Invited Review

A Narrative Review of Depression and Suicide in Adolescent Females to Guide Assessment and Treatment Recommendations

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A B S T R A C T

Study Objective: Suicide is a leading cause of death for adolescents. Medical professionals are increasingly being asked to screen for depressive symptoms and suicidal ideation with little training. The purpose of this paper is to review factors related to suicidal thoughts and actions, assessment of symptoms, and initial suggestions for treatment for medical providers.
Methods: A literature review of risk and resilience factors, assessment measures, and treatment options for depression and suicidal ideation and behavior in adolescent females was conducted.
Results: Given the higher risk of suicidal thoughts and depressive symptoms in adolescent females, accurate and thorough assessment of symptoms is recommended.
Conclusion: Medical providers should be aware of symptoms related to depression and suicidal ideation in order to provide more effective assessments. Recommendations for brief assessment measures that can be used in the clinic and possible first line treatments are provided.
Keywords: Suicidality, Depression, Adolescents, Screening, Treatment

Depression and suicidality in adolescence are public health problems worldwide. The 2021 National Survey on Drug Use and Health (NSDUH)[1] approximated 5.0 million (20.1%) adolescents aged 12-17 years old had at least 1 major depressive episode (MDE) during the past year. The prevalence of a MDE was higher in females (29.2%) compared to males (11.5%) in this age group. Race and ethnic differences were also found for individuals identifying as Hispanic (22.2%), White (20.7%), Black (14.0%), Asian (13.8%) or Multi-Racial (27.2%). Persistent depression in adolescence is associated with academic problems, negative family relationships, social isolation, and poor peer interactions with respect to victimization.[2] These findings are consistent with results from the 2021 survey indicating over 75% of female adolescents reporting an MDE experience severe impairment in daily functioning.[1] Depression in childhood and adolescence has also been related to poorer outcomes as adults in terms of mental health, physical health, risky/criminal behavior, financial/educational and social functioning, especially when onset is in adolescence.[3] Data from the survey on adults' mental health supports the mental health finding in that the percentage of MDE was highest among young adults 18-25 years old (18.6%) compared to those 26-49 years old (9.3%) and 50 years or older (4.5%). The rates of MDE in females, again, were higher than rates for males within the 18-25 year-old age range (27.2% vs 18%).

A MDE is defined by The Diagnostic and Statistical Manual of Mental Disorders (DSM-5)[4] as: 5 (or more) of the following symptoms being present during the same 2-week period and represent a change from previous functioning with at least 1 of them being either: (1) depressed mood or (2) loss of interest or pleasure: (a) significant change in weight/appetite; (b) insomnia/hypersomnia; (c) psychomotor agitation/retardation; (d) fatigue/loss of energy; (e) feelings of worthlessness or excessive or inappropriate guilt; (f) diminished ability to concentrate or indecisiveness; (g) recurrent thoughts of death, (h) recurrent suicidal ideation with or without a specific plan, or (i) a suicide attempt. The effect of substances or other medical condition should be ruled out for diagnosis, which is pertinent for gynecologists working with adolescents and young adults.

Detection of and intervention for depression are particularly important as depression can lead to suicide[5] and suicide is the leading cause of death among youth worldwide.[6] Suicidal ideation ranges from thoughts of wishing to be dead to thoughts of killing oneself with a specific plan and intent. Suicide behaviors include preparatory acts, attempts that were interrupted or aborted, to actual attempts.[7] Results from the 2021 NSDUH survey reflect a conservative estimate of suicide ideation due to reports of being "unsure" of ideation or attempts. The term "suicidality" encompasses both ideation and behaviors, as well as outcomes. Data also indicate suicidal ideation moves to suicidal behavior within 1-2 years of onset of ideation.[5] Medical providers may have limited exposure to and training regarding how to assess and provide recommendations/treatment for these concerns. The purpose of this paper is to review the literature on depression and suicidality

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and offer recommendations for treatment in clinical settings.

