IMPLICATIONS

Addressing the needs of the adolescents in the Tenth Five-Year Plan (2002-2008) Mr K C Pant, Deputy Chairperson, Planning Commission said that 10th Five-Year Plan will ensure an integrated approach in handling Adolescent Welfare and Development. The strategy is to harness the strengths of educators, NGOs, Youth and Community based organization towards catering to all the unmet needs to the population segment. The Planning Commission report declares that the adolescent have very special and distinct needs, which can no longer be overlooked. It proposes that the Central Government allocate Rs.112 crore towards adolescent Welfare and Development programmes and suggest that the States and Union territories allocate Rs. 5 to 10 crore (depending on their size) for the same. While the effectiveness and adequacy of the implementation of these programmes remains an issue, children and adolescents have received greater attention during the twentieth century than before.

Hindering solution strategies is the stigma that remains attached to mental health problems, especially for youth. Poor mental health awareness, limited clinic, school and other community based services, and perceived stigma combine to make adolescents an underserved population in our country. It is important however, to recognize the signs of adolescent depression early and the identification of early risk factors highlights the need for services for adolescents. Children and teenagers rarely present to a parent or practitioner complaining of depression. Parents, especially those who have a history of depression themselves, might suspect a mood problem, but, more often than not, if the young person is brought to clinical attention at all, it is because of some signal event, such as unusually poor grades, a suicide attempt, or a change of behavior linked to some psychosocial disturbance, such as divorce, separation, or the illness or death of a loved one or a close friend. Teenagers’ natural reticence, ready sense of shame, and concern about letting down the family (or being criticized by them) can conspire to hold back any disclosure of dysphoric feelings or thoughts.
Surveys and studies of service utilization suggest that most of these youngsters
do not receive treatment of any type. The high prevalence rate combined with the
potential range of long-term negative consequences supports the need and
requirement for effective treatment procedures. Treatment approaches for depression
in children and adolescents are, for the most part, modifications or direct applications
of procedures developed for use with adults. Various therapies have been used with
adolescent depression. Unfortunately it is harder to medically treat adolescent
depression than adult depression because adolescents are less likely to respond to the
medication. Therefore, alternative treatments such as counseling have proven more
successful. Physicians would prescribe anti-depressant medication to a depressed
adolescent, but if that child appears suicidal, a psychological counselor will also
become involved. A number of factors need to be considered when adopting a
particular treatment approach. These include comorbidity, such as anxiety, substance
abuse, gender, multiculturalism, the type of mental health professional available,
practical constraints, such as the involvement of a physician to prescribe medications
in the use of pharmacological treatments and the treatment setting, such as a school or
clinic.

Pharmacotherapy of depression in children and adolescents is somewhat
controversial due to the limited treatment response reported in numerous clinical
trials. Rationales for this lack of treatment efficacy have ranged from invalidity of the
diagnosis of depression in children using current classification systems to errors in
design methodology and insufficient sample size. A large number of case reports and
a limited number of experimental studies have been published examining the efficacy
of Tricyclic antidepressants (TCAs), Monoamine Oxidase Inhibitors (MAOIs),
Selective Serotonin Reuptake Inhibitors (SSRIs), and other heterogeneous group of
antidepressant drugs for the treatment of unipolar depression. By far, the majority
investigations on antidepressants for the treatment of depression in children and
adolescents have utilized tricyclic antidepressants (TCAs) such as imipramine,
amitriptyline, nortriptyline, and desipramine and SSRIs. Because of its mild side
effects, SSRIs have become an increasingly popular medication choice, despite the
lack of empirical evidence demonstrating its effectiveness with adolescent depression.
MAOIs though considered effective for adults, have not been recommended for
children and adolescents because of its dietary restrictions imposed by the use of the 
medication, and difficulties in monitoring their food intake. It is usually suggested 
that use of antidepressant medications is warranted when depressive symptoms are 
severe, have not been alleviated by psychosocial interventions, or show no sign of abating.

The present study highlights the salient role played by negative cognitive 
processes in adolescent depression and so the use of cognitive coping strategies 
should be challenged and promoted in treatment to make adolescents more resilient in 
the presence of negative life events. Cognitive therapies look to improve and 
examine metacognition and increase more positive thought patterns. It may be 
especially important to aim intervention efforts at cognitive coping strategies, for 
example, by challenging “unadaptive” strategies such as self-blame and 
catastrophizing and supplying more “adaptive” strategies such as positive reappraisal. 
This approach could be linked to the well-established cognitive theories and would 
focus on changing dysfunctional and irrational cognitions.

