

Treating Depression in Adolescence: A Review of the Effectiveness of Cognitive-Behavioral Treatments

Diane Marcotte¹

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The literature of the last decade reveals a renewed interest in treating adolescent depression. Several treatments have been proposed that are derived from adult models, but few studies have evaluated their efficiency. Those that have been done, have typically used a cognitive-behavioral approach. This article reviews studies published from 1980 to 1994 on the efficacy of these programs. Groups of 6–10 adolescents were treated in these programs. Some programs also included treatment for parents. Treatments were multimodal, utilizing intervention strategies from cognitive and/or behavioral models of depression. Treatment components included relaxation, cognitive restructuring, self-control skills, and communication and problem-solving skills. Studies were most often done in school settings but only rarely in a clinical milieu. Depression measures included self-report questionnaires and semistructured interviews. Results suggest that short-term group cognitive-behavioral interventions are effective with early and late adolescents. Furthermore, depressive symptoms remained improved at follow-up. No single strategy, however, seemed to be clearly more effective than the others.

INTRODUCTION

Since the beginning of the 1980s, clinical researchers have become interested in treating depression in adolescents. This interest has been sparked

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¹Department of Psychology, Université du Québec à Trois-Rivières. Received Ph.D. in clinical psychology from the University of Ottawa in 1991. Current research interests include the treatment of depression in adolescence. To whom correspondence should be addressed at Psychology Department, Université du Québec à Trois-Rivières, C. P. 500, Trois-Rivières, Québec, Canada, G9A 5H7.

by the recognition that adult DSM-III (1980) criteria can be used to diagnose depression in children and adolescents and that there are high rates of depression and suicide in youngsters. In the general population, 20–35% of boys and 25–40% of girls report having depressed mood (Petersen *et al.*, 1993), and 4–12% of them are clinically depressed (Reynolds, 1992). Affective disorder, is in fact, the most frequent diagnosis for adolescents seen in mental health centers. Depressive symptoms increase markedly from childhood to adolescence. Girls have higher rates than boys and this discrepancy could possibly be linked to puberty status rather than chronological age (Rutter, 1986). A few treatment strategies have appeared in the literature but few studies have addressed their effectiveness. At this point, most published outcome studies have been done in schools or with samples recruited from schools, thus limiting the generalizability of results. Also, nearly all of the programs have used a cognitive-behavioral approach. Treatment consists of 10–12 group sessions using a psychoeducational approach. This article reviews these few outcome studies.

SELECTION OF STUDIES

A PsycLit search was conducted using the keywords “adolescence, treatment and depression.” Studies published between 1980 and 1994 in English or French were selected. Sixty-one articles were identified. From these, studies that met the following criteria were retained.

1. Subjects with depressive symptoms were selected by some systematic procedure.
2. The design included a control group and systematic treatment procedures, which were specified in a manual.

Case studies and studies that did not use statistical procedures to compare treatment and control conditions were excluded. Seven studies met these criteria and are included in this review. Table I summarizes information about the sample characteristics, selection criteria, treatment used, and results of these studies. Headings for this review were inspired by Mann and Borduin (1991).

STUDIES OF THE EFFECTIVENESS OF COGNITIVE-BEHAVIORAL TREATMENTS

Butler *et al.* (1980) pioneering outcome study of group cognitive-behavioral treatment of depression included a population of children and early adolescents (10–13 yr). Four conditions were compared: role play,

cognitive restructuring, attention-placebo, and control. The role play and cognitive restructuring treatments were school-based intervention programs. The role play program included teaching of social skills and problem solving skills. The cognitive treatment strategy was taken from the Beck (1976), Ellis (1962), and Knaus (1974) approaches. Treatments consisted of ten weekly one hour sessions. Students in the attention-placebo group learned to solve problems cooperatively. Subjects were selected from a pool of 562 5th and 6th graders. They had to meet two criteria. They had to be referred by teachers and have scores at least 1.5 standard deviations above the mean on two or more of the four self-report measures or a global score 1.5 standard deviations above the mean. Although cognitive restructuring was effective in this study, role play was more effective. It led to greater improvement on each measure of the depression battery. However, this study did not include any follow-up.

