EFFECTIVENESS OF SCHOOL BASED COGNITIVE BEHAVIORAL DEPRESSION PREVENTION PROGRAMME ON DEPRESSION AND ANXIETY AMONG ADOLESCENTS.

A DISSERTATION SUBMITTED TO THE TAMILNADU DR.M.G.R.MEDICALUNIVERSITY, CHENNAI, IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING

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CERTIFICATE

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TABLE OF CONTENTS

Chapter No	Contents	Page No
I	**INTRODUCTION**	
	Background of the study.	1-3
	Significance and need for the study.	4-5
	Statement of the problem.	5
	Objectives.	5-6
	Hypothesis.	6-7
	Operational definitions.	7-9
	Assumptions.	10
	Delimitations.	10
	Projected outcomes.	10
	Conceptual framework.	11-14
II	**REVIEW OF LITERATURE**	
	Concepts related to adolescents	15-17
	Literature and studies related to depression anxiety	18-23
	Literature and studies related to cognitive behavior Therapy	23-29
III	**RESEARCH METHODOLOGY**	
	Research approach	30
	Research design	30-31
	Setting of the study	31
	Study population	32
	Sample	32

Chapter No	Contents	Page No
	Sample size	32-33
	Sample technique	33
	Criteria for sample selection	34-35
	Research tool and technique	35-36
	Intervention	37-38
	Testing the tool	38-39
	Pilot study	39
	Data collection procedure	39-42
	Plan for data analysis	43
	Protection of human rights	43
IV	**ANALYSIS AND INTERPRETATION OF DATA**	**44-72**
V	**DISCUSSION**	**73-79**
VI	**SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS**	**80-86**
REFERENCES		**87-91**
APPENDICES		**i-xix**

LIST OF TABLES

Table No	Title	Page No.
1	Frequency and percentage distribution of subjects in the experimental group and the control group based on their demographic data.	46-49
2	Prevalence of depression and anxiety among adolescents.	51
3	Distribution of adolescents according to their level of depression in the Experimental and the control group.	52
4	Distribution of adolescents according to their level of anxiety in the Experimental and the control group.	53
5	Comparison of mean pre- test and post- test score of depression among adolescents in the experimental and the control group.	54
6	Comparison of mean pre- test and post- test score of anxiety among adolescents in the experimental group and the control group.	56
7	Comparison of mean post- test depression score of adolescents between experimental group and the control group.	58
8	Comparison of mean post- test anxiety score of adolescents between experimental group and the control group.	60
9	Relationship between mean post -test score of depression and anxiety among Adolescents in the experimental group.	62
10	Association between mean pre- test score of depression in the experimental group and selected demographic variables.	63-67
11	Association between mean pre -test score of anxiety in experimental group and selected demographic variables.	68-72

LIST OF FIGURES

Figure No	Title	Page No.
1	Conceptual frame work based on Roy's adaptation model	14
2	Sampling frame	33
3	Comparison of mean pre-test and post -test depression score of adolescents in the experimental group.	55
4	Comparison of mean pre-test and post- test anxiety score of adolescents in the experimental group.	57
5	Comparison of mean post test depression score of adolescents in the experimental group and the control group.	59
6	Comparison of mean post test anxiety score of adolescents in the experimental group and the control group.	61

LIST OF APPENDICES

Appendix No	Title	Page No.
1	Copy of letter seeking experts opinion for tool and content validity.	i
2	Copy of letter seeking permission from the school principal to conduct The study.	ii-iii
3	List of expert	iv
4	Demographic Variables - Part I	v
5	English Tool –Part II (Kutcher adolescent depression scale)	vi
6	English Tool-Part III (Beck depression inventory scale)	vii
7	English Tool –Part IV (Beck Anxiety rating scale)	viii
8	Demographic Variables – Part I	ix
9	Tamil Tool-Part I (Kutcher adolescent depression scale)	x
10	Tamil Tool-Part II (Beck depression inventory scale)	xi
11	Tamil Tool –Part III (Beck Anxiety rating scale)	xii
12	Intervention (School Based Depression Prevention Programme for students –English)	xiii
13	Teaching session on teachers	xiv
14	Teaching session on parents	xv