Cognitive Behaviour Therapy (CBT) is the most widely used psychological 
method in the treatment of depression. Cognitively-based techniques are used to 
change negative views about oneself and the world, and behaviorally-based 
techniques are used to modify environmental contingencies and change behaviour. 
Therefore, CBT interventions are designed to help adolescents identify and correct 
distorted or irrational beliefs and develop a repertoire of effective and gratifying 
behaviors. Techniques such as self-reinforcing, self-reinforcement, challenging 
automatic thoughts, cognitive restructuring, goal setting, social skills training and 
relaxation techniques are used in this approach. Recent meta-analytic reviews have 
concluded that cognitive-behavioural techniques are effective in the treatment of 
adolescent depression. CBT strategies are ideal for adaptation to school based 
programs and, with a minimum of education, school counselors can use these 
strategies in classroom, group, and individual setting. CBT is particularly appropriate 
for use in schools because its format reflects the familiar structures of school, 
including (a) the process of CBT involving exploration, study, homework, and 
learning new information and skills; (b) the pattern of each CBT session with goal 
setting, researching problems, and experimenting with new ideas; and (c) the
A collaborative style of CBT which can engage students, teachers, and parents. Moreover, the flexible application of CBT complements the developmental considerations of adolescents.

In **cognitive restructuring**, the adolescents learn to replace their self-defeating thoughts with more useful ones. This often involves thought stopping in which adolescents learn to interrupt self-defeating cognitions. The counselor collaborates with adolescents in exploring alternative more realistic interpretations. The goal is to reconstuct the adolescent’s way of thinking and establish a repertoire of effective gratifying behaviors. In group counseling with adolescents, feedback from peers is potent in confronting cognitive distortions.

**Affective education** is a process of CBT that can also enhance functioning in adolescents manifesting some problems. In affective education, adolescents learn how to identify feelings and emotions. Adolescents who feel understood can then learn that emotions are experienced along a continuum according to the intensity of the experiences (e.g., from happy to sad that it hurts). Discussion encourages them to reveal their emotions, identify situations that precipitate different feelings, and recognize behavior associated with these emotions.

**Activity scheduling** is a CBT strategy that involves planning daily pleasurable and goal-directed activities to reduce boredom, passivity, and brooding. It is suggested that adolescents with depression develop a daily schedule that includes both pleasure and mastery-related activities. It is important that adolescents not only increase the number of pleasant activities, but also reward themselves for successful activity completion.

**Relaxation training** techniques have been found to be effective adjuncts to CBT in reducing symptoms of anger, anxiety, and low self-esteem, often associated with depressive mood. Adolescents learn the relationship between stress, muscle tension, and depression; and basic relaxation skills that emphasize choosing a quiet place, sitting or lying quietly, closing their eyes, relaxing all muscles, breathing easily, and thinking positively. The counselor can offer some instruction in relaxation techniques and then encourage adolescents to practice the techniques when faced with stressful situations that cause feelings of anger, anxiety and sadness. Many schools
have targeted depression by teaching at-risk students coping strategies for stress. School administrators and teachers feel that the more successful programs are those that are taught to parents for working with adolescents in their own homes.

Problem-solving and social-skills training are appropriate for primary prevention because the goal of these techniques is enhancing coping mechanisms and interpersonal abilities. In **problem solving skills training**, adolescents are taught to confront problems using the following steps: (a) identify the problem, (b) identify the aim, (c) think of alternative solutions, (d) consider possible outcomes for each solution, (e) choose and enact the best solution, (f) evaluate the outcome, and (g) self-reinforce the positive outcome and reconsider the negative.

**Social skill training involves** instruction in behavioral strategies to enhance interpersonal skills as well as attention to cognitive processes involved in interpreting cues in the social environment. Social skills training emphasizes basic assertiveness as well as both verbal (e.g., suitable language, appropriate voice tone) and nonverbal (e.g., eye contact, facial expression) communication skills. Enhancing relationship skills may not only promote positive peer interactions but also help adolescents to resist peer pressure.

