Adolescent family therapy Depression and suicidal thoughts:
Asystematic reviews and meta-analyses

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Abstract

Objective: We set out to check if family therapy works as well as other active treatments for adolescents stuck with depression or dealing with suicidal thoughts.

This project is a systematic review and meta-analysis that, generally speaking, tries to piece together evidence without following a too-rigid order.

Methods: We began by rummaging through several databases – starting with the Cochrane Central Registry of Controlled Trials and then wandering into Medline, Embase, PsycINFO, AMED, CINAHL, and WebScience.

Our approach wasn't always linear; in most cases, we planned on running two separate meta-analyses—one zeroing in on depressive symptoms and another tracking suicidal ideation outcomes.

 Results: While sorting through roughly 3,040 records (yes, that many!), we ended up spotting 10 home-based randomized controlled trials that tackled interventions for depression or suicidal ideation in adolescents.More exactly, nine of these studies presented outcome measures for depressive symptoms, and four talked about suicidal ideation. Our analysis will see if the final depression levels differ notably between family therapy and alternative comparator therapies, and it will also look into whether suicidal ideation substantially disrupts how families experience treatment, all while comparing different treatment styles in a less predictable order.

 Conclusion: In the end, we hope to figure out whether there really is no significant difference in depression outcomes when family therapy is compared with other active treatments—or if, on the contrary, suicidal ideation makes a considerable impact on the treatment dynamics families go through. We also want to know if home-based treatment turns out to be better than other psychological methods at easing depression or boosting outcomes for suicidal thoughts. Given the generally low-quality evidence currently available, one must wonder if more research is needed, especially considering the huge public health stakes tied to suicidal behavior (O'Connor et al., 2018), (Kirtley et al., 2018).

Keywords: Familytherapy, adolescent, depression, suicidal ideation, systematic review, meta

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العلاج الأسري للمراهقين: الاكتئاب والأفكار الانتحارية: مراجعات وتحليلات تجميعية غير منهجية

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الخلاصة :

الهدف: شرعنا في التحقق من فعالية العلاج الأسري، إلى جانب العلاجات الأخرى الفعّالة، للمراهقين الذين يعانون من الاكتئاب أو الأفكار الانتحارية.

يُعد هذا المشروع مراجعة منهجية وتحليلًا تجميعيًا، ويحاول، بشكل عام، تجميع الأدلة دون اتباع تسلسل صارم.

المنهجية: بدأنا بالبحث في العديد من قواعد البيانات – بدءًا من سجل كوكرين المركزي للتجارب السريرية، ثم انتقلنا إلى قواعد ميدلاين، وإمباس، وسايك إنفو، وأميد، وسيناهل، وويب ساينس.

لم يكن نهجنا دائمًا خطيًا؛ ففي معظم الحالات، خططنا لإجراء تحليلين تلويين منفصلين – أحدهما يُركز على أعراض الاكتئاب والآخر يتتبع نتائج الأفكار الانتحارية.

النتائج: أثناء فرز ما يقرب من ٣٠٤٠ سجلًا (نعم، هذا العدد!)، وجدنا ١٠ تجارب منزلية عشوائية محكومة تناولت تدخلات لعلاج الاكتئاب أو الأفكار الانتحارية لدى المراهقين. وبشكل أدق، قدمت تسع من هذه الدراسات مقاييس نتائج لأعراض الاكتئاب، وتحدثت أربع دراسات عن الأفكار الانتحارية. سيُحدد تحليلنا ما إذا كانت مستويات الاكتئاب النهائية تختلف بشكل ملحوظ بين العلاج الأسري والعلاجات المقارنة البديلة، وسيبحث أيضًا فيما إذا كانت الأفكار الانتحارية تُؤثر بشكل كبير على تجربة الأسر للعلاج، كل ذلك مع مقارنة أساليب العلاج المختلفة بترتيب أقل قابلية للتنبؤ.

الخلاصة: في النهاية، نأمل في معرفة ما إذا كان هناك فرق جوهري في نتائج الاكتئاب عند مقارنة العلاج الأسري بالعلاجات الفعالة الأخرى، أو ما إذا كان للأفكار الانتحارية، على العكس من ذلك، تأثير كبير على ديناميكيات العلاج التي تمر بها الأسر. كما نريد أن نعرف ما إذا كان العلاج المنزلي أفضل من غيره من الطرق النفسية في تخفيف الاكتئاب أو تحسين نتائج الأفكار الانتحارية. ونظرًا لضعف جودة الأدلة المتوفرة حاليًا، يتساءل المرء عما إذا كانت هناك حاجة إلى مزيد من البحث، لا سيما بالنظر إلى المخاطر الصحية العامة الكبيرة المرتبطة بالسلوك الانتحاري (أوكونور وآخرون، ٢٠١٨)، (كيرتلي وآخرون، ٢٠١٨).

الكلمات المفتاحية: العلاج الأسري، المراهقون، الاكتئاب، الأفكار الانتحارية، مراجعة منهجية، تحليل تلوي

Introduction

Depression affects kids and teens in huge numbers. Almost 20% of adolescents in their mid-to-late years report a depressive episode in just one year – and plenty mention that they've battled a bout of depression even before hitting 18 (Hankin et al., 2015; Jane Costello et al., 2006; World Health Organization, 2017).