15	Intervention (School Based Depression Prevention Programme for students –Tamil)	xvi
16	Teaching session on parents – Tamil	xvii
17	Worksheet	xviii
18	Training Certificates	xix

ABSTRACT

Background: Depression and anxiety are thought to be one of the most common emotional problems in adolescents. Depression is under recognized among adolescents because depressive symptoms are considered a familiar part of adolescent experience. **AIM:** A quasi-experimental study to assess the efficacy of School Based Depression Prevention Programme on depression and anxiety among adolescents in selected rural schools in Melur was carried out. **Methodology:** Non- probability sampling technique was employed to recruit adolescents in the age group of 13-17 years .Beck depression inventory and anxiety rating scales were used to assess the depression and anxiety level. School Based Depression Prevention Programme for students comprised of 10 sessions lasting for 1hour per day over 4 weeks and one session for parents and teachers was carried out. **Results:** Findings showed that in pre- test 16 (53%) adolescents were in moderate level and 14(47%)were in severe level of depression and 8 (27%) adolescents were in mild level,16 (53%) were moderate level and 6 (20%) were in severe level of anxiety whereas in the post- test none of them were in severe level of depression and anxiety .But in the control group ,depression and anxiety level remained unchanged. The mean post- test depression and anxiety score (19.1and9.0) of the experimental group was lower than the mean post - test depression and anxiety score (27 and 13.7) of the control group ($P< 0.001$) level. There was a significant positive relationship between depression and anxiety ($r =0.9$, $P < 0.001$ level). **Conclusion:** The study suggested that the school based depression prevention programme can be used effectively to treat both depressive and anxious adolescents.

CHAPTER I

INTRODUCTION

"Adolescents represent a positive force in society now and for the future"

(Health Action)

BACKGROUND OF THE STUDY

Adolescence is the period (12-18) that begins with the onset of puberty and ends at the age of 19 years. Adolesecence is a distinct and dynamic phase of development in the life of an individual. It is also an important period of transition from childhood to adulthood, which brings about physical, psychological, social, behavioral and emotional challenges. Emotional problems are generally influenced by the sudden and rapid forces that adolescents find it difficult to face problems in adjustment and interaction .Among the emotional problems, depression and anxiety are more common among adolescents (Hockenberg &Wilson 2007).

Depression is a common mental health disorder that presents with depressed mood, loss of interest (or) pleasure, decreased energy, feelings of guilt (or)low self- esteem, disturbed sleep (or) appetite and poor concentration. Moreover depression often comes with symptoms of anxiety (WHO, 2008).

WHO fact sheet, August 2010 reports that in any given year about 20% of adolescents will experience a mental health problem, most commonly depression and anxiety. Suicide also is one of the leading causes of death due to depression in young people. Depression is a risk factor for suicidal thinking among adolescents. So teen depression is a challenge for parents, teachers and communities. Adolescents should be provided with psychosocial support to promote their mental health and to protect them from high risk behaviors.

Depression has a significant contribution to the global burden of disease and it affects people in all communities across the world. Today depression is estimated to be affecting 350 million people. The World Mental Health Survey conducted in 17 countries found that on an average about 1 in 20 people reported having an episode of depression in the previous year. Depressive disorders often start at young age and they reduce people functioning and for these reasons depression is the leading cause of disability worldwide in terms of total years lost due to disability**.** The world mental health day theme for October 2012, was Depression a global crisis. One out of 10 people suffer from major depression and almost one out of five persons has suffered from the disorders during his or her life time (Kisser et al 2008). By 2020 depression will be the leading cause of world disability and by 2030 i.e is expected to be the largest contributor to disease burden (WHO,2008).The prevalence of teen depression is higher in girls than boys. The common symptoms were feelings of worthlessness, sadness and somatic disorder(Beck et al 2007).In addition teens who were depressed often develop anxiety disorders and dependency on alcohol, unemployment and early parenthood also can have `a higher expectancy rate in teen depression (Fergusson 2007).

