all medications. No effects were detected for MDD episodes; a nonsignificant trend favoring CBT was detected on the CES-D.
Diamond et al ¹⁸	Ages 13–17 (n = 32)	Diagnoses of DSM-III-R MDD based on the K-SADS	Family	<p>1 ABFT</p> <p>2 Minimal-contact, WLC group</p>	Extensive family involvement in ABFT	Immediate; 6 months	At post-treatment, 81% treated no longer met criteria for MDD vs 47% of patients in the waitlist group. The ABFT patients showed greater reduction in depressive and anxiety symptoms and family conflict. At follow-up, 87% of the ABFT patients continued to not meet criteria for MDD.
Diamond et al ¹⁹	Ages 12–17 (n = 66)	Endorsement of suicidal ideation in primary care, BDI >20, and SIQ-JR >31	Family	<p>1 ABFT</p> <p>2 EUC</p>	Extensive family involvement in ABFT	Immediate; 6 months	87% of those who participated in ABFT met criteria for clinical recovery in terms of suicidal ideation as compared to 52% receiving EUC.
Fine et al ⁹⁸	Ages 13–17 (n = 66) 83% female	Diagnosis of MDD or DD based on K-SADS interview	Group	<p>1 TSG</p> <p>vs</p> <p>2 SSG</p>	None	Immediate; 9 months	At post-test both groups improved; TSG significantly more effective than SSG in reducing depression on K-SADS with more subjects in non-clinical range. Group differences disappeared at follow-up.

References	Subjects	Diagnostic/Risk Assessment	Format(s)	Intervention Type(s)	Degree of Family Involvement	Post-Treatment Assessment	Impact of Treatment
Goodyer et al ⁹⁴	Ages 11–17 (n = 208)	Referred to clinical care; MDD diagnosis; failure to respond to initial brief psychosocial intervention	Individual	1 SSRI + routine care 2 SSRI + routine care + CBT	Inclusion of parents at end of CBT session; no more than three family sessions	12 weeks 28 weeks	No differences between the treatment groups on Health of the Nation Outcome for children and adolescents, CDRS-R, GAF, or Clinical Global Improvement scale.
Kennard et al ⁹⁹	Ages 12–18 (n = 334)	Diagnosis of MDD on K-SADS interview, CDRS-R 40, CGI-S 4, and nonresponsive to SSRI treatment for at least 6 weeks	Individual	1 Medication switch 2 Medication switch and CBT	Family sessions offered	Immediate	Participants who had more than nine CBT sessions were 2.5 times more likely to have adequate treatment response than those with 9 sessions or fewer.
Lewinsohn et al ⁹	Ages 14–18 (n = 59)	Diagnosis of major, minor, or intermittent depression based on K-SADS interview with mother and adolescent	Group; Family	1 Adolescent-only CBT training group 2 Adolescent–parent CBT training groups 3 WLC	Extensive parent involvement in the adolescent–parent CBT groups only	Immediate; 1 month; 6 months; 12 months; 24 months	Significantly fewer youths in the treatment groups met criteria for depressive disorders after treatment and at follow-up. Significantly improved on self-reported depression, anxiety, number of pleasant activities, and depressogenic thoughts. Trend for adolescent–parent condition to outperform adolescent only group.
Melvin et al ¹¹	Ages 12–18 (n = 73)	Diagnosis of DSM-IV MDD, DD, or DDNOS based on the K-SADS	Individual	1 CBT 2 Antidepressant medication (Sertraline) 3 Combined CBT and medication	Concurrent parent sessions plus two family sessions	Immediate; 6 months	All groups showed significant improvement on outcome measures and this was maintained at follow-up. Combined group was not superior to monotherapy. CBT alone was superior to medication alone.
Mufson et al ¹²	Ages 12–18 (n = 48)	Clinician diagnosis of MDD based on the HRSD	Individual	1 IPT-A 2 Clinician monitoring	None	Immediate	IPT-A patients reported greater decrease in depressive symptoms, improved social functioning, and improved problem-solving skills compared to controls. In the IPT-A condition 74% recovered compared to 46% in the control condition.
Mufson et al ¹⁶	Ages 12–18 (n = 63)	DSM-IV diagnosis of MDD, DD, adjustment disorder with depressed mood, or DDNOS and	Individual	1 IPT-A 2 Treatment as usual	None in IPT-A group; several family/parent sessions for some participants in the TAU group	Immediate	IPT-A associated with fewer clinician-reported depression symptoms on the HRSD, better functioning on the C-GAS, better overall social functioning on the Social

