Depressive disorders are a leading cause of impairment and disability. While prevalent across the lifespan, rates of depression in youths are particularly alarming given the immediate impact of the disorder on global functioning and developmental trajectory as well as the long-term negative sequelae. Depression occurs in an estimated 1% to 5% children, while increasing markedly during the transition to adolescence to ~5% to 8% of the population. Evidence suggests that rates of depression might have increased over time. Suicide is a leading cause of youth mortality and those who attempt suicide are at increased risk of re-attempting and completing suicide. Youth who complete suicide typically experience at least one type of psychiatric illness, most commonly depressive disorders.

A variety of clinical skills and treatments are necessary to best meet the needs of depressed and suicidal youths. Depression and suicidality both require timely management which may include psychosocial and/or pharmacologic treatment. Such a response is necessary as depression and suicidality during childhood and adolescence are serious, debilitating, and potentially life-threatening illnesses. A range of treatment modalities are required to address depression and suicidality in youths given that not all will respond to any one treatment. An important component of clinical management of youth is the accurate assessment of suicidal ideation and behavior (suicidality), which needs to occur routinely as part of clinical practice. Suicidality, of course, is highly prevalent in depressed children and adolescents, but is also strikingly common in young normal populations as well, which stresses the importance of assessment. This month's CNS Spectrums presents three articles relevant to the treatment and assessment of depressed and suicidal youths.

Likely in response to an increasingly identified public health need, antidepressants in youths are widely used. However, there has been much confusion and relatively limited information to inform practitioners about their efficacy and safety. Despite this, they remain a popular treatment of choice which makes further research findings on their efficacy all the more vital. Of all the antidepressants available, fluoxetine is the only antidepressant approved by the Food and Drug Administration for the treatment of depressive disorders in children and adolescents, given the findings from two randomized controlled trials.

Taryn L. Mayes, MS, and colleagues from the research team led by Graham Emslie, MD, at South Western University provide a critical and important contribution to the literature, enhancing our understanding of the efficacy of antidepressants in child populations. Prior to these findings, it was commonly believed that antidepressants were not very effective in children. The authors inform us that previous studies have typically focused on efficacy in adolescents and those that included children have not been able to address the impact of age due to sample-size limitations. In this context, further data on the efficacy of fluoxetine relative to placebo with child populations is considered valuable. Specifically, Mayes and colleagues found a greater treatment response in children (<12 years of age) com-

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pared with adolescents, contrary to what was expected. These important findings add to the body of evidence about the efficacy of selective serotonin reuptake inhibitors in youths and provide some confidence for their use as an option for depressed children.

Psychosocial interventions are typically used as a monotherapy for mild to moderate depressive disorders in youth and are also used in conjunction with antidepressants. Given the decrease in rates of antidepressant prescription evident since the introduction of the black box warning on antidepressants, psychosocial treatments might be in greater demand for the management of depression. In their review, Anat Brunstein Klomek, PhD, and Barbara Stanley, PhD, provide an up-to-date précis of the current empirical basis of the treatment of depression and suicidality. The evidence supporting many treatments for depressive disorders in youth is examined, including cognitive-behavioral therapy, interpersonal psychotherapy for adolescents, and attachment-based family therapy. While shorter-term efficacy for these treatments has been demonstrated, data on longer-term efficacy is limited.

Limited empirical investigation of treatments for youths suicidality has been performed. Dialectical behavior therapy, an empirically based treatment for adult suicidality, has been modified for use with adolescents. Another novel approach involves the supplementation of treatment with a youth-selected group of supportive adults who can be available to the youth while also receiving their own support. A promising cognitive-behavioral-therapy-based treatment developed with a National Institute of Mental Health multi-site trial is also described by Klomek and Stanley. The authors note the importance of further investigation of the established treatments, particularly in terms of longer-term efficacy for depression and the need for randomized controlled trials for the newer approaches designed to treat suicidality. Effective widespread dissemination and training of community clinicians in these empirically based treatments presents a challenge for the future.

Conducting a suicide risk assessment in youths can be very worrisome tasks for clinicians. Suicidality may be evident in youths across a range of psychiatric diagnoses and is even prevalent in normal populations. Kelly Posner, PhD, and colleagues describe key risk factors that require consideration in such an assessment of suicidality. This information provides the clinician with specific content to assess during an evaluation. Related to the issue of conducting an assessment of suicidality is the use of a standardized method for classifying the suicidality detected during the assessment. The development of consistent definitions and terminology for suicidal ideation and behavior has been clearly needed for some time. The issue is worth pursuing given the advantages inherent in clinicians’ being able to clearly communicate with each other about a patient's suicidal ideation and behavior. Posner and colleagues present a series of definitions of suicidal ideation and behavior and provide the clinician with suggested questions useful when interviewing suicidal youth. Some useful tools to aid assessment are also described. These skills may be useful in the assessment of adults and given the prevalence of suicidality across all populations, assessment should be incorporated into all routine psychiatric evaluation.

This issue provides information that is intended to strengthen the clinician’s armamentarium by updating understanding of pharmacotherapy for depressed children, psychosocial treatments for youth depression and suicidality, and providing skills in assessment of youth suicide risk.

REFERENCES