The main risk factor for adolescent depression and anxiety are

- Frequent non- specific physical complaint
- Lack of interest in friends
- Outburst of crying and moody behavior
- Decreased interaction and communication
- Alcohol or drug use
- Sensitivity to rejection or failure
- Absence from school

- Poor school performance
- Frequent non- specific physical complaint.
- Irritability, angry or hostile demeanor
- Decreased interaction and communication
- Lack of interest in usual hobbies like sports and recreational activities

Relationship problems, hoplessnes, family conflict, low bending to family and friends and extreme economic deprivation (Stuart, 2007).

The prevention of depression is an area that deserves attention. Many depression prevention programs are implemented to reduce depressive symptoms. The treatment options consist of basic psychosocial support combined with antidepressant medication (or) psychotherapy such as cognitive behavioral therapy(CBT), interpersonal therapy and problem solving approaches. Among these cognitive behavior therapy is very effective to reduce the depressive symptoms of adolescents and this will strengthen the protective factors among adolescents in schools and communities. Research has shown that CBT can be effective in the treatment of depression and anxiety in children and adolescents (Stellar and Richardson 2011).

Parents, family members and school all play an important role to prevent teen depression. Numerous studies have demonstrated that the way adolescents connect to their social world influences their health and development and protects them from high risk behavior. Consistent positive emotional connections with a caring adult can help young people feel safe and secure and giving them the resilience to manage the challenges in their lives (Townsent, 2007).

NEED FOR THE STUDY

The life time prevalence of depression, anxiety and stress among adolescents around the world is currently estimated to range from 5% to 70%. An Indian study reported that depression among adolescence was very high with about 87% having depression also suffering from anxiety disorder. Detecting depressive anxiety and stress related symptoms in the school is a critical preventive strategy which can help in preventing disruption to the learning process (Khees 2010).Epidemiological studies have investigated depression and their association with suicidality.Taking account of the methodological limitation of the study, the current evidence provides clear relationship between depression and risk of suicidality in adolescents. There appears to be a bit of increased risk of suicidal ideation and attempts (Nischal & Tripathi). A school based study was conducted in Delhi, India, 242 adolescents students belonging to 9th-12th std were selected for the study, DASS-21 questionnaire was used for assessing their depression and anxiety. It was seen that depression was significantly higher among board classes i.e.10th and 12th as compared to 9th and 11th . All were found to have on inverse relationship with the academic performance of the students. Depression and stress were found to be significantly associated with the number of adverse events in the student's life that occur. So the study suggests that some protective steps should be taken at the school and community level. Improved parent adolescent communication is needed for amelioration of the problem (Bhasin & Sharma).

According to WHO 2012, depression is a wide spread illness that affects individual, their families and their peer. It is a treatable condition and so depression prevention programme is essential to reduce depressive and anxiety symptoms among adolescents.

In depression prevention, cognitive behavior therapy(CBT) is very effective to reduce depressive and anxiety symptoms among adolescents in school settings.

Neil and Ham (2009) conducted a study on school Based cognitive behavior therapy for depression and anxiety among adolescents in Australia.7207 adolescents were randomly enrolled. adolescence in the school based –sample completed significantly more (mean=9.38, SD=6.84) ten adolescents in the anxiety (mean=3.10,SD =3.85).A multiple linear regression revealed that school based setting(p<.001) and female gender (p<.001)were predictive of greater adherence , as were living in a rural area and lower pre-test Anxiety (p=.33)and lower pre- test Depression scores (p=.01). So study suggested that the CBT Intervention programme is very effective for reducing depression and anxiety among school students in adolescent period and understanding these differences may improve the program's effectiveness and efficiency. So based on the review of literature and the researcher's experience, it was felt that identifying the adolescents with depression, assessing the effectiveness of programme is needed to prevent them from suicide. There are no such school based programmes existing in the selected study settings.

PROBLEM STATEMENT

A study to assess the effectiveness of school based cognitive behavioral depression prevention programme on depression and anxiety symptoms among adolescents in selected rural schools at Melur.