That figure is frankly staggering and hints at a serious public health concern, impacting personal lives as well as how society functions. Suicidal thoughts also tend to show up alongside depression, which only ups the danger of the condition. Teens dealing with depression seem to be more likely to face repeated episodes, often coupled with persistent suicidal ideation that can spill over into adulthood (Birmaher et al., 2002; Nock et al., 2013). In most cases, it becomes really important that treatment plans for adolescents mix in solid strategies – for example, cognitive behavioral therapy has been shown to help ease both the depressive blues and those dangerous recurring thoughts, ultimately aiming to cut down long-term issues.

This way of handling things fits in with established treatment guidelines that generally push for broad, well-rounded intervention tactics for this vulnerable group (O'Connor et al., 2018), (Kirtley et al., 2018).

Cognitive Behavioral Therapy and Interpersonal Psychotherapy

Cognitive Behavioral Therapy (CBT) pops up a lot as the go-to treatment for depression – many clinical guidelines, like those from the National Collaborating Center on Mental Health (2019), back it up as an evidence-based first step.

Even though CBT's merits are well-documented,several meta-analyses,generally speaking, show its overall impact seems quite modest; this might be owing to a somewhat limited pool of evidence for some specific groups (Weisz et al., 2013; Zhou et al., 2015). On the other hand, Interpersonal Psychotherapy (IPT), which arrived on the scene more recently, has proven to be just as effective as CBT – in fact, some studies hint that in certain circumstances (Eckshtain et al., 2020) it might even outperform CBT, especially when it comes to tackling the personal side of depression. It's also a bit troubling that, despite having these solid treatment options, about 30–40% of adolescents still don't get the help they need, with some kids even seeing their condition worsen (Brent et al., 1997, 2008; Kennard et al., 2009). This continuing treatment gap clearly shows that we need to keep exploring better therapeutic options and work on making mental health services more accessible – after all, both CBT and IPT remain key threads in the wider fabric of depression care (Dubicka et al., 2018), (Callesen E et al., 2022).

Suicidal Ideation and Adolescent Suicidal Behavior

Suicidal thoughts in depression often get brushed aside—in many cases, they aren't directly tackled (Schneider et al., 2020). Yet, over roughly the past 15 years, efforts to dial down suicidal actions among youngsters have been on the rise, a trend that reflects our growing grasp of how tangled adolescent mental health can be. For teens, a number of treatments now seem capable of addressing both the dangerous ideas and the actions that might follow (Glenn et al., 2019). Interestingly, dialectical behavior therapy – you know, DBT – has made its mark as a strong tool; its versions are wedded to the unique developmental needs of adolescents, often mixing in family-based elements that foster involvement and even a bit of support. In most cases, such an approach not only cuts down on suicidal thoughts but also helps reduce self-harm and the deep depressive moods seen in some young people with traits similar to borderline personality disorder (Mehlum et al.,

2014, 2016), which, generally speaking, underscores the importance of interventions specifically designed for these vulnerable groups.

Also, the integrated motivational-volitional model of suicidal behavior paints a wider picture by showing how feelings of entrapment and defeat can spark these harmful thoughts – suggesting that we should target not just the symptoms but the deeper motivators, too (Kirtley et al., 2018), (O'Connor et al., 2018).

Psychosocial Treatments and Family Therapy

Miklowitz et al. (2020) found that young people at high risk for bipolar disorder tend to see their suicidal thoughts drop noticeably over a span of about 1–4 years when they receive family-focused care along with extra usual support. This result hints that, generally speaking, psychosocial treatments might work well for this group. The study dug into how these interventions change suicidal ideation by checking for shifts in living conditions and how teens feel about family conflict—almost as if the way families interact is tightly linked to mental health outcomes. At the same time, these treatments seem to lower suicidal ideation effectively, yet they're rarely used for teens who are mainly diagnosed with unipolar depression, especially when severe suicidal feelings also crop up.

It's pretty important to see if using similar family-based approaches might cut down suicide risk among depressed teens. Depressed youths often face a host of issues across different parts of life—not least problems with family relationships—which can make their struggles even worse. There's plenty of evidence (Brent & Melhem, 2008; King & Merchant, 2008; Restifo & Béogels, 2009; Sheeber et al., 1997) suggesting that family-related challenges play a big role in the onset and persistence of both depression and suicidal thoughts in children and adolescents.