Reynolds and Coats (1986) compared outcomes decreases in depressive symptoms of high school students getting two types of cognitive-behavioral therapy to those of a waiting list control group. The cognitive-behavioral treatment, which was based on Rehm's self-control model of depression (1977), focused on teaching of self-control skills. It included self-monitoring, self-evaluation, and self-reinforcement. The relaxation training program followed a procedure described by Jacobsen (1938). Subjects were selected from a pool of about 800 adolescents according to a three-stage screening procedure that included self-questionnaires and a clinical interview. Subjects in both treatment groups were significantly and similarly improved at the posttest. Improvements on two of the three measures of depression were maintained at the follow-up. All subjects who participated in treatment scored within the normal range by follow-up after having score in the moderately depressed range earlier. The author explained the similarity in effectiveness of the two treatments by asserting that both treatments produced an increased sense of personal mastery in subjects.

Study by Lewinsohn *et al.* (1990) was both methodologically sound and original. It was original in that they compared a group of depressive adolescents who received cognitive-behavioral treatment with another group of adolescents who received the same treatment but whose parents also received a complementary treatment. The "Adolescent Coping with Depression Course" (CWD-A) is an adaptation of a treatment originally developed and tested with depressive adults (Lewinsohn *et al.*, 1984). This multimodal treatment that rests on social learning theory, is presented in sixteen very detailed and structured sessions described in leaders' and students' manuals. Students are taught relaxation and social skills, and they are taught to engage in more pleasurable activities, control negative and irrational thoughts, and use problem-solving strategies. The Beck Depres-

Table I. Outcome Studies of Treatment of Depression in Adolescence

Study	Sample Characteristics	Selection Criteria
1. Butler <i>et al.</i> (1980)	1. Students, Grades 5 and 6, 10-13 yr; <i>N</i> = 54 ^a (14 subjects by group) ^b	1. Teacher referral + Depression Battery: Score > 59 (including measures of depression, self-esteem, cognitive distortions and locus of control)
2. Reynolds and Coats (1986)	2. Students, <i>M</i> = 15.7 yr; <i>N</i> = 24 (19-11 subjects by group)	2. Score > 12 on Beck Depression Inventory (BDI), score > 72 on Reynolds Adolescent Depression Scale (RADS), score > 20 on Bellevue Index of Depression (BID)
3. Lewinsohn <i>et al.</i> (1990)	3. Adolescents from school settings and from the community, 14-18 yr; <i>N</i> = 59 (19-21 subjects by group)	3. DSM-III diagnosis of major depressive disorder or RDC diagnosis of current episode of minor or intermittent depressive disorder based on Children's Schedule for Affective Disorders and Schizophrenia (K-SADS-E)
4. Kahn <i>et al.</i> (1990)	4. Students, 10-14 yr; <i>N</i> = 68 (17 subjects by group)	4. Score > 15 on CDI, score > 72 on RADS, score > 20 on BID
5. Fine <i>et al.</i> (1991)	5. Adolescent outpatients, 13-17 yr; <i>M</i> = 15.1; Grades 7-12; <i>N</i> = 47	5. Self-report (CDI) and diagnostic of major depressive disorder or dysthymic disorder
6. Marcotte and Baron (1993)	6. Students, 14-17 yr; <i>M</i> = 15.3 yr; <i>N</i> = 25 (12-13 subjects by group)	6. Score > 15 on BDI and score > 10 on Hamilton Depression Scale (modified cotation)
7. Reed (1994)	7. Adolescents, 14-19 yr; <i>N</i> = 18 (exp. group: <i>N</i> = 12; control group: <i>N</i> = 6)	7. DSM-III diagnosis of major or dysthymic disorder, score > 12 CDI, score > 16 Face Valid Depression Inventory (FVDI)
Treatment	Results on Depression Measures	Results on Other Measures
1. a. Role Play (RP), 10 sessions b. Cognitive Restructuring (CR), 10 sessions.	1. Self-report measures: RP, CR, C improved; RP > CR, C <i>Teachers observations:</i> RP improved more vs. CR, AP, C	1. Self-esteem: RP, CR improved <i>Stimulus appraisal:</i> RP improved <i>Locus of control:</i> RP improved
c. Attention-Placebo (AP), 10 sessions d. Classroom controls (C)		