Results from the 2021 NSDUH[1] found 3.3 million (12.7%) of adolescents aged 12- to 17-years-old had serious thoughts of suicide, 1.5 million (5.9%) made a suicide plan, and 892,000 (3.4%) attempted suicide in the past year. The percentage of high school students who reported attempting suicide over the past year increased from 6.3% in 2009 to 9% in 2019, with females (11%) reporting more often than males (6.6%).[8] The 2021 survey also highlighted high rates of females between the ages of 18- and 25-years old reporting suicide ideation (17.6%), a suicide plan (8.6%) and attempted suicide (4.8%). Other survey data indicate over 1 in 4 bisexual females and 1 in 7 lesbian females had an MDE compared to 1 in 10 straight females. In addition, the rates of suicide ideation (14.7% vs 10.4%), plan (5.0% vs 4.2%) and attempt (2.4% vs 1.3%) were higher in females who identified as bisexual vs lesbian.[9] Recent adjustments in age-cohort suicide mortality rates indicate a more rapid increase in mortality risk for females than males.[10] Survey data also show that youth, adolescents, and young adults between the ages of 10 and 24 years-old have higher rates of emergency department visits for self-harm compared to individuals above the age of 25-years-old.[8]

Contributing Factors

Much research has examined the risk and protective factors associated with suicidal behaviors. Gordon and Melvin[11] suggest that risk factors fall into 4 categories: demographic (eg, sex assigned at birth, ethnicity); clinical (eg, presence of a mental health diagnosis); family/environmental (eg, life stress, access to weapons); and mental state (eg, current suicidal ideation, intoxication). Sheftall et al.[12] found a significant increase in suicide in Black youth between 2003 and 2017, with the biggest change for adolescents between 15 and 17 years of age for males (4.9%) and for females (6.6%). Non-Hispanic, American Indian, and Alaskan Natives between the ages of 10 and 24 years also appear at high risk for suicide (28.2%).[13] Additionally, being a member of the LGBTQ community increases risk. A history of suicide attempts or being on psychotropic medications at baseline have been found to best predict future attempts 1 year following initial attempt.[14]

There are additional risk factors that are unique to those who identify as female. Specifically, for minority populations, being female increases the risk of suicidal ideation and behavior.[15] Additionally, for females, having an eating disorder history,[16] being a victim of sexual abuse,[17] and having a previous suicide attempt[18] all increase the risk of future suicidal thoughts and actions. Women with premenstrual dysphoric disorder (PMDD) are also more likely to report suicidal thoughts, plans, and intent than women without PMDD.[19]

There is a smaller, but emerging, research base on protective and resilience factors on suicidality. Research has shown that protective factors can reduce the effect of stress on depression and suicidal behavior.[20] Gallagher and Miller[21] provide a review of protective factors for suicidal thoughts and behaviors. Their review posits protective factors in 4 areas: individual capacities (eg, self-esteem, coping strategies); family (eg, good communication, connectedness); peer (close friend group, peer acceptance); and school/community (eg, school counselor, caring adult).

Assessment

Many clinicians are tasked with assessing depression and suicidal ideation in adolescents in clinical settings. Given the limited amount of time for clinical care, identifying measures that are brief, yet accurate can be a challenge. The importance of early detection is noted by results from the 2021 Survey indicating that 3.5 million or 60% of individuals reporting MDE had not received treatment for depression.[1] One measure widely used in the literature and clinical practice for assessing depression is the Patient Health Questionnaire-9 Modified for Adolescents (PHQ-A).[22] The PHQ-A consists of 9 questions assessing depressive symptoms that is administered on paper or electronically and scored by support staff. Results of the PHQ-9 may be used for screening and monitoring of symptoms and provide insight about whether further evaluation is needed. The PHQ-A is widely used in practice due to its short form, ease of scoring and interpretation, and use in longitudinal monitoring.[23]

Assessment of suicide behaviors and suicidal ideation can be difficult due to a lack of standard terminology and differences in clinician risk tolerance.[11] For example, an adolescent may express that they would rather be dead, and 1 clinician may believe this statement to be a normative (if intense) expression of feelings, while another may go on to complete a safety plan with the adolescent. There has been some research attempting to provide standard understanding amongst clinicians for ideation, nonsuicidal self-injurious behavior (NSSI), plans, preparation, behavior, attempts, and completed suicide.[23,24] The first step in assessing suicidal ideation and behavior is understanding the key risk factors associated with suicidal behaviors and feeling comfortable with different types of ideation and behavior that may be present.