Depression, after all, can be passed along through both genetic and environmental means (Dunn et al., 2011; Rice et al., 2002), which makes family therapy a logical, and perhaps effective, option for treating depression in young people.
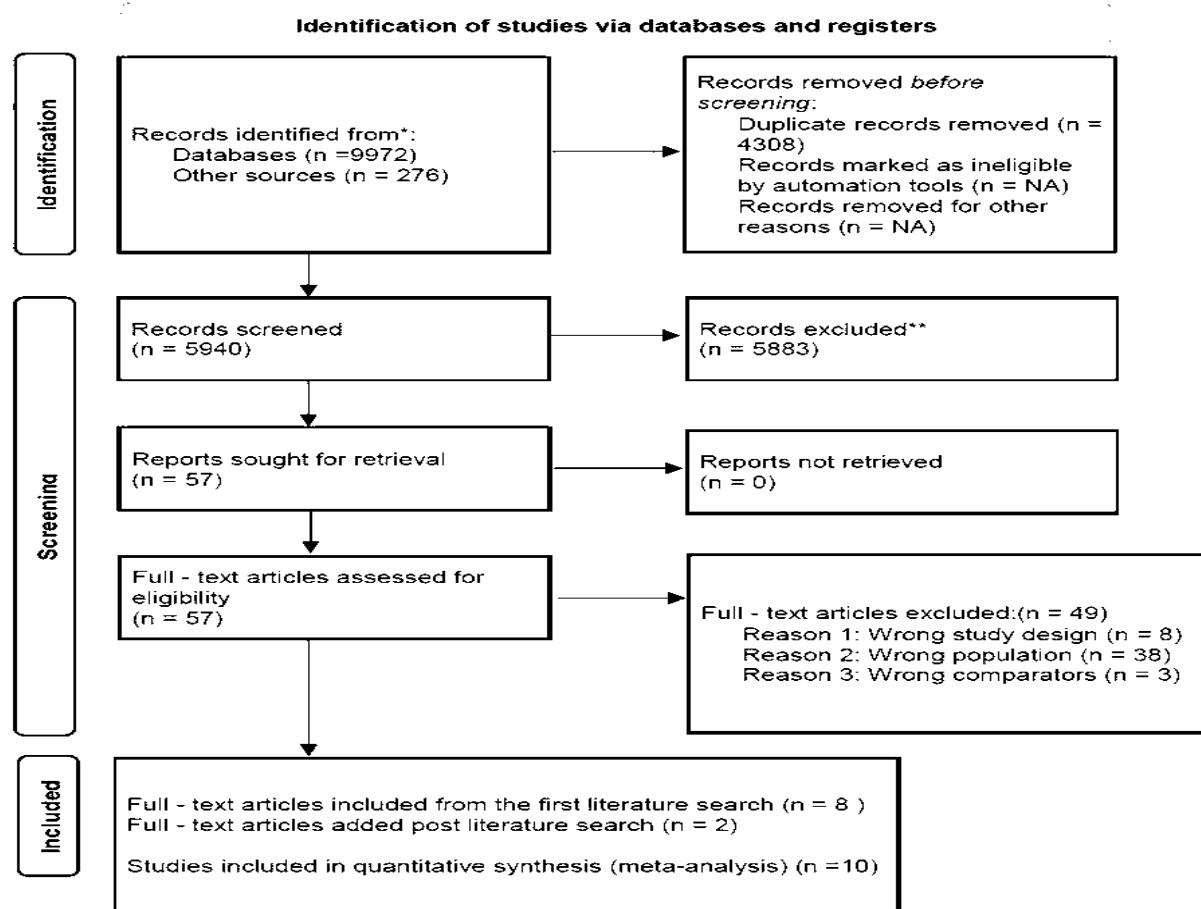
In simple terms, family therapy is usually defined as any form of psychotherapy that aims directly at changing how family members relate to one another – it's meant to improve how the whole family operates or help individual members function better (Cottrell & Boston, 2002).

A comprehensive Cochrane review from over a decade ago generally concluded that family therapy beats waiting-list or no-treatment conditions for depression (Henken et al., 2007); yet, the review couldn't run a full meta-analysis because of a lack of high-quality studies, small sample sizes, and a lot of variation in both interventions and outcomes. Also, no recent systematic reviews or meta-analyses seem to compare family therapy with active controlled treatments for adolescent depression, which really points to a gap in the current literature.

Given how strongly family dynamics are involved in triggering and shaping depression among teens, home-based therapy is often the chosen strategy. Of course, decisions on which interventions to use shouldn't rest on just one study's findings; it's crucial to look at all the available evidence. Meta-analysis, then, offers a useful way to combine all the data—including insights from newer studies (Altman et al., 2001), (Bailey et al., 2013)—to assess how effective family treatments really are.

Method

We stuck closely to the PRISMA guidelines throughout our review process (Page et al., 2021). If you glance at Figure 1, you'll see a flow chart that loosely tracks how we organized our steps—its layout isn't overly rigid but gives a fair idea of our approach. When the study is finished, we plan to register it in PROSPERO, the international database that collects a wide range of systematic review protocols; this helps curb duplicative efforts, lower the chance of reporting bias, and boost overall transparency in our research (Kirtley et al., 2018). It's important to note that keeping up such rigorous methods is key, especially when we face the tricky task of disentangling suicidal ideation from behavior—something many modern theoretical models have tried to explain in their own ways (Abdellaoui et al., 2016).