References	Subjects	Diagnostic/Risk Assessment	Format(s)	Intervention Type(s)	Degree of Family Involvement	Post-Treatment Assessment	Impact of Treatment
		HRSD 10 and a C-GAS score 65					Adjustment Scale-Self-Report, greater clinical improvement, and greater decreases in clinical severity on the Clinical Global Impressions scale.
Reed ¹⁰⁰	Ages 14-19 (n = 18)	Clinician diagnosis of MDD or DD	Group	1 Social skills training 2 Attention placebo control	None	Immediate; 6-8 weeks	Skills group participants scored significantly higher than control group on clinicians' rating of improvement. Male subjects improved, but female subjects deteriorated.
Rohde et al ¹³	Ages 13-17 (n = 91)	DSM-IV diagnoses of MDD and Conduct Disorder based on the K-SADS-E-5	Group	1 CWD-A 2 Life skills tutoring/control	Two informational sessions offered to parents	Immediate; 6 months; 12 months	Post-treatment MDD recovery rates better in CWD-A group (36%), compared to life skills/tutoring (19%). CWD-A participants reported reductions in BDI-II and HDRS scores and improved social functioning post-treatment. Group differences in MDD recovery rates at follow-up were nonsignificant.
Rosselló and Bernal ¹⁴	Ages 13-18 (n = 71)	Diagnosis of MDD, DD, or both	Individual	1 CBT 2 IPT 3 WLC	Parent consultations offered on an as-needed basis	Immediate; 3 months	Both active treatments were associated with significant reductions in depression when compared to wait list. IPT was superior to CBT in enhancing social functioning and self-esteem.
Rosselló et al ¹⁵	Ages 12-18 (n = 112)	DSM-III-R criteria for MDD, deemed by clinical interviewer to be impaired, or CDI 13	Individual, Group	1 Individual CBT 2 Group CBT 3 Individual IPT 4 Group IPT	Three to five parent consultation sessions offered	Immediate	CBT produced greater decreases in depressive symptoms and improved self-concept as compared to IPT.
TADS Team ¹⁰	Ages 12-17 (n = 439)	DSM-IV diagnosis of MDD based on the K-SADS-PL	Individual	Twelve weeks of: 1 Fluoxetine alone 2 CBT alone 3 CBT with fluoxetine 4 Placebo	Two psychoeducation sessions for parents and one to three family sessions	Immediate	There were significant differences between combination treatment and placebo on the CDRS-R. Combined treatment was superior when compared with fluoxetine alone and CBT alone. Fluoxetine alone was superior to CBT alone.

References	Subjects	Diagnostic/Risk Assessment	Format(s)	Intervention Type(s)	Degree of Family Involvement	Post-Treatment Assessment	Impact of Treatment
Vostanis et al ²⁰	Ages 8–17 (n = 56)	Diagnosis of MDD, DD, or minor depression based on K-SADS	Individual	1 Depression treatment program 2 Attention placebo	None	Immediate; 9 months	No difference in remission rates; remission rates were high in both groups.
Wood et al ²¹	Ages 9–17 (n = 48)	Diagnosis of MDD or RDC minor depression based on K-SADS interview with both parent and child	Individual	1 CBT 2 Relaxation training	None	Immediate; 6 months	Post-test revealed greater reductions in depressive symptoms and an advantage in overall outcome in the CBT group. At follow-up, group differences were attenuated.