2. a. Cognitive-Behavioral (CB), 10 sessions
 b. Relaxation Training (RT), 10 sessions
 c. Control (C)
2. *Posttest*: CB, RT improved more vs. C on three measures (BDI, RAD5, BID)
Follow-up (5 weeks): CB, RT improved more vs. C on two measures (BDI, BID)
3. a. Cognitive-Behavioral, Adolescents only (CB), 14 sessions
 b. Cognitive-Behavioral, Adolescents + Parents (CBP), 14 sessions
 c. Control (C)
3. *Interview* (K-SADS-E): Posttest and follow-up (6 months): CB, CBP improved; CB + CBP improved more vs. C
Self-questionnaires: Posttest and follow-up (6 months)—CB, CBP improved more vs. C on both measures (BDI and CES-D)
Parent report: no difference
4. a. Cognitive-Behavioral (CB), 15 sessions
 b. Relaxation Training (RT), 12 sessions
 c. Self-Modeling (SM), 6-8 individual sessions
 d. Control (C)
4. Posttest and follow-up (1 month): CB, SM, RT, and C improved; CB, SM improved more vs. C only on BID
Parent-report: CB, SM, RT, and C improved
5. a. Social skills training (SS), 12 sessions
 b. Therapeutic support (based on interpersonal approach; TS), 12 sessions
 d. Control (C)
5. *Posttest*: K-SADS—TS, SS improved; Children's Depression Inventory (CDI)—TS improved; TS improved more vs. SS on both measures
Follow-up (9 months): TS, SS improved
6. a. Rational-Emotive Therapy (RET), 12 sessions
 b. Control (C)
6. BDI: Posttest—RET, C improved; Follow-up—RET improved
 Teachers' observations: RET, C improved more vs. C
7. a. Structured Learning Therapy (SLT), 6 sessions
 b. Control (C)
7. *Clinical judgment*: Posttest—SLT improved; SLT improved Posttest and follow-up—males improved more vs. females
FYDI: Posttest and follow-up—males improved more vs. females
CDI: Posttest and follow-up—males improved more vs. females
2. *Anxiety*
 Posttest: RT improved more vs. C
Academic self-concept
 Posttest: RT, CB improved more vs. C
 Follow-up: CB improved more vs. C
3. *Conflict resolution*
 Follow-up: CB, CBP improved
Anxiety, Pleasant Activities and Depressogenic Cognitions
 Posttest: CB, CBP improved
Problems checklist (CBCL):
 Posttest: CBP improved more vs. CB; Follow-up: CBP, CB improved
4. *Self-esteem*
 Posttest and follow-up: CB, SM, RT, and C improved; CB improved more vs. C
5. *Self-concept*
 Posttest: TS improved; TS improved more vs. SS
 Follow-up: TS, SS improved
Cognitive distortions: Nonsignificant
6. *Irrational Beliefs*: Posttest and follow-up: RET improved
7. *Self-esteem*: Posttest and follow-up: males improved more vs. females

^aN after attrition at the posttest.

^bNumber of subjects who started treatment in each condition.

sion Inventory and a diagnostic interview were used to assess depression in this study. Several of the outcome measures utilized in this study were abbreviated, however. Some scales comprised only 5-10 items. Both forms of treatment produced conclusive improvements at posttest that were maintained at follow-up. More qualitatively, 52.4% of those who received treatment for themselves and their parents and 57.1% of those who received treatment for themselves alone were still depressed at posttest compared with 94.7% of subjects in the control group. In a sample of early adolescents, Kahn *et al.* (1990) compared the CWD-A with relaxation training and behavior modification (clients' modeling of their own videotaped desirable behavior). Relaxation training took place in small groups whereas the behavior modification was administered individually. Again, the three treatments were equally effective in decreasing depressive symptoms.

Surprisingly Fine *et al.* (1991) found that a therapeutic support group was more effective than social skills training for alleviating depressive symptoms in adolescent outpatients ($M = 15.1$, $SD = 1.2$ yr old). Although both treatments were effective, subjects in the support group had improved more at posttest according to self-ratings of depression and an interview. The difference, however, had disappeared at follow-up. This study had some limitations, however. There was no control group, subjects in the two groups were receiving other treatments concurrently, and subjects who were not clinically depressed were included in the sample. Nevertheless, the efficacy of the therapeutic support intervention requires explanation. Fine *et al.* (1991) suggested that depressive adolescents might need the self-expression and enhancement of self-concept that support group therapy provides before they can benefit from skills-oriented interventions. They also suggest that there might be a latency period before subjects can fully utilize cognitive skills. This might explain why in the next study the experimental and control groups differed more on depression at follow-up than at posttest.