Identification of studies via databases and registers

Identification

Records identified from*:
Databases (n =9972)
Other sources (n = 276)

→

Records removed *before screening*:
Duplicate records removed (n = 4308)
Records marked as ineligible by automation tools (n = NA)
Records removed for other reasons (n = NA)

Screening

Records screened
(n = 5940)

→

Records excluded**
(n = 5883)

Reports sought for retrieval
(n = 57)

→

Reports not retrieved
(n = 0)

Full - text articles assessed for eligibility
(n = 57)

→

Full - text articles excluded:(n = 49)
Reason 1: Wrong study design (n = 8)
Reason 2: Wrong population (n = 38)
Reason 3: Wrong comparators (n = 3)

Included

Full - text articles included from the first literature search (n = 8)
Full - text articles added post literature search (n = 2)

Studies included in quantitative synthesis (meta-analysis) (n =10)

Inclusion Criteria for Family Therapy Studies

The review leans on what we call the PICOS framework—that's Population, Intervention, Comparison, Outcome, and Study Design (Liberati et al., 2009). We start by looking at randomized controlled trials that pit family therapy head-on against another kind of psychotherapy, one which tackles depression or suicidal thoughts in youngsters aged 9–18. In these studies, participants should either score high on a depression checklist from a formal interview, pass preset limits on standardized tests for depressive symptoms, or show signs of suicidal ideation measured by reliable symptom tools. We're not fussed about whether these teens also have other mental or physical issues, since life is rarely so clear-cut, and there's a tangled mix of factors in adolescent mental health (Salari N et al., 2020). Family psychotherapy methods of every stripe count here—no matter how long or frequent

the sessions are. For a study to qualify, its comparison group must be untreated, whether that means a waitlist, placebo, non-intervention group, or even a program aimed at parents of non-depressed teens; studies sticking solely with maintenance or other psychotherapy forms get left out so that the therapy's effects remain unmistakable. You can find the nitty-gritty details on what makes the cut in Table 1. Now, regarding outcomes—honestly, while we can't say exactly what the numbers will show, our plan is to see whether there's a noticeable difference in depressive symptoms or suicidal ideation between the home treatment and the control groups (evaluated by either self-reports or physician assessments) (Michelle B Riba et al., 2019). On top of that, we're planning to follow up over the long haul, checking in on depressive signs, suicidal thoughts, social functioning, relationships, quality of life, any adverse events, treatment dropouts, and even family conflict. In most cases, this broad look helps us capture the true, multifaceted impact of the therapy.

Table 1. Selection criteria for including and excluding studies.

Inclusion criteria

Participants	Adolescents between 9 and 18
Study design	Randomized controlled trials (RCTs)
Setting	All (multi-center and single-center)
Language	English languages
Intervention	Any form of family therapy
Comparison	Any active treatment
Diagnosis	Depression disorder diagnoses must be based on a structured assessment according to the criteria of DSM-IV or ICD-10 Or suicidal ideation
Primary Outcome	Significant reduction of symptoms of depressive disorder and reduction in suicidal ideation, according to recognized outcome measure instruments
Exclusion	Adults
Criteria	Children (<9)

Other mental disorders as the primary diagnoses Studies with no treatment comparison groups e.g. waiting list, placebo or a non-intervention

Study Design and Methodology

We began by scouring several major databases—Cochrane Central Register of Controlled Trials (CENTRAL), Medline (Ovid), Embase (Ovid), PsycINFO (Ovid), AMED (Ovid), CINAHL (EBSCO), and even Web of Science—with our search parameters running through 2023. At the same time, we made a point not to rely solely on these sources; instead, we also dug into gray literature by checking out Open Gray, ClinicalTrials.gov, and the WHO International Clinical Trials Registry Platform (ICTRP) to catch both ongoing and unpublished studies.

Our approach involved crafting search strategies that were just right for each database, mixing in a wide array of terms such as depression, suicidal ideation, adolescents, family therapy, and study planning, repeating some of these key ideas along the way. We

didn't set any limits based on publication year, language, or type—this helped us snag a broader range of literature than if we'd been too picky. We even took time to pore over the bibliographies of all the studies we included, breaking the process into smaller, iterative reviews to solidify our analysis framework. Given how crucial it was to keep an eye on publication bias, we also pulled in unpublished studies like theses and dissertations that showed acceptable methodological quality, following recommendations found in (Kirtley et al., 2018) and (Chanen A et al., 2013).

Data Extraction and Risk of Bias Assessment

Risk assessment plays a crucial role in keeping randomized trials honest since bias can show up in unexpected ways.

There might be bias sneaking in during the randomization stage that upsets the truly random spread of treatments; bias can also arise when the actual intervention strays from what was planned, sometimes muddling treatment details.

Often, missing outcome data ends up painting a misleading picture, while inconsistent ways of measuring outcomes can warp the results. And then there's the issue of choosing only certain outcomes to report, which might selectively shade the overall picture. In general, researchers must wrap all these observations into one overall judgment—typically marked as low risk, some concerns, or high risk of bias—to give a practical sense of the evidence's trustworthiness.

To help with this, a Summary of Findings (SoF) table (Table 3) is planned following the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) guideline—a pretty solid framework for pulling together evidence. The GRADE system, in most cases, looks into a handful of essential features: study limitations (i.e., the internal validity that may be weakened by bias); inconsistency, which checks how much treatment effects vary between studies; indirectness, which basically compares differences across populations, treatments, comparators, and the outcomes we care about; inaccuracy (or random error), which tells us if the estimated effect is solid enough to base a clinical call on it; and publication bias, where selective reporting may skew the final picture. Altogether, the quality of the evidence gets classified as high, medium, low, or very low—a judgment process that, as previous research has noted (Backhouse et al., 2016), (Altman et al., 2001), is essential for steering both clinical practice and policy decisions.