Abbreviations: ABFT, Attachment-Based Family Therapy; BDI, Beck Depression Inventory; CBT, cognitive-behavioral therapy; CDI, Children's Depression Inventory; CDRS-R, Revised Children's Depression Rating Scale; CES-D, Center for Epidemiologic Studies – Depression Scale; CGI-S, Clinical Global Impression Severity Scale; CWD-A, Adolescent Coping with Depression Course; DD, dysthymic disorder; DDNOS, depressive disorder not otherwise specified; EUC, enhanced usual care; GAF, Global Assessment of Functioning Scale; HRSD, Hamilton Rating Scale for Depression; IPT-A, interpersonal psychotherapy for depressed adolescents; K-SADS, Schedule for Affective Disorders and Schizophrenia for School-Aged Children; MDD, major depressive disorder; SBFT, Systematic Behavior Family Therapy; SIQ-JR, Suicidal Ideation Questionnaire; SSG, social skills group; TAU, treatment as usual; TSG, therapeutic support group; WLC, waitlist control.

Table 2

Randomized clinical Intervention trials for preadolescents with depression

References	Subjects	Diagnostic/Risk Assessment	Format(s)	Intervention Type(s)	Degree of Family Involvement	Post-Intervention Assessment	Impact of Treatment
Asamow et al ²⁷	4th-6th graders (n = 23)	School screening; CDI 8	Group	1 CBT and family education 2 WLC	One psychoeducation session	Immediate	Children in the intervention group were more likely to show reductions in depressive symptoms, negative cognitions, and internalizing coping.
Butler et al ¹⁰¹	5th-6th graders (n = 56)	Teacher referral; high scores on CDI	Group	1 Role play problem solving 2 Cognitive restructuring 3 Attention control	None	Immediate	Role play group showed significant reduction on CDI and improved classroom functioning. One of two groups in cognitive restructuring showed significant reductions on CDI.
De Cuyper et al ¹⁰²	Ages 10–12 (n = 20)	CDI score 11 and/or T score 23 on CBCL Internalizing and Anxious/Depressed subscale; at least one MDD criterion but without other apparent Axis-I	Group	1 CBT program ("Taking Action") 2 WLC group	None	Immediate; 4 months; 12 months	Four-month follow-up comparisons with baseline measures, showed significant improvement on the CDI and the Self-Perception Profile only for CBT group. At the 12-month follow-up, CBT group showed further improvement and significant decreases on the CDI, STAI, and CBCL.
Fristad et al ²⁹	Ages 8–12 (n = 165)	DSM-IV diagnosis of MDD, DD, or bipolar disorder type I, type II, or mood disorder NOS	Family Group	1 MF-PEP + TAU 2 WLC + TAU	Extensive family involvement in the MF-PEP group	6 months; 12 months; 18 months	MF-PEP + TAU was associated with lower MSI scores at follow-up in intent-to-treat analyses compared with WLC + TAU. The WLC group also showed a similar decrease in MSI scores 1 year later, after their treatment.
Jaycox et al ¹⁰³ , Gillham et al ¹⁰⁴	Ages 10–13 (n = 143)	Z-scores on CDI + Child Perception Questionnaire > 0.50	Group	1 Cognitive 2 Social problem solving 3 Combined (both above Treatments) 4 WLC 5 No participation control	None	Immediate; 6 months; 12 months; 18 months; 24 months	No differences between the treated groups. Treated groups had fewer depressive symptoms at post-test and at follow-up and improved classroom behavior (teacher report) than untreated groups. Effects more pronounced among children from high