OBJECTIVES:

- To assess the pre-test and post- test level of depression among adolescents in the experimental group and the control group.

- To assess the pre and post-test level of anxiety among adolescents in the experimental group and the control group.
- To evaluate the effectiveness of school based cognitive behavioral depression prevention programme on depression among adolescents.
- To evaluate the effectiveness of school based cognitive behavioral depression prevention programme on anxiety among adolescents.
- To find out the relationship between depression and anxiety among adolescents in the experimental group.
- To find out the association between selected demographic variables (such as age, sex, education, academic performance, difficulty in school, family disharmony, conflict among parents) and their depression level among adolescents in the experimental group.
- To find out the association between selected demographic variable(such as age, sex, education, academic performance, difficulty in school family disharmony, conflict among parents, depressive symptoms) and their anxiety level among adolescents in the experimental group.

HYPOTHESIS:

H_1 : The mean post- test depression score will be significantly lesser than their mean pre- test score among adolescents in the experimental group who received cognitive behavioral depression prevention programme.

H_2: The mean post test anxiety score will be significantly lesser than their mean pre- test score among adolescents in the experimental group who received cognitive behavioral depression prevention programme.

H_3: The mean post- test depression score of the experimental group who received school based cognitive behavioral depression prevention programme will be significantly lesser than the mean post test depression score of control group.

H_4: The mean post- test anxiety score of the experimental group who received school based cognitive behavioral depression prevention programme will be significantly lesser then the mean post- test anxiety score of the control group.

H_5: There will be a significant relationship between post test score of depression and anxiety among adolescents in experimental group.

H_6: There will be a significant association between the pre- test level of depression among adolescents in the experimental group and their demographic variables such as age, sex, education, academic performance, difficulty in school, family disharmony and conflict among parent.

H_7: There will be a significant association between the pre- test anxiety level of adolescents in the experimental group and their demographic variables such as age, sex, education, type of family, academic performance, family disharmony and conflict among parents and depressive symptoms.

OPERATIONAL DEFINITION

1. EFFECTIVENESS:

Effectiveness means producing desired (or) intended results.

In this study effectiveness is measured through the reduction in the post- test depression and anxiety symptoms score as elicited through Beck depression inventory and Beck anxiety rating scale.

2. DEPRESSION:

Depression is a condition of mental disturbance typically with lack in energy and difficulty in concentration (or) interest in life (Stuart,2007).

In this study it refers to the depressive symptoms experienced by the adolescents like absence from school, poor school performance, moody behavior, decreased interaction and communication, lack of interest in friends, lack of interest in usual hobbies like sports, recreational activities, sensitivity to failure as elicited through Beck depression adolescent inventory scale.

3. ANXIETY:

Anxiety is characterized by a diffuse unpleasant vague sense of apprehension often accompanied by somatic symptoms such as headache, palpitations, fitness in the chest and mild stomach discomfort (Stuart,2007).

In this study it refers to adolescent anxiety symptoms like fear of losing control, feelings of choking, indigestion (or) discomfort in abdomen, nervousness, numbness (or) fringing, unable to relax as elicited through Beck anxiety rating scale.

4. SCHOOL BASED COGNITIVE BEHAVIOURAL DEPRESSION PREVENTION PROGRAMME:

It is an intervention to reduce depression among adolescents. The interventions for students were adopted from "cognitive behavior therapy for coping with Depression course" by Peter M.Lewinshon David and Antonuccio O, which consists of 10 sessions for students and one session for parents and teachers.

- **For Students:** The session included cognitive behavior therapy to change the behavioral pattern of the students.

- **For Teachers:** Discussion session on how to identify and screen adolescents with depression and anxiety and deal with adolescent depression and anxiety
- **For parents:** Discussion session on how to improve parent adolescent communication at home.

5. COGNITIVE BEHAVIORAL THERAPY:

It is a group of psychological treatments which share the aim of bringing about improvement in depression by altering maladaptive thinking and behavior.

In this study the cognitive behavioral approach consists of ten sessions which includes discussion, group work ,take home assignments and individual interactions with the adolescents on the following topics.