Data Synthesis and Analysis

Sometimes an experimental paper might skip reporting the mean and standard deviation, and in those cases you can use different numbers to work out the effect sizes – a method that generally fits with the Cochrane manual's push for a rigorous evidence summary (Higgins & Thompson, 2002).

We often lean on something called the heterogeneity index, which comes out as a percentage; this trick is pretty common in systematic reviews when people try to get a feel for how much study outcomes differ (Borenstein et al., 2009). A reading of 0% just tells you there's no variability at all, while higher percentages point to growing differences across studies, offering a clue on how consistent the findings actually are. Knowing this variability is pretty important, as it shapes how pooled estimates are understood and even nudges our next analytical moves during the synthesis phase (Higgins et al., 2011). In short, giving these calculations close attention is key for making our data synthesis both trustworthy and solid—and it keeps us in line with the best practices out there (Backhouse et al., 2016), (Banu et al., 2016).

Study Heterogeneity and Bias Assessment

About 25%, 50%, and 75% are the usual markers for low, moderate, and high heterogeneity respectively (Higgins et al., 2003). This often implies that differences in study outcomes might seriously sway overall conclusions.

Q statistics is set to come into play too – basically giving us a numerical insight into just how much effect sizes vary across different studies. We also planned to break the data down by sex and comorbidities; this is pretty key if one wants to check whether enough essential info was recorded in a reasonable number of studies.

Higgins et al. (2019) generally notes that having at least 10 studies per feature is necessary to get meaningful results – a guideline that also applies when looking into publication bias with a funnel plot.

A funnel plot, in simplest terms, is a scatter diagram where individual study estimates go on one axis (typically horizontal, tied to study precision) and the corresponding effect sizes go on the vertical. When these plots look oddly skewed, it's often taken as a hint of publication bias – a sign that selective reporting might be coloring the overall picture. One snag, however, was that subgroup analysis couldn't be pursued because the groups turned out too small, which really challenges both validity and reliability. As a result, we weren't able to explore any secondary outcomes that might have provided extra insights into the findings and their broader implications.

 Results

We started our search and ended up with 10,248 datasets that seemed to match what we were exploring. After a careful pass, we weeded out 4,308 duplicate entries and then sifted through roughly 5,940 records at the title and abstract stage – oddly enough, 5,883 of these didn't make the cut because they were either off-target or just lacking in data quality. Next, we dug into 57 full-text articles and, based on a set of defined rules (in most cases pretty clear-cut), we dropped 49 of them; for a closer look at why these were excluded, check out the PRISMA flow chart in Figure 1 (Clinical Child Psychology and Psychiatry). In the end, we zeroed in on 10 articles for a full review – note that two of these actually came from the same study, one was centered on depressive symptoms, and another separately addressed suicidal ideation. Across the nine trials that contributed to our final review, there were 788 respondents in total – 377 in the treatment group and 411 in the control group. The average age came in at about 14.73 years, and roughly 65.3% were female, which hints at some interesting demographic trends impacting our overall findings (O'Connor et al., 2018), (Kirtley et al., 2018).

Brief Summary of Family Therapy Approaches

Out of the 10 studies that we looked at (Bernal et al., 2019; Brent et al., 1997; Diamond et al., 2010, 2019; Esposito-Smythers et al., 2019; Israel and Diamond, 2013; Poole et al., 2018; Trowell et al., 2007; Waraan et al., 2021; Waraan et al., 2020), three mainly zeroed in on both depressive symptoms and suicidal ideation (Diamond et al., 2010, 2019; Esposito-Smythers et al., 2019). In most cases, another six focused only on depressive symptoms (Bernal et al., 2019; Brent et al., 1997; Israel and Diamond, 2013; Poole et al., 2018; Trowell et al., 2007; Waraan et al., 2021), and just one looked solely at suicidal ideation. You can see the chosen details laid out in Table 2, which kind of gives you a systematic view of the study characteristics. Treatment durations varied a lot between approaches. Typically, sessions spanned 8 to 16 weeks; however, it is worth noting that two of the studies ran over much longer periods—one extended to 12 months

with sessions gradually thinning out over time (Trowell et al., 2007) and another went for 9 months. Five different family therapy models cropped up across these investigations. For example, Bernal et al. (2019) and Esposito-Smythers et al. (2019) employed what you might call modified cognitive-behavioral family therapy (F-CBT). Poole et al. (2018) adopted a family systems approach known as BESTMOOD, which interestingly blends in bits of attachment theory to boost relational dynamics. Trowell et al. (2007) took on a systemic integrated family therapy style that directly addresses recurring patterns of family dysfunction.