There are several assessment tools available for clinicians (for review[25,26]). The Ask Suicide Screening Questions (ASQ) toolkit is a set of measures endorsed by the National Institute of Mental Health (NIMH) to screen for suicidal thoughts and behaviors in pediatric and adult settings.[26,27] The ASQ is uniquely suited for use in medical settings as it is short and easy to interpret (4 questions, administration time of about 1 minute). If an adolescent screens positive for suicidal ideation or behavior, they can then be seen by a mental health professional for further safety assessment. One of the most commonly used measures for this second layer of assessment is the C-SSRS.[9,28] Clinicians use the C-SSRS to complete a thorough evaluation of history of suicidal ideation and behavior, current ideation and potential suicide plans. Information gathered from the C-SSRS is used to design a safety plan with the patient and family (if the patient is a child). Completing the safety plan is often considered an intervention in itself.

As noted earlier, there are some factors unique to females that should be incorporated into a thorough

assessment for depression and suicidal behavior. A full psychological history including asking direct questions about previous mental health concerns, eating disorders, and trauma (including sexual abuse) is critical in making an accurate assessment. Research suggests that although females are more likely to attempt suicide[29] they are also more likely to respond better to treatment,[30] underscoring the need for thorough assessment of these symptoms in the hopes of preventing these behaviors.

Initial Management

Once the patient has screened positive for depressive symptoms or suicidal ideation, a plan for initial management should be developed. For mild depression with mild impairment, education and supportive counseling paired with symptom monitoring is recommended.[41] Patients with moderate symptoms may benefit from brief intervention within primary or specialty care. For those with severe symptoms, a trial of medication and referrals to specialty care may be indicated. The American Academy of Pediatrics (AAP) recommends monitoring patients with depression until they connect with specialty care. If symptoms persist after the initial phase of treatment (approximately 6-12 weeks), additional treatment considerations may be warranted.

Behavioral activation can be introduced to gradually increase engagement in activities and responsibilities that are likely to improve mood. Targeted intervention, such as education on sleep hygiene, negative impact of social media on mood, and nutrition and exercise, may be beneficial based on specific items endorsed by the adolescent as problematic. Some research has demonstrated that female adolescents worry about problems rather than actively trying to solve them, and they tend to choose more passive and ineffective problem-solving strategies than male adolescents.[35] As such, they may benefit from engaging in collaborative problem-solving for specific issues that may be occurring at home or school.

Treatment

Medication. Pharmacological treatment has been demonstrated to be an appropriate option for moderate to severe depression in adolescents. Previous medication and psychotherapy trials indicate that the combination of antidepressant medication and psychotherapy has the greatest impact on symptom reduction, including treatment-resistant adolescent depression.[31] Selective serotonin reuptake inhibitors (SSRIs) are the most effective medications for this population.[32] Escitalopram and fluoxetine are approved by the FDA, and others, including sertraline and citalopram, have been used successfully, though data is more limited.[33] Other classes of antidepressants used in pediatric patients, but with far less evidence of efficacy, include serotonin-norepinephrine reuptake inhibitors (SNRIs) and the atypical antidepressants bupropion and mirtazapine.[33]

The FDA issued a “black box” warning in 2004 due to a small percentage of adolescents treated with SSRIs for depression who exhibited suicidal ideation and discussion of self-harm; however, untreated depression is also associated with increased suicidal ideation. The risks and benefits of taking an SSRI should be discussed, and close monitoring of suicidal thoughts when starting a medication is recommended.[33] There are several additional key points to discuss with adolescents and their caregivers when prescribing SSRIs. It can take up to 8 weeks for SSRIs to reach their full benefit, and others (eg, caregivers) may notice improvements before the adolescent.[33] Commonly reported side effects include nausea, appetite changes, headaches, and sleep disturbance.

Therapy. Cognitive behavioral therapy (CBT) and interpersonal psychotherapy (IPT) have been demonstrated to be well-established interventions for the treatment of adolescent depression.[34] CBT includes the use of behavioral components, such as behavioral activation (ie, increasing engagement in activities that promote pleasure and mastery), activity scheduling, and relaxation training to improve mood. CBT also incorporates cognitive components, such as problem-solving and cognitive restructuring, to help adolescents identify and challenge unhelpful thoughts and beliefs. This component is especially important in females, who, relative to males, tend to exhibit more rumination and negative beliefs about the self in response to negative events or when facing problems.[35] CBT has also been demonstrated to be a well-established treatment for adolescent depression when administered in a group format.[6,36]