- Depression and social learning
- How to design self change plan
- Learning to relax
- Relaxation in everyday situations
- Pleasant activities and depression
- Formulating a pleasant activities plan
- Approaches to constructive thinking
- Formulating a plan for constructive thinking
- Developing a life plan and
- Maintaining gain

6. ADOLESCENTS:

Refer to children of both sex between the age of 13-17 years and enrolled in the selected schools.

ASSUMPTIONS:

- Depression and anxiety will differ from individual to individual.
- Incidence of depression and anxiety are high in adolescents and it leads to suicidal ideation
- Parents and teachers have a critical role in helping adolescents cope up with depression.

DELIMITATION:

- The study was delimited to the age group of 13-17 years.
- The data collection period was limited to 6 weeks.
- Cognitive behavioral depression programme was limited to only 10 sessions with and selected techniques only.

PROJECTED OUTCOME:

- The findings of the study may help to identify the effectiveness of depression prevention programme on the depression and anxiety among adolescents
- The findings on the demographic characteristics may help to identify the factors which influence the depression and anxiety among adolescents .

CONCEPTUAL FRAMEWORK

The conceptual framework in this study is based on the "SISTER CALLISTA ROY'S ADAPTATION MODEL'' (1939) which involves four concepts: Person, Nursing, Health and environment. The adoptive system has four components like input, process, effectors, and output.

Person:

Roy states that the recipient of nursing care may be the individual , a family , a group, a community or society .Each is considered as adaptive system. In this study the focus will be on the individual (adolescent school going student who is having depression and anxiety as in inclusion criteria).

Nursing :

Nursing is a practice -centered discipline geared toward and their responses to stimuli and adaptation to the environment. It includes assessment, diagnosis, goal setting, intervention and evaluation.

In this study the role of nurse is to assess the status of adolescents and help them to adapt to the environment.

Health:

Health is defined by Roy as a process of being and becoming an integrated and whole person :Health is viewed as the goal of the person's behavior and the person's ability to be an adaptive organism.

Environment:

It is defined by Roy as all conditions, circumstances, and influences surrounding and affecting the development and behavior of persons and groups.

In this study it includes background factors like personal charecteristics, family background, school environment, relationship with friends and recreational activities.

Regulator and Cognator Subsystem:

The constant interaction of person with their environment is characterized by both internal and external changes , with this world. Person must maintain their own integrity, Both the subsystem (Cognater and regulator subsystem) consist of input, process, and output .

Regulator subsystem: Control internal process related to physiologic needs .

Cognator subsystem: Control internal process related to higher brain function such as perception, information, processing, learning from past experience judgement and emotions .

In this study, the cognator subsystem refers the psychological state such as depression and anxiety.

Input:

Roy says input as a stimuli which is coming from the environment or from within a person. In this study the factors leading to depression and anxiety will be considered as input.

Process:

According to the theory process refers to the adaptive changes taking place internally (Cognator subsystem) .

In this study, the process refers to the School Based Depression Prevention Programme administered to the students. This programme is based on cognitive

therapy which includes 10 sessions like concepts related to Depression and Social learning, Relaxation in Everyday situations, Approaches to constructive thinking etc and includes one teaching session for parents and teachers.

Out put:

Output is the outcome of the system , the system is a person . Output refers to the person's behavior .Output is categorized as adaptive response or ineffective response.

Adaptive response: This refers to the positive changes after the school based depression prevention programme i.e the changes in the level of depression. In this study it is the change in their level of depression and anxiety.

Ineffective response: This response does not promote goal achivement. In this study ineffective response denotes negative results i.e no changes in the level of depression and anxiety for control group. In this case negative result becomes the feedback where it must be reassessed to make modification in the treatment approach.