In our study (Marcotte and Baron, 1993), we choose to test the effectiveness of an exclusively cognitive intervention to decrease depressive symptoms and irrational beliefs in depressed adolescents. From a pool of 586 high school students, 28 ($M = 15.3$, $SD = 1.03$ yr old) were selected following a procedure inspired by Reynolds and Coats (1986). Subjects in the treatment group received a form of rational-emotive group therapy (Bernard and Joyce, 1986). In this program, twelve sessions are offered and they are designed for the specific ages and cognitive capacities of the participants. The program designed for 14- to 17-year-olds was used. Like the CWD-A, the content of each session of this program is clearly described in a manual. The treatment and control groups differed on the depression measure at the follow-up but not at posttest. However, the experimental group had begun to improve on depression by posttest and they had fewer

irrational beliefs. The results suggested that there might be a latency period before which learned cognitive skills can begin to be used and show an effect on mood. Furthermore, we observed more spontaneous remissions of depression in younger adolescents than in older adolescents. This leads us to question the stability of depressive symptoms in early adolescence. The rational-emotive treatment was especially efficient in decreasing three types of irrational beliefs: tendency to dramatize, low tolerance for frustration, and beliefs about self-value.

In a final study (Reed, 1994), depressed adolescents from different ethnic backgrounds received Structured Learning Therapy, a social skills program (Goldstein *et al.*, 1980). From one hundred adolescents of low to middle socioeconomic status, 18 subjects were selected according to the criteria of major depression or dysthymic disorder and their questionnaires responses. The treatment included skill instruction, modeling, role playing, and performance appraisal. Art and imagery exercises were offered to the control group. Two experienced clinicians judged subjects in the treatment group to be improved. The treatment was considered "moderately successful" whereas the control was considered "unsuccessful." The small and unequal numbers of subjects in the different conditions and the total reliance on clinical judgments to assess the efficacy of the treatment are weaknesses of this study. Nevertheless, it raises an important question concerning sex differences in the efficacy of treatment. The authors suggested that because this program enhanced assertiveness, it would benefit boys more than girls. Assertiveness is considered more appropriate for males than females in our culture.

To assess the effectiveness of these treatment programs, effect size indexes (d) were computed when data were available. Treatment groups were thereby compared with control groups (Cohen, 1988). Because standard deviations differed, averaged standard deviations were calculated (Hopkins, Glass, and Hopkins, 1987). For three studies, it was not possible to determine effect size indexes. No control group was present in the Fine *et al.* (1991) study and standard deviations were not included in the Butler *et al.* (1980) and Reed (1994) studies. Results are presented in Table II.

Using Cohen's (1988) cutoff criteria, these results confirm that treatment programs produced more improvement than control conditions. Effect sizes range from 0.41 to 1.70, reflecting some small but many large differences between treatment and control conditions. In all cases where effects size were computed at follow-up, the effect of treatment was still evident. Here again, the fact that large effect sizes ($d > .80$) were found for treatment groups in several studies supports the idea that there are no significant differences between treatment conditions. However, there is some evidence that type of treatment might determine how long improve-

Table II. Effect Size Index for Comparison of Treatment Conditions to Control Groups

Study	Treatment	<i>d</i> (Posttest)		<i>d</i> (Follow-up)	
1. Butler <i>et al.</i> (1980)	—	—	—	—	—
2. Reynolds and Coats (1986)	Cognitive-behavioral	1.60	Large	1.57	Large
	Relaxation	1.70	Large	1.39	Large
3. Lewinsohn <i>et al.</i> (1990)	Adolescents only	0.94	Large	—	—
	Adolescents and Parents	1.48	Large	—	—
4. Kahn <i>et al.</i> (1990)	Cognitive-behavioral	0.41	Small	1.03	Large
	Relaxation	1.06	Large	0.60	Medium
	Self-modeling	1.11	Large	0.63	Medium
5. Fine <i>et al.</i> (1991)	—	—	—	—	—
6. Marcotte and Baron (1993)	Rational-emotive therapy	0.56	Medium	1.69	Large
7. Reed (1994)	—	—	—	—	—

ments will last. Kahn *et al.* (1990) compared the CWD-A program with two other conditions. In the short term, subjects who received the relaxation or self-modeling programs benefited more than subjects who participated in the CWD-A program. However, the CWD-A subjects maintained their gains longer than the other subjects. The comparison of young with older adolescents' outcomes from the CWD-A program is also interesting. The results suggest that this program is more effective with older (Lewinsohn *et al.*, 1990) than younger (Kahn *et al.*, 1990) subjects at the posttest, but that younger adolescents integrated the skills they learned during the treatment in the long term. Finally, depressed adolescents might benefit more if their parents are treated concurrently. In the study that compared adolescent-only with adolescent and parent treatment (Lewinsohn *et al.*, 1990), the effect size was larger when parents are included in treatment. Lewinsohn *et al.* (1990) found a difference when they compared means, but not when they used a multivariate analysis of variance.