For adolescents who are already experiencing some difficulties, a typical **group counseling** session can address any number of problems experienced by teenagers. It involves, setting the agenda, reviewing, working with the day’s problems and / or introducing new ideas and setting homework.

To effectively target adolescent depression, schools need to **target self-esteem**. The approach to improving self-esteem should be different from the traditional view of individualized pep talk. Self-esteem can only be improved taking into account the environment and in terms of interpersonal skills and social acceptance. Those adolescents with particularly low self-esteem need to have the opportunity for belonging. A collective self-esteem through group and team membership can be especially helpful for persons whose family environment lacks the acceptance and support necessary for healthy self development. There are some ways parents can improve self-esteem in their adolescent include improving communication, limit setting and setting expectations, and nurturing a sense of
responsibility. To improve responsibility, parents should determine all the tasks a child is capable of doing and then insist on them doing them.

More than any other intervention approach, psychodynamic therapy attends to developmental issues that are particularly salient during adolescence. This approach assists the adolescent with working on unresolved conflicts. Transference issues, interpretation, and insight are key techniques used. Despite the usefulness of this therapy, there is little evidence to support its effectiveness. Furthermore, it has been argued that more intensive sessions, such as 4 to 5 per week rather than 2, may be more practical in successfully treating depressed youth.

Since most teenagers spend a majority of their day in schools, it is not unreasonable to assume that school counselors may need to play a role in addressing adolescent depression. Though school counselors are not expected to diagnose mental health disorders, but with knowledge of depressive symptomatology, including the developmental variables and cognitive patterns characteristic of adolescent depression and comorbid (co-occurring conditions) could help them identify students in need of referral to and treatment by appropriate mental health care providers. Making effective referrals for evaluation and treatment may include, expressing concern about students’ welfare as a consequence of the symptomatology manifested, framing the referral in terms that are congruent with students’ ethical, racial, cultural, and psychological status, explaining the nature of the services offered to these students and understanding, exploring, and responding to elements of ambivalence.

Beyond identification, school counselors can develop school-based prevention programs. At the primary prevention level, these programs address the needs of the entire population of adolescents in schools as they cope with developmental growth and change. Secondary prevention focuses on adolescents already exhibiting some signs of problems as well as those exposed to known risk factors (e.g., a parent with a depressive disorder). School counselors can conduct small group counseling with these at-risk adolescents, focusing the group sessions on the specific problem (e.g., low self-esteem, social isolation) or particular risk factor. These efforts also target prevention of suicide, since depression is an important risk factor for attempted suicide in youth. Tertiary prevention activities are designed to promote optimal
functioning in students who have already developed some depressive symptoms and include initial assessment and referral. The school counselor can conduct assessments by interviewing students individually, consulting with teachers who have considerable day-to-day contact with students, and/or soliciting parent input. There are a variety of self-report instruments designed to assess for depression that are appropriate for use with adolescents and can be easily administered by a school counselor. School counselors can also provide follow-up and ongoing monitoring for students who have received inpatient treatment for depression to prevent a reoccurrence. This could involve short individual sessions to help the student reintegrate into the school setting and cope with day-to-day problems.

At all levels of prevention, collaboration with teachers, parents and community mental health care providers is critical. Teachers may refer students experiencing problems to school counselors and conversely, the counselor may provide the teachers with information to enhance their abilities to make referrals. Collaborative efforts with parents may increase the chances for positive outcomes for students at risk for the development of depression or those already manifesting depressive symptoms. Parents influence a child’s cognitive development through modeling ways of thinking and behaving. The school counselor can help parents learn how to deal with the adolescent’s behavior more positively and to become actively involved in reinforcing prevention strategies or maximizing the use of community resources for evaluation and/or treatment. Additionally, establishing mutually supportive and collaborative relationships with other community agencies providing youth services (e.g., churches, community centres) may provide a safety net for vulnerable youth.

LIMITATIONS

Despite the contributions offered by the present study, some limitations are worth noting as they provide directions for future research.

1. A limitation of the design was the reliance upon participant’s self-reports which could be subject to certain biases. Although children generally have the best information regarding internalizing symptoms such as those that characterize the syndrome of depression. Cognitive and vegetative symptoms
are sometimes difficult for others to observe and may go undetected by parents and significant others. It is important for future studies it would be useful to obtain multimethod assessments such as interviews, expert judgments, or experiments and other sources of information such as parents, teachers, peer group.