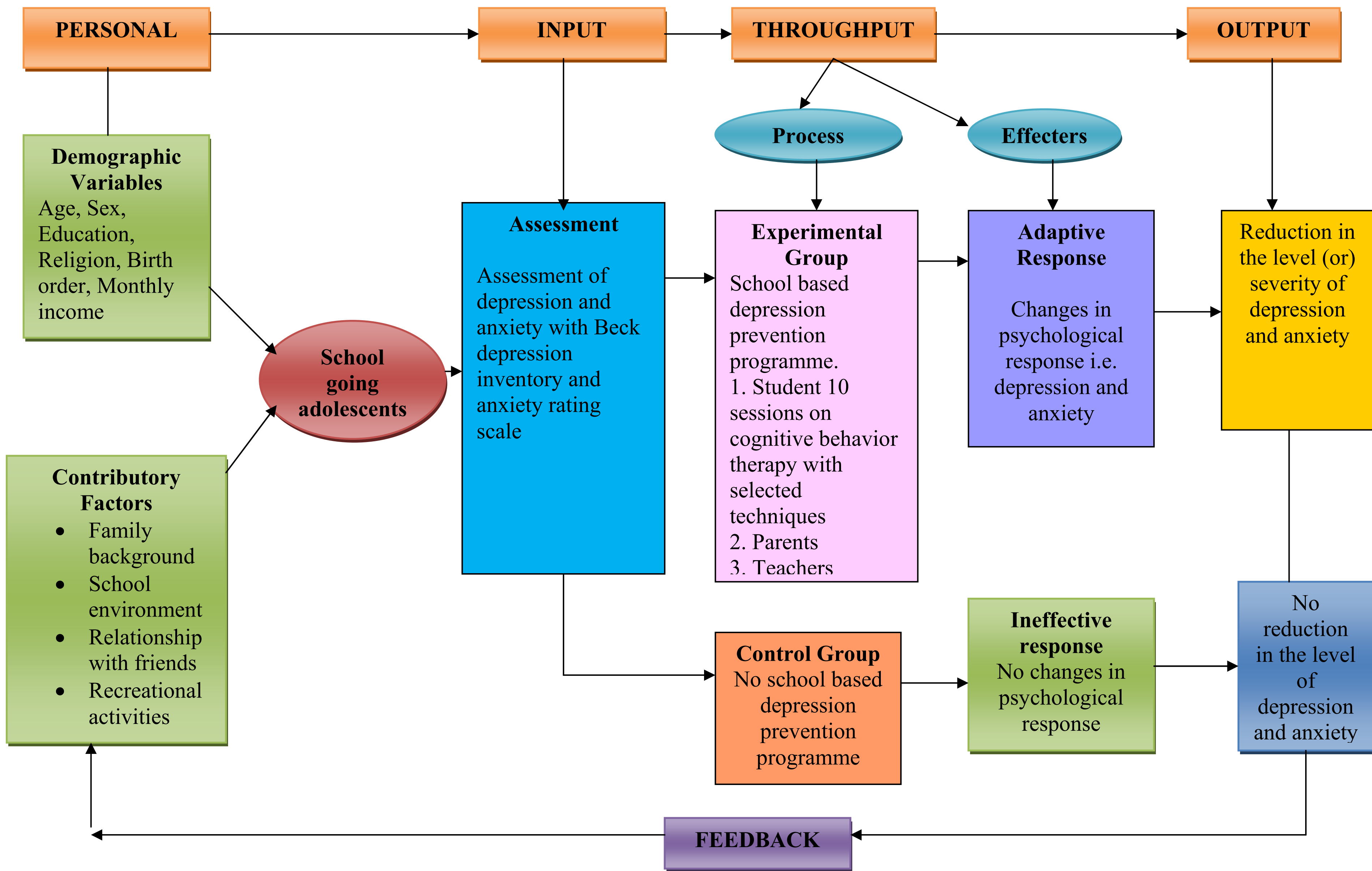


FIGURE:2 CONCEPTUAL FRAMEWORK BASED ON CALLISTA ROY'S ADAPTATION MODEL

CHAPTER II

REVIEW OF LITERATURE

The primary purpose of reviewing literature is to give a broad background of knowledge and understanding of information that is available related to the research problem of interest. (Burns, 1997).

The review of literature was done from published articles, textbooks, reports and Medline search. Literature review is organized and presented under the following headings.