Generally speaking, the most common treatment was Attachment-Based Family Therapy (ABFT), a method that really leans into the importance of attachment ties in therapeutic settings. Several studies (Diamond et al., 2010, 2019; Israel and Diamond, 2013; Waraan et al., 2020, 2021) also wedded a systems approach with attachment theory insights, reinforcing its overall framework. Notably, Brent et al. (1997) stands apart by featuring three treatment arms—systemic behavioral therapy, cognitive-behavioral therapy, and non-directive supportive treatment—thereby offering a comparative lens on effectiveness. Additionally, six studies compared home-based treatments with either usual or enhanced usual care conditions (Diamond et al., 2010; Esposito-Smythers et al., 2019; Israel & Diamond, 2013; Poole et al., 2018; Waraan et al., 2020, 2021). Two investigations directly pitted family therapy against cognitive-behavioral therapy (Bernal et al., 2019; Brent et al., 1997), while another focused on family-enhanced nondirective therapy (FE-NST) (Diamond et al., 2019), and yet another examined individual psychodynamic therapy (Trowell et al., 2007). Out of the four studies that homed in on suicidal ideation as an outcome, three predominantly centered on ABFT (Diamond et al., 2010, 2019; Waraan et al., 2020), with one also exploring the effects of F-CBT (Esposito-Smythers et al., 2019).

Overall, this collection of research underscores the many different angles used in family therapy and highlights just how important it is to tailor interventions when dealing with the complex nature of mental health issues in families.

Table 2. Selected basic characteristics of all included studies in the systematic review.

Study	Year	Country	N	% Female	Age (M)	Age range	Treatment weeks	Follow up (weeks)	Treatment	Comparison group	Outcome		Results
Bernal et al.	2019	Puerto Rico	121	53.4		[13, 17.5]	12	24, 36, 52, 72	CBT + TEPSI	CBT	CDI	Depression	No difference*
Brent et al.	1997	USA	107	75.7	15.6	[13, 18]	16	No	SBFT	CBT, NST	BDI, MDD	Depression	CBT better then SBFT and NST
Diamond et al.	2010	USA	66	83	15.1	[12, 17]	12	24	ABFT	TAU	SIQ-JR, BDI-II	Depression/ suicidal ideation	ABFT better than TAU
Diamond et al.	2018	USA	129	81.9	14.87	[12, 18]	16	24, 32, 40, 52	ABFT	FE-NST	SIQ-JR, BDI-II	Depression/ suicidal ideation	No difference*
Esposito-Smythers et al.	2019	USA	147	76.19	14.90	[12,18]	24–52	52, 72	F-CBT	E-TAU	SIQ Jr, CDI-2	Depression/ suicidal ideation	No difference*
Israel and Diamond	2012	Norway	20	55	15.60	[13, 17]	12	No	ABFT	TAU	BDI, HAM-D	Depression	ABFT better than TAU
Poole et al	2018	Australia	64	73.4	15.20	[12, 18]	8	12	BEST MOOD program	PAST	SMFQ	Depression	No difference*
Trowell et al	2007	UK	72	38	11.71	[9, 15]	36	24	SIFT	F-IPP	CDI	Depression	No difference*
Waraan et al	2020	Norway	60	86.7	14.90	[13, 18]	16	No	ABFT	TAU	GRID-HAMD	Depression	No difference*
Waraan et al	2021	Norway	60	86.7	14.90	[13, 18]	16	No	ABFT	TAU	SIQ-JR	Suicidal ideation	No difference*

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Risk of Bias

Figures 2A and 2B clearly show that not one study ended up with a low bias risk across all five quality areas—a fact that, generally speaking, raises serious doubts about the overall solidity of the research findings. It appears that if no study manages low risk in every domain, there could be hidden weak points in the methods used, as the National Health Services have pointed out by stressing the importance of trimming bias in clinical evaluations (Backhouse et al., 2016). In a somewhat perplexing twist, eight studies ended up with an overall "some risk" of bias, which kind of reflects the messy reality of evaluation procedures and the inherent difficulty of sticking to strict research standards. Then, only two studies, in most cases, earned a low-risk badge overall; this small number naturally casts doubts on how reliable their conclusions really are, and on whether their findings can apply more broadly. One might note, too, that earlier research has hinted at how flawed methods can obscure the real picture of suicide risk assessments and even slow down effective interventions (O'Connor et al., 2018). All in all, these insights point to a pressing need for more painstakingly rigorous evaluations in order to boost confidence in study outcomes and to better guide clinical practice.

Outcome Evaluation

Several investigations dove into how individuals reported their own feelings of depression, each taking a slightly different route with their tools.

In four studies, researchers measured symptoms using the BDI-II (Beck et al., 1996), while three others opted for the Childrens Depression Inventory (CDI, Poznanski & Mokros, 1996) – a choice that shows the variety in approach. Then, one study brought in the Grid Hamilton Depression Inventory (GRID HAMD, Williams et al., 2008) and another relied on the Short Mood and Affect Questionnaire (SMFQ; Angold et al., 1995) for a broader outcome evaluation (see Table 2).