Interpersonal therapy for adolescents (IPT-A) was developed from IPT for adults and is primarily focused on the relationship between an adolescent’s mood and current relationships.[38] Social supports act as a protective factor against depression, and interpersonal stress is associated with greater depression. Treatment includes improving communication and problem-solving skills and enhancing social functioning. Treatment also assists adolescents in the transition from childhood to adolescence. IPT has also been found to be effective in a group format, though somewhat less consistently than group based CBT.[34]

Other treatment modalities have demonstrated efficacy in improving depression symptoms. Mindfulness-based interventions, which focus on increasing awareness of the present moment, purposely and nonjudgmentally, have been shown to reduce anxiety and depression symptoms in adolescents.[38] Dialectical Behavior Therapy (DBT), a cognitive-behavioral treatment originally developed for chronically suicidal females with borderline personality disorder, has demonstrated limited, but promising effects on nonsuicidal self-injury (NSSI) and emotion regulation, as well as overall depressive symptoms in adolescent females with depression.[39]

Several family-based therapy interventions have also been developed to treat depression in adolescents. These interventions aim to decrease family stress and enhance the availability of familial social support.[40] Core features of effective family therapies include providing information about depression, improving parent-adolescent communication, promoting secure parent-adolescent attachment, and increasing coping skills to manage depressed

mood. Additional goals include decreasing negative interactions within the family system and reframing maladaptive family interaction patterns.

Safety Planning. Safety planning is a key component of the management of suicidal ideation in adolescents.[42] A safety plan is comprised of a set of specific and individualized coping skills and resources that a patient can use in the event that their thoughts of self-harm/suicide return. These are developed with the patient and can be conceptualized as an intervention in itself.[43] These plans should be written and given to the patient and family to be used and may require referral for the treatments listed above for ongoing maintenance.

Conclusion

Depression and suicidality are prevalent in adolescence and affect a significant percentage of adolescent females. Within the past year, 25.2% of adolescent females reported having experienced a MDE. Medical professionals can play a key role in the identification and initial management through screening in clinic for depression and suicidal ideation, as standardized and routine screening have been shown to be effective and easily implemented in clinical practice.[22] Female adolescents who screen positive for depression may require education and support, brief intervention and follow-up, or initiation of an antidepressant medication and referral to a mental health professional. Important areas to address initially include sleep hygiene, social media use, and nutrition and exercise. Behavioral activation and problem-solving interventions are also beneficial ways to address depressive symptoms in adolescents.

Suicide is the second leading cause of death among adolescents, with a recent study revealing 24.1% of adolescent females have seriously considered attempting suicide.[10] Medical professionals should be aware of the risk and protective factors associated with increased risk for suicidal ideation, as well as initial steps in screening for suicidal ideation. In females, risk factors include the presence of a premorbid mental health concern, previous attempts, and membership in an underrepresented minority group or in the LGBTQ+ community. Far less is known about protective factors outside of individual self-esteem and coping skills and positive social support from family, friends, and the community. It will be imperative to continue to examine resilience/protective factors for females who may experience suicidal thoughts and behaviors to be able to better target interventions. This starts with more widespread screening so that females experiencing symptoms can be monitored. When female adolescents screen positive for suicidal ideation, additional actions may include development of a safety plan, regular follow-up and monitoring, and provision of appropriate referrals.[42]

Understanding the prevalence of depression and suicidality, being aware of standard definitions, providing screening and initial management, and implementing safety plans is key for medical professionals to be able to provide much needed care for female adolescents struggling with depression.

Conflicts of Interest

The authors have no conflicts to disclose.