1. Concepts related to adolescents
2. Literature and Studies related to depression and anxiety
3. Literature and studies related to Cognitive behavior therapy.

SECTION - I: Concepts related to Adolescents

India has the largest population of adolescents in the world being home to 243 million individuals aged 10-19 years. The country's adolescents constituted 20 per cent of the world's 1.2 billion adolescents, stating nine out of ten among the 1.2 billion adolescents live in the developing world. In this `youthful, human resource' lies the promise and potential of becoming a healthy, strong and egalitarian society. This, however, comes with the onerous responsibility on the part of the state and civil society actors, including parents and guardians, to nurture and harness the energy and potential of these adolescents" (WHO 2011)

a) Phases of adolescence (Towensent 2007)

Early adolescence (13-15years)

Middle adolescence(15-17years)

Late adolescence (17-19years).

Adolescence is an unique stage of development that occurs between the ages 11 and 20years,when a shift in growth and learning occurs. The developmental tasks that emerge during adolescence threaten the person's defences.They can either stimulate new adoptive ways of coping or lead to regression and mal adoptive coping responses. (WHO, 2011)

b) Tasks that should be accomplished during adolescence are as follows (Havighurst, 2007)

- Achieving new and more mature relations with age of both sexes.
- Achieving masculine or feminine social roles.
- Accepting physical build and using the body effectively.
- Achieving emotional independence from parents and other adults.
- Acquiring a set of values and an ethical system as a guide to behavior and developing ideology.

c) Theoretical views of adolescents

1. Biological theory:

Emphasis is only on physical growth, behavior and the environment, which influence feelings, thoughts, and actions.

2. Psycho analytical theory.

According to Sigmund Freud, puberty is called the genital stage, in which sexual interest is weakened. Biological changes upset the balance between the ego and id, and new solutions must be negotiated.

3. Psychosocial theory

According to Erick Erickson, adolescents attempt to establish an identity within the social environment. They seek to coordinate self- security, intimacy and sexual satisfaction in their relationships.

4. Attachment theory

According to Rosenstein &Horowitz, adolescents focus on the quality of attachments of defining one's vulnerability to developmental changes and sees in secure attachments as a risk factor that can result in maladaptive responses to loss or trauma.

5. Cultural Theory

Anthropologists, view adolescence as a time when a person believes that adult privileges are deserved but be held. This stage ends when society gives full power and status of an adult.

6. Multidimensional theory.

According to Meeks (1990), adolescence is seen as adaptation on a continuum of development. There is less emphasis on age and more on the developmental level and timing of biological, psychological and environmental influences.

d) Issues in adolescent development

The issues of body image, identity, independence, social role and sexual behavior can produce adaptive or maladaptive responses as the adolescents attempt to cope with the developmental tasks. In process of this, many adolescents develop low self- esteem.

SECTION - II

A. Concepts related to teen depression and anxiety

1. Definition.

Depression is a condition of mental disturbances typically with lack in energy and difficulty in concentration (or) interest in life. (Stuart, 2005).

2. Causes and risk factors (Birdwell, 2009).

- Abuse and teen depression
- Being bullied at school
- Conflict at home
- Insomnia and fatigue
- Isolation
- Low self -esteem
- Nutrient deficiencies
- Presence of underlying disorders
- Substance abuse

3. Symptoms of adolescent depression and anxiety (Mayo, 2010)

- Frequent non- specific physical complaints
- Absence from school
- Poor school performance
- Lethargy
- Outburst of crying or moody behavior
- Lack of interest in friends
- Decreased interaction and communication
- Lack of interest in usual hobbies like sports or recreational activities

- Sensitivity to rejection or failure
- Relationship problems
- Changes in appetite and sleeping patterns
- Low self- esteem and worthlessness

d) Diagnosing teen depression (Mayo, 2010)

- **Physical examination**

A physical examination can help to determine whether the adolescents have depression (or) another medical condition causing symptoms.

- **Neurological examination**

Neurological exam is a series of questions and tests that provides information about the health of our brain and nervous system.

- **Psychiatric examination**

This is done to test some of our mental functions such as attention span and memory. Both of these are negatively affected by teen depression.