When it came to gauging suicidal thoughts, all four studies used the Suicide Ideation Questionnaire for Adolescents (SIQ-Jr; Reynolds, 1987); this tool, frankly, is key for checking how well interventions are doing. Interestingly, two studies comparing control treatments generally revealed that family therapy seemed to have better effects (Diamond et al., 2010; Israel & Diamond, 2013), hinting at its promise. Yet, quite notably, seven studies reported no significant differences in treatment outcomes (Bernal et al., 2019; Diamond et al., 2019; Esposito Smythers et al., 2019; Poole et al., 2018; Trowell et al., 2007; Waraan et al., 2020, 2021) – a reminder that the connection between therapy type and its effectiveness can be pretty tangled. Oddly enough, one particular study even noted that family therapy was less effective (Brent et al., 1997). All in all, these mixed findings point to the many layers involved in depression and suicidal ideation among youth, meaning we really need to keep re-evaluating and fine-tuning our therapeutic methods, as suggested by current research (Leech et al., 2020), (O'Connor et al., 2018).

Table 3. Summary of findings.

Family therapy compared to active treatment or treatment as usual (TAU)

Participant: Adolescents diagnosed with depression

Interventions: Family therapy

Comparison: Another active treatment or treatment as usual (TAU)

Utfall	Studies (number of participants)	Assumed effect in comparison group	Effect estimates	Certainty of the evidence (GRADE)	Beskrivelse
Symptoms of depression End of treatment	9 studies (786)	—	Hedge`s g= 0.08 (KI 95% −0.10 to 0.25)	Low	$I^2 = 36.5$
Suicidal ideation End of treatment	4 studies (402)	—	Hedge`s g = 0.34 (KI 95% 0.12–0.57)	Moderate	$I^2 = 19.8$

Meta-Analysis of Depression and Suicidal Ideation

Our meta-analysis kicks off by asking if family therapy and active therapy really differ in treating depressive symptoms in teens. Right away, we look at whether family therapy trims suicidal ideation in a modest way or if its effect is more marked – a question that hits home given the increasing mental health struggles among adolescents these days (Au-Yeung et al., 2021).

We decided to leave out studies using waitlist controls because, frankly, those comparisons tend to exaggerate effect sizes, muddying the overall picture. Typically, psychotherapy research prefers Treatment as Usual (TAU) or other defined treatments as a baseline (Weisz et al., 2013; Zhou et al., 2015), but TAU groups themselves bring a host of challenges.

The condition labeled as TAU can vary greatly between studies, which adds extra heterogeneity into the effect estimates and might twist our interpretations. Many of the studies didn't even lay out clearly what their TAU entailed. Interestingly, two studies mentioned that TAU often acted more like a waitlist comparator since many participants hadn't started any treatment when data were collected (Diamond et al., 2010; Israel & Diamond, 2013). While these studies showed that family therapy is a promising approach, they stopped short of proving that treatment for depression was comprehensively effective. It's crucial to remember that meta-analyses are prone to bias; generally speaking, studies that register as low risk usually report smaller improvements in suicidal ideation (O'Connor et al., 2018). In fact, only a pair of studies in our bias check fit the low-risk bill – both solid randomized trials where both treatment groups saw a drop in depressive symptoms. This could be hinting at a broader issue: TAU often ends up looking a lot like family therapy, making it hard to pinpoint their unique impacts. With TAU family meetings being almost standard practice for treating depression in teens, it gets really tricky to argue that home treatment is superior, as the results tend to echo those of the active treatment arms themselves. Some authors even flagged that this might be a sticking point in their own work (Esposito-Smythers et al., 2019; Israel & Diamond, 2013; Poole et al., 2018). Another knot to untangle is the sheer diversity within family interventions. Family therapy isn't a one-track

method – it packs a range of approaches all anchored in broad systemic ideas, yet they differ quite a lot in practice.

This mix makes it hard to generalize outcomes across the board. For some families, the method might lean on a psychoeducational model, focusing on easing negative feelings, retracing the steps of the illness, teaching coping strategies, and offering support to the family (Bernar et al., 2019).

On the flip side, a systems model argues that troubled family relationships actually contribute to, or even worsen, depressive symptoms, prompting efforts to rework dysfunctional interaction patterns. Family dynamics play out in various unexpected ways (Brent et al., 1997; Trowell et al., 2002) – and that only adds another layer of complexity when trying to nail down a unified sense of treatment efficacy.

Effectiveness of Treatments for Adolescent Depression

Family therapy digs right into mending the broken bond that forms between parents and kids; it's all about trying to rebuild a warm, protective connection (Diamond et al., 2010). Family-oriented CBT doesn't zoom in on every developmental need, but it still stresses key parts – think learning about mental health, tackling problems, shifting negative thoughts, getting active, and keeping emotions in check (Esposito-Smythers et al., 2019).

All these approaches lean heavily on family dynamics and the idea of changing symptoms to justify treatment choices. Looking at the bigger picture, when researchers brought these strategies together as part of an overall family model, family therapy ended up feeling more like a baseline or control rather than the main event. In fact, one study found that CBT works a lot better than not only family therapy but also systemic behavioral therapy and even indirect supportive care.

These days, CBT is seen as the go-to for teen depression – it usually produces notable, if only modest, improvements, which fits in with what most people expect (Weersing et al., 2017; Weersing et al., 2013). Systemic behavioral therapy, on the other hand, calls for everyone in the family to be involved.

Parents and adolescents team up to figure out and talk about family conflicts that might spark specific issues. Yet, a challenge arises when symptoms sometimes show up midway through treatment – a hiccup that can throw a wrench in even the best-laid plans. Developmentally speaking, having parents on board is generally critical, especially when teens are juggling all those changes.