References	Subjects	Diagnostic/Risk Assessment	Format(s)	Intervention Type(s)	Degree of Family Involvement	Post-Intervention Assessment	Impact of Treatment
Kahn et al. ¹⁰⁵	Ages 10–14 (n = 68)	Multistage Gating. Stage 1: CDI > 14; RADS > 71. Stage 2: Reassessment 1 month later with CDI and RADS. Stage 3: Interview, BDI > 19. No other depression treatment	Group	<ol style="list-style-type: none"> 1 Cognitive-behavioral 2 Relaxation training 3 Self-modeling 4 WLC 	None	Immediate; 1 month	All three active treatment groups showed significant improvement in depression compared to control. Most children in both CBT and relaxation groups went from dysfunctional to functional range on depressive symptoms; self-modeling group less improved than other active treatment groups.
King and Kirschenbaum ²⁸	Grades KG–4 (n = 135)	Children who scored above a cutoff on the Activity Mood screening questionnaire	Group	<ol style="list-style-type: none"> 1 Social skills training plus consultation with parents and teachers 2 Consultation only 	Parent consultations offered	Immediate	Combined program showed reduced depression based on interview data as compared to consultation only. Multidimensional ratings of behavior and skills improved across both groups.
Little and Spence ¹⁰⁶	Ages 7–11 (n = 31)	CDI 19 CDRS-R 40	Group	<ol style="list-style-type: none"> 1 Social competence training 2 Attention placebo control 3 WLC 	None	Immediate; 3 months	No group differences at pretest, post-test, or follow-up. All groups declined on CDI scores and increased on teacher's reports of problem behavior.
Stark et al. ¹⁰⁷	4th–5th graders (n = 29)	CD I scores > 12 on 2 administrations	Group	<ol style="list-style-type: none"> 1 Behavioral problem solving 2 Self-control 3 WLC 	None	Immediate; 8 weeks	Both active treatment groups showed significant reductions in depressive symptoms; however, in Behavioral Problem Solving both mothers and children reported differences, whereas in self-control only children reported differences.
Stark et al. ¹³⁰	Ages 9–13; all female (n = 159)	Clinical level scores on the CDI and DSM-IV-TR symptom interview and a depressive disorder dx on the KSADS	Group	<ol style="list-style-type: none"> 1 CBT 2 CBT + PT 3 Minimal contact control 	Extensive parent involvement in the CBT+ PT group	Immediate; 1 year	ACTION treatment with and without PT was more effective than the minimal contact control but the two active treatments did not differ significantly. After

References	Subjects	Diagnostic/Risk Assessment	Format(s)	Intervention Type(s)	Degree of Family Involvement	Post-Intervention Assessment	Impact of Treatment
Weisz et al ¹⁰⁸	3rd–6th graders (n = 48)	CDI 10 or identified by teachers/counselor as depressed; and CDRS-R interview score 34	Group	<p>1 Primary and secondary control enhancement training</p> <p>2 No treatment control</p>	None	Immediate; 9 months	<p>treatment, 80% of the girls in the active treatments no longer met criteria for a depressive disorder dx versus 47% in the control group. Treatment gains were maintained for majority of girls 1 year post treatment. Girls in the CBT+PT group reported better family communication and cohesiveness.</p> <p>At post-test, treated group showed significantly greater reductions on both CDI and CDRS-R. At follow-up (60% available), group differences remained.</p>

Abbreviations: BDI, Beck Depression Inventory; CDI, Children's Depression Inventory; CDRS-R, Revised Children's Depression Rating Scale; CES-D, Center for Epidemiologic Studies – Depression Scale; DD, dysthymic disorder; DDNOS, depressive disorder not otherwise specified; GAF, Global Assessment of Functioning Scale; K-SADS, Schedule for Affective Disorders and Schizophrenia for School-Aged Children; MDD, major depressive disorder; MF-PEP, multifamily psychoeducational psychotherapy; MSI, Mood Severity Index; PT, parent training; TAU, treatment as usual; WLC, waitlist control.