5. Managing teen depression Anxiety

Depression is a severe mental disorder that requires medical attention .Teen depression often gets worse if it's left untreated. Effective ways managing teen depression are outlined below.

a. Managing physical health.

Some of the effective depression management strategies are

- Avoiding alcohol and drugs
- Eating a healthy balanced diet
- Exercising
- Plenty of sleep

b. Managing mental and emotional health: Managing depression will be making some life style challenges that are.

- De – stress
- Express the feelings
- Maintain supportive friendship
- Relax
- Set manageable goals

6. Prevention of teen depression and anxiety

Parent and teacher play a vital role in prevention of teen depression. Some practical ways are outlined below.

- Encourage healthy eating habits
- Encourage your child to participate in sports
- Encourage teenager to be active
- Make sure your children know how much you them care about at home
- Praise your teen's strength and be sensitive when addressing weakness.
- Talk with your teen and listen carefully
- Try to enforce on early to bet
- Involving counseling sessions with a psychotherapist (or)school counselor.(Mayo, 2010).

II .B. Studies related to depression and anxiety among teens

Mohanraj and Subbaiah (2010) conducted a study on prevalence of depressive symptoms among adolescents in South India (Chennai). The study was a school based cross sectional survey in which data were collected through self- administered questionnaire from adolescents studying in classes X , XI and XII . Beck depression inventory was administered to nine hundred and sixty four adolescent boys (n=507) and girls(n=455)studying in 2 schools spread across the city. Based on the cut off score 378 adolescents (39.2%) were found to be non- depressed 338(37%) were mildly depressed, 187(19.4%) were moderately depressed and 41(4.3%) were severely depressed .There were no significant gender differences but a higher rate proportion of girls(27%)reported moderate to severe depression than boys.

Bhasin and Sharma (2010) in their study to find out the depression and anxiety symptoms among adolescents in Delhi.242 adolescent students belonging to 9th to 12th were selected for the study. DAS -21 questionnaire was used for assessing depression, anxiety and stress. Depression (p=0.025), Anxiety (p=0.005) and stress ($p<0.001$) which were all significantly higher among the board classes i.e,10th and 12th as compared to the classes 9th and 11th. All the three (DAS) were found to have an inverse relationship with the academic performance of the student.

A study was conducted by Axelson and Birmaher (2001) to find out the relationship between anxiety disorder and depression among adolescents in Bangladesh. A total of 4757 subjects aged 13 to 18 years both males and females were enrolled randomly in a cross sectional study. Anxiety and Depressive disorders are frequently co-morbid in children and adolescents; about 25-50% depressed youth have co- morbid anxiety disorders and about 10-15% anxious youth have depression.

Sahoo & Khess (2010) conducted a study to determine prevalence of current depressive and anxiety symptoms among young adolescents in Ranchi city of India. The subjects belonged to the age group of 12 to 18 years. Depressive symptoms were present in 18.5% and Anxiety in 24.4%. Depression was present in 12.2% and generalized anxiety disorder in 19.0% was high with about 87% of these having depression also suffering from anxiety disorder.

Pao et al (2011) conducted a study on Anxiety among adolescents in Bethesda, USA. The prevalence rate of anxiety disorders among youth with chronic medical illnesses was high compared to their healthy counterparts. So the study suggested that Anxiety disorders can have serious consequences in adolescents. Therefore proper identification and treatment was necessary and may improve not only psychiatric symptoms but also physical symptoms.

Muzammil et al (2009) in their cross sectional study, estimated the prevalence of depression among adolescents in Uttarakhant at Doiwala block among 842 adolescents selected by multistage random sampling ,the overall prevalence of depression among the adolescents was found to be 31.2%.The depression were more in males (34.77%) as compared to females(27.6%) . So the study suggested that there is need of strengthening the existing package of services for adolescents in various initiatives and programs.'

A study was conducted by Kearny et al (2009) in Australian National University, Canberra, Australia, to evaluate the benefits of self –directed Internet intervention for depression (mood GYM) delivered as