DISCUSSION

This review of outcome studies supports the effectiveness of short-term cognitive-behavioral interventions to treat depression in adolescence. The programs tested seemed to be as effective with younger adolescents (Butler *et al.*, 1980; Kahn *et al.*, 1990) as with older ones (Reynolds and

Coats, 1986; Lewinsohn *et al.*, 1990; Marcotte and Baron, 1993; Fine *et al.*, 1991). Furthermore, the systematic comparisons of treatment programs including control groups and systematic procedures for selecting depressed subjects represent improvements in research design. Also, treatment procedures are more often systematized and specified in manuals. School settings remain the milieu most commonly used for implementing treatments, leaving unresolved the issue of how applicable these treatment programs are to real clinical populations.

Despite this progress, few controlled outcome studies were found. From 61 studies, only 7 met selection criteria. Among the remaining 54 articles and book chapters, many were devoted to clinical practice of cognitive-behavioral therapy with depressed adolescents, including case studies and practical guides of procedures. Other studies used experimental designs in which cognitive-behavioral programs were offered to special populations. In these studies, depression was used as a dependant variable rather than a criterion for selecting subjects. Finally, few papers reviewed the literature on topics related to depression in adolescence. Additionally, outcomes studies for treatments that are not based on the cognitive-behavioral model would advance our knowledge of psychotherapy with depressed adolescents. A promising treatment is Interpersonal Psychotherapy (IPT; Mufson *et al.*, 1991, 1993). This treatment addresses depression in the context of five possible areas of conflict in interpersonal relationships. A systematic and detailed description of the treatment process is described for each domain. Originally developed for adults (Klerman *et al.*, 1984), an IPT also exists for depressed adolescents (Mufson *et al.*, 1993). IPT was applied by Robins *et al.* (1989) to a population of adolescents hospitalized for major depression and was found to be effective. Although the adult form of IPT was used and the procedures were not systematized, the preliminary results are promising for the future.

It is possible to state a few other conclusions from this review. First, although most programs tested turned out to be effective, most studies report no differences in efficacy between different types of treatment (e.g., Reynolds and Coats, 1986; Kahn *et al.*, 1990). Perhaps we are seeing a placebo effect (Lewinsohn *et al.*, 1990) or an overall effect rather than effects of particular treatment components. Also, these treatments are usually designed for adults, and the modifications made for their application with adolescents are often superficial. The language and activities are modified to accommodate adolescents' lifestyles or settings such as school; however, additional developments are needed that consider which cognitive, social, and affective influences on the adolescent might place them at risk for depression. In spite of the known parallel between depression in adolescents and adults, research is needed to identify characteristic reactions that ado-

lescents might have to stress that might lead to specific vulnerability to depression. Furthermore, patterns of depressive phenomenology associated with age need to be known, as well as family and social characteristics of depressed adolescents in order to integrate findings in treatments proposed. Gender differences in reactions to treatment strategies should also be considered. In the future, developmental approaches (Cicchetti *et al.*, 1992; Rutter, 1986) and cognitive behavioral treatments might be integrated to treat depression in young populations.

Finally, because high rates of spontaneous remission of depressive symptoms are reported in control groups, long term studies are necessary to confirm the long-term effects of treatments. This is all the more important since the risk of relapse later in adolescence or in adult life following a depressive episode during adolescence is particularly high and is associated with lower psychosocial functioning (Kandel and Davis, 1986; Kovacs *et al.*, 1984).