2. By using a high school student sample, we may simply be examining an analog of clinical depression (hence the lack of enduring mood response). Longitudinal studies using high-risk samples and with more aversive negative events need to be conducted to rule out this possibility.

3. Further, the study had a cross-sectional design. Therefore, no conclusions can be drawn regarding the causality or temporal order of the variables. In order to solve these cause and effect issues, longitudinal research is needed.

4. Another point of concern is the study sample was limited to the age range of 15-17 years (stage of mid-adolescence). In order to generalize these findings, future research can aim to evaluate and include the early and late adolescence in the sample for the purpose of examining the developmental differences.

5. Another drawback is regarding the sample selection limited to community and non-clinical sample i.e., senior high school students who served as participants and so the results may not be generalizable to other samples. Future studies should seek to replicate the current findings in other clinical samples (e.g., psychiatric inpatients or outpatients) in addition to the community sample.

6. The present study incorporates a subjective and global measure of stress and so does not take into consideration an objective measure of stress in relation to specific life events and the related subjective experience of these adolescents.

**SUGGESTIONS**

With the best of efforts and most perfectionistic attitude, no investigator can claim to have carried out a study totally free from limitations. Particularly this being an exploratory study, the investigator could not visualize some of the problems and limitations. Following suggestions are submitted for further research and improvement in this area:
1. The use of additional assessment instruments (e.g., structured clinical interviews) also would be helpful for understanding symptoms of depressive disorders and its correlates among a non-clinical sample of adolescents. The use of interview based approaches that are relatively objective, but are still sensitive to evaluating the social support network and severity of life stress seems advisable.

2. Longitudinal data examining possible changes in relationships between depression and its correlates such as negative cognition, stress, social support and gender from early to middle and late adolescence would be a valuable contribution in terms of examining developmental differences in this area and would further elucidate the causal pathways.

3. Future investigations may benefit by continuing to assess depressive symptoms at repeated time points at specific intervals following the occurrence of negative events.

4. The use of multiple data collection strategies to explore stress could uniquely contribute to our understanding of how this group of teens perceives and copes with stress. For example, data from parents may help confirm or disconfirm adolescents' attestations and if such correlations are found to be high, then adolescents' attestations are proved accurate and not simply a function of differential willingness or ability to acknowledge feelings.

5. Multimethod programs of research using self-reports, experimental and observational methods to explore the viability of existing and newly proposed findings for gender differences in depression among mid-adolescents should be encouraged.

6. Additionally, multi-informant methods could be used to assess the gender differences, depressive symptomatology, actual or received social support and the cognitive diathesis-stress, symptom or aetiological models that predict depressive symptoms to corroborate the self-reported information by these mid-adolescents with those rated by other sources such as parents, peer group and teachers.
7. Although findings from this study offer important directions for understanding the prevention of depressive symptoms among adolescents from a community sample, the study of similar processes in a clinically referred sample would be useful to elucidate interpersonal and cognitive factors that could be associated with more severe levels of depressive symptoms.

8. The future investigations could attempt to explicitly activate depressogenic schemata prior to their assessment by using the priming methods among a clinical population of depressed adolescents to explore the latent nature of schemata and provide a stringent validity test of both the diathesis-stress and causal mediation components of the aetiological chain of the cognitive theory and a valid assessment of cognitive vulnerability.

9. More studies are needed in a cross-cultural context, to examine the incremental contributions of negative cognitions, stressors, and their interaction and to explore the detrimental effects of social support in the prediction of depressive symptoms and disorders in clinical as well as community samples mid-adolescents.

10. Future research examining interpersonal correlates of adolescents’ depressive cognitions and perceived stress also might benefit from behavioral observations of social behaviors and the study of mechanisms that may explore the existence of contagion effects targeting specific multiple sources to which adolescents are exposed e.g., parents, peer group both within and outside the school setting, etc.

11. There seems to be consensus that integrating interpersonal and cognitive perspectives will enhance the knowledge of the development of depressive vulnerability and the processes involved in the onset of depression. Continued exploration of the associations between interpersonal development in adolescence and cognitive vulnerability to depression should be illuminating.

12. Future models of depressive vulnerability need to continue to integrate research from various fields. Theories from developmental psychopathology, cognitive and social psychology need to continue to be merged.