Still, it's not always a win – particularly when young people are eager to carve out their own space or when parents are busy grappling with their own problems. It's also worth noting that many studies tend to overlook the specific case of adolescent depression linked with suicidal thoughts or behaviors.

In reality, research into teen suicidal behavior is surprisingly light. Indeed, only one study even looked at major depressive disorder (MDD) as a marker for suicidal ideation (Waraan et al., 2020).

Meanwhile, three other studies leaned more toward using suicidal ideation as the main filter, rather than tackling depressive symptoms head-on.

This naturally stirs up questions about how we define depressive disorders as mental illnesses and about the impact that treating depression might have on suicidal behavior. With mental health issues on the rise, hospital stays for suicide-related problems among adolescents have climbed sharply in the past decade (Plemons et al., 2018), and, sadly, some young folks end up taking their own lives because of depression.

This only underscores the urgent need for more research focused on this group (Ougrin et al., 2015; Restivo and Biogels, 2009). So, it's clear that setting up treatments backed by solid evidence is essential if we're to ease teen symptoms effectively.

There's hope that new or alternative therapies might eventually show even stronger empirical support when it comes to handling adolescent depression or suicidal ideation. Although CBT has proven its worth as a trusted framework for adolescents, it still isn't all that common in everyday practice within Child and Adolescent Mental Health Services (CAMHS). Policymakers in health really need to step up here, encouraging or even facilitating providers, school nurses, and local community figures to put evidence-based approaches like Treatment as Usual (TAU) into action – any push in that direction could help ease the burden of depressive symptoms among teens. Looking ahead, the next big step in psychological intervention research might be to dig into and understand the inner workings of these treatments; uncovering the underlying mechanisms could ultimately boost how effective they are overall (Velasco AA et al., 2020), (Myin I-Germeys et al., 2018).

Advantages and Limitations

This review's main advantage is that it follows a strict protocol and builds on a wide-ranging search of the literature—which, in most cases, will be carefully examined for risks and then subjected to a rigorous quantitative synthesis (Ametaj et al., 2020). Still, every study we looked at shows some methodological shortcomings that, to a degree, weaken the overall strength of the findings.

It seems that more meticulously designed work could really help clarify the evidence for specific psychotherapies—after all, various factors, like participant demographics and different therapy types, tend to affect outcomes (Leech et al., 2020). The somewhat moderate quality of the included studies makes it hard to draw solid conclusions about efficacy.

Also, the diverse family backgrounds of the participants and the varying characteristics of the treatments further muddle any clear clinical interpretation of the results. Moreover, a mix of control methods was employed across the studies; consequently, some investigations ended up being more tightly controlled than others, which introduces a fair bit of heterogeneity—and, frankly, a dose of uncertainty—in the overall findings.

Conclusion

Many studies in recent years have looked into how well treatments for depression and suicidal behavior work, and there's been a noticeable surge in fresh ideas around this critical area—progress is evident, even if it sometimes feels a bit unpredictable. Research generally points out that moving from just suicidal thoughts to actual attempts isn't a straightforward process; it gets wedded up with a mix of factors such as mental health issues and personal life experiences, which, in most cases, signals that we need broader, more comprehensive treatment approaches ((Favril et al., 2020)). The rise of smartphone apps as intervention tools is another interesting development. They not only mark a step forward in technology but also hint at the real hurdles many young people face when trying to get help for depression, self-harm, and suicidal thoughts ((Leech et al., 2020)).

Taken together, these trends imply that even though boosting treatment effectiveness remains a key goal, truly understanding the layered complexity of suicidality is equally crucial for shaping better, future interventions and enhancing overall mental well-being. Moreover, efforts to improve access to care and resources should ideally be built on both solid research and the genuine, lived experiences of those affected, ultimately fostering a more supportive environment for populations at risk.

Treatment Approaches for Adolescent Depression

Treating depression in teens is still a huge challenge in mental health. Many people often turn to family therapy for help, yet generally speaking it sometimes falls short of solid proof, leaving us to wonder if it really works the same for every group (Britton et al., 2014). Research keeps nudging us toward blending different approaches; a mix of methods seems better at tackling the many, sometimes messy, needs of depressed adolescents. In many cases, individual therapy, like cognitive behavioral therapy (CBT) or even simple behavioral therapy, teamed up with medication tends to lift results noticeably (Barlow et al., 2017). It also feels important to mix in things like clear explanations (psychoeducation), addressing the back-and-forth in parent-child conflicts, and figuring out attachment issues, all of which round out a complete treatment plan (Britton et al., 2014).

Although the evidence isn't yet strong enough to claim that treatments provided at home always beat other methods, there's still a lot of room for trying new ways to connect with struggling teens. Interestingly, family therapy has shown some promise for those dealing with suicidal thoughts – though, of course, a bit more digging is necessary to be sure (Barlow et al., 2017). Besides, looking into what really sparks change during therapy could open up a world of insights for refining our approaches with these vulnerable individuals. Looking ahead, future research should really focus on creating and testing short-term, flexible treatments that zero in on the key change factors and practical steps which can be tweaked to fit the unique needs of depressed adolescents across different settings.

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