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REFERENCES

- American Psychological Association. (1980). *DSM-III: Diagnostic and Statistical Manual of Mental Disorders (3rd ed.)*. Author, Washington, D.C.
- Beck, A. T. (1976). *Cognitive Therapy and the Emotional Disorders*. New York: International Universities Press.
- Bernard, M. E., and Joyce, M. R. (1986). *Rational-Emotive Therapy with Children and Adolescents: Theory, Treatment Strategies, Preventative Methods*. John Wiley and Sons, New York.
- Butler, I., Mieizitis, S., Friedman, F., and Cole, E. (1980). The effect of two school-based intervention programs of depressive symptoms in preadolescents. *Am. Educat. Res. J.* 17: 111-119.
- Cicchetti, D., Nurcombe, B. and Garber, J. (1992). Developmental approaches to depression. *Develop. Psychopathol.* 4: 1-3.
- Cohen, J. (1988). *Statistical Power Analysis for the Behavioral Sciences (2nd)*. Lawrence Erlbaum Associates, Hillsdale, New Jersey.
- Ellis, A. (1962). *Reason and Emotion in Psychotherapy*. Lyle Stuart, New York.
- Fine, S., Forth, A., Gilbert, M., and Haley, G. (1991). Group therapy for adolescent depressive disorder: A comparison of social skills and therapeutic support. *J. Am. Acad. Child Adolesc. Psychiat.* 30: 79-85.
- Goldstein, A. P., Sprafkin, F. P., Gershaw, M. J., and Klein, P. (1980). *Skill Streaming the Adolescent: A Structured Learning Approach to Teaching Prosocial Skills*. Research Press, Champaign, IL.
- Hopkins, K. D., Glass, G. V., and Hopkins, B. R. (1987). *Basic Statistics for the Behavioral Sciences*. Prentice-Hall, Englewood Cliffs, New Jersey.
- Jacobsen, E. (1938). *Progressive Relaxation*. University of Chicago Press, Chicago.

- Kahn, J. S., Kehle, T. J., Jenson, W. R., and Clark, E. (1990). Comparison of cognitive-behavioral, relaxation, and self-modeling interventions for depression among middle-school students. *School Psychol. Rev.* 19: 196-211.
- Kandel, D. B., and Davis, M. (1986). Adult sequelae of adolescent depressive symptoms. *Arch. Gen. Psychiat.* 43: 255-262.
- Klerman, G. L., Weissman, M. M., Rounsaville, B. J., and Chevron, E. S. (1984). *Interpersonal Psychotherapy of Depression*. Basic Books, New York.
- Knaus, W. (1974). *Rational-Emotive Education: A Manual for Elementary School Teachers*. Institute for Rational Living, New York.
- Kovacs, M., Feinberg, T. L., Crouse-Novak, M. C., Paulauskas, S. L., Pollock, M., and Finkelstein, R. (1984). Depressive disorders in childhood. *Arch. Gen. Psychiat.* 41: 643-649.
- Lewinsohn, P. M., Antonuccio, D. O., Steinmetz, J., and Teri, L. (1984). *The Coping With Depression Course: A Psychoeducational Intervention for Unipolar Depression*. Castalia Press, Eugene, OR.
- Lewinsohn, P. M., Clarke, G. N., Hops, H., and Andrews, J. (1990). Cognitive-behavioral treatment for depressed adolescents. *Behav. Ther.* 21: 385-401.
- Mann, B. J., and Borduin, C. M. (1991). A critical review of psychotherapy outcome studies with adolescents: 1978-1988. *Adolescence*. 26: 505-541.
- Marcotte, D., and Baron, P. (1993). L'efficacité d'une stratégie d'intervention émotivo-rationnelle auprès d'adolescents dépressifs du milieu scolaire. *Rev. canad. counsel.* 27: 77-92.
- Moreau, D., Mufson, L., Weissman, M. M., and Klerman, G. L. (1991). Interpersonal psychotherapy for adolescent depression: Description of modification and preliminary application. *J. Amer. Acad. Adolesc. Psychiat.* 30: 4, 642-651.
- Mufson, L., Moreau, D., Weissman, M. M., and Klerman, G. L. (1993). *Interpersonal Psychotherapy for Depressed Adolescents*. Guilford Press, New York.
- Petersen, A. C., Compas, B. E., Brooks-Gunn, J., Stemmler, M., Ey, S., and Grant, K. E. (1993). Depression in adolescence. *Am. Psychol.* 48: 155-168.
- Reed, M. K. (1994). Social skills training to reduce depression in adolescents. *Adolescence*. 29: 293-301.
- Rehm, L. P. (1977). A self-control model of depression. *Behav. Ther.* 8: 787-804.
- Reynolds, W. M. (1992). Depression in children and adolescents. In Reynolds, W. M. (ed.), *Internalizing Disorders in Children and Adolescents*. Wiley and Sons, New York.
- Reynolds, W. M., and Coats, K. I. (1986). A comparison of cognitive-behavioral therapy and relaxation training for the treatment of depression in adolescents. *J. Consult. Clin. Psychol.* 54: 653-60.
- Rutter, M. (1986). The developmental psychopathology of depression: Issues and perspectives. In Rutter, M., Izard, C. E., and Read, P. B. (eds.), *Depression in Young People: Clinical and Developmental Perspectives*. Guilford, New York.