References

1. Substance Abuse and Mental Health Services Administration. (2022). Key Substance Use and Mental Health Indicators in the United States: Results From the 2021 National Survey on Drug Use and Health (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data//report/2021-nsduh-annual-national-report.
2. Weavers B, Heron J, Thapar A.K, et al: The antecedents and outcomes of persistent and remitting adolescent depressive symptom trajectories: a longitudinal, population-based English study. Lancet Psychiatry; 2021; 8:1053–61.
3. Copeland W.C, Alaie I, Jonsson U, et al: Associations of childhood and adolescents depression with adult psychiatric and functional outcomes. J Am Acad Child Adolesc Psychiatry 2021; 60:604–11.
4. American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders. 5th Ed. Arlington, VA, American Psychiatric Association, 2013.
5. World Health Organization. World health Statistics 2016. World Health Organization, Geneva. https://www.who.int/gho/publications/world_health_statistics/2016/en.
6. Glenn C.R, Kleiman E.M, Kellerman J, et al: Annual research review: a meta–analytic review of worldwide suicide rates in adolescents. J Child Psych Psy 2020:294–308.
7. Posner K, Brent D, Lucas C, et al Columbia –Suicide Severity Rating Scale (C-SSRS). New York, NY, Research Foundation for Mental Hygiene, 2018.
8. Ivey-Stephenson AZ, Demissie Z, Crosby AE, et al: Suicidal ideation and behaviors among high school students - Youth Risk Behavior Survey, United States, 2019. MMWR 2020; 69(1):47–55. doi:10.15585/mmwr.su6901a6.
9. Substance Abuse and Mental Health Services Administration. (2023). Lesbian, Gay, and Bisexual Behavioral Health: Results From the 2021 and 2022 National Surveys on Drug Use and Health (SAMHSA Publication No. PEP23-07-01-001). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data//report/LGB-Behavioral-Health-Report-2021-2022.
10. Yu B, Chen X: Age and birth-cohort-adjusted rates of suicide mortality among US male and female youths aged 10 to 19 years from 1999 to 2017. JAMA Network Open 2019; 2(9):e1911383. doi:10.1001/jamanetworkopen. 2019.11383.
11. Gordon M, Melvin G: Risk assessment and initial management of suicidal adolescents. Austr Fam Phys; 2014; 43:367–72.
12. Sheftall AH, Vakil F, Ruch DA, et al: Black youth suicide: investigation of current trends and precipitating circumstances. J Am Acad Child Adolesc Psychiatry 2021; 61(5):1–14.
13. Centers for Disease Control and Prevention; National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. 2021 www.cdc.gove/injury/wisqars.
14. Mirkovic B, Cohen D, Garny de la Rivière S, et al: Repeating a suicide attempt during adolescence: risk and protective factors 12 months after hospitalization. Eur Child Adolesc Psychiatry 2020; 29(12):1729–40 Epub 2020 Feb 12. Erratum in: Eur Child Adolesc Psychiatry. 2020 Mar 12;: PMID:32052175. doi:10.1007/s00787-020-01491-x.
15. O'Donnell L, O'Donnell C, Wardlaw DM, et al: Risk and resiliency factors influencing suicidality among urban African American and Latino youth. Am J Community Psychol 2004; 33(1-2):37–49. doi:10.1023/b:ajcp.0000014317.20704.0b.
16. Franko DL, Keel PK: Suicidality in eating disorders: occurrence, correlates, and clinical implications. Clin Psychol Rev 2006; 26(6):769–82.
17. Fergusson DM, Mullen PE: Childhood sexual abuse. An evidence based perspective by David M. Fergusson and Paul E. Mullen, Sage, Thousand Oaks, 1999. 134 pp. ISBN 0-7619-1136-7. Child Abuse Rev 1999:91–4.
18. Cooper J, Kapur N, Webb R, et al: Suicide after deliberate self-hard: A 4-year cohort study. Am J Psychiatry 2005; 162(2):297–303.
19. Osborn E, Brooks J, O'Brien P.M.S, et al: Suicidality in women with Premenstrual Dysphoric Disorder: a systematic literature review. Arch Women Mental Health 2021; 24:173–84.
20. Breton JJ, Labelle R, Berthiaume C, et al: Protective factors against depression and suicidal behaviour in adolescence. Can J Psychiatry 2015; 60(2 suppl 1):S5–S15.
21. Gallagher ML, Miller AB: Suicidal thoughts and behavior in children and adolescents: an ecological model of resilience. Adolesc Res Rev 2018; 3(2):123–54. doi:10.1007/s40894-017-0066-z.
22. Kemper AR, Hostutler CA, Beck K, et al: Depression and suicide-risk screening results in pediatric primary care. Pediatrics 2021; 148(1). doi:10.1542/peds.2021-049999.
23. Crosby AE, Ortega L, Melanson C. Self-Directed Violence Surveillance: Uniform Definitions and Recommended Data Elements. Atlanta, Georgia: CDC; 2011. www.cdc.gov/violenceprevention/pdf/self-directed-violence-a.pdf
24. Johnson JG, Harris ES, Spitzer RL, et al: The patient health questionnaire for adolescents: validation of an instrument for the assessment of mental disorders among adolescent primary care patients. J Adolesc Health 2002; 30(3):196–204.
25. Hammad TA, Laughren T, Racoosin J: Suicidality in pediatric patients treated with antidepressant drugs. Arch Gen Psychiatry 2006; 63(3):332–9. doi:10.1001/archpsyc.63.3.332.

26. Winters NC, Myers K, Proud L: Ten-year review of rating scales. III: scales assessing suicidality, cognitive style, and self-esteem. J Am Acad Child Adolesc Psychiatry 2002; 41(10):1150–81. doi:10.1097/00004583-200210000-00006.
27. Aguinaldo LD, Sullivant S, Lanzillo EC, et al: Validation of the Ask Suicide-Screening Questions (ASQ) with youth in outpatient specialty and primary care clinics. Gen Hosp Psychiatry 2021; 68:52–8.
28. Horowitz LM, Bridge JA, Teach SJ, et al: Ask Suicide-Screening Questions (ASQ): A brief instrument for the pediatric emergency department. Arch Pediatr Adolesc Med 2012; 166(12):1170–6. doi:10.1001/archpediatrics.2012.1276.
29. Posner K, Brown GK, Stanley B, et al: The Columbia-Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. Am J Psychiatry 2011; 168(12):1266–77.
30. Murphy GE: Why women are less likely than men to commit suicide. Compr Psychiatry 1998; 39(4):165–75.
31. Hawton K: Sex and suicide. Gender differences in suicidal behavior. Br J Psychiatry 2000; 177:484–5.
32. March J, Silva S, Petrycki S, et al: Treatment for Adolescents with Depression Study (TADS) team. Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents with Depression Study (TADS) randomized controlled trial. JAMA 2004; 292(7):807–20. doi:10.1001/jama.292.7.807.
33. Cousins L, Goodyear IM: Antidepressants and the adolescent brain. J Psychopharmacol 2015; 29(5):545–55. doi:10.1177/0269881115573542.
34. Dwyer JB, Bloch MH: Antidepressants for pediatric patients. Curr Psychiatr 2019; 18(9) 26–42F.
35. Weersing VR, Jeffreys M, Do MT, et al: Evidence base update of psychosocial treatments for child and adolescent depression. J Clin Child Adolesc Psychol 2017; 46(1):11–43. doi:10.1080/15374416.2016.1220310.
36. Stark KD, Streusand W, Krumholz LS, et al Cognitive-behavioral therapy for depression: the ACTION treatment program for girls. In: Weisz J.R, Kazdin A.E, editors. Evidence-Based Psychotherapies for Children and Adolescents. New York, The Guilford Press, 2010, pp. 93–109.
37. Keles S, Idsoe T: A meta-analysis of group cognitive behavioral therapy (CBT) interventions for adolescents with depression. J Adolesc 2018; 67:129–39. doi:10.1016/j.adolescence.2018.05.011.
38. Miller L, Hlastala SA, Mufson L, et al: Interpersonal psychotherapy for adolescents with mood and behavior dysregulation: evidence-based case study. Evid Based Pract Child Adolesc Ment Health 2016; 1(4):159–75. doi:10.1080/23794925.2016.1247679.
39. Lin J, Chadi N, Shrier L: Mindfulness-based interventions for adolescent health. Curr Opin Pediatr 2019; 31(4):469–75. doi:10.1097/MOP.0000000000000760.
40. Cook NE, Gorraiz M: Dialectical behavior therapy for nonsuicidal self-injury and depression among adolescents: preliminary meta-analytic evidence. Child Adolesc Ment Health 2016; 21(2):81–9. doi:10.1111/camh.12112.
41. Carr A: Family therapy and systemic interventions for child-focused problems: the current evidence base. J Family Ther 2019; 41(2):153–213. doi:10.1111/1467-6427.12226.
42. Abbott-Smith S, Ring N, Dougal N, et al: Suicide prevention: what does the evidence show for the effectiveness of safety planning for children and young people? A systemic scoping review. J Psychiatr Ment Health Nurs 2023; 30:899–910. doi:10.1111/jpm.12928.
43. Stanley B, Brown GK: Safety planning intervention: a brief intervention to mitigate suicide risk. Cognit Behav Pract 2012; 19(2):256–64. doi:10.1016/j.cbpra.2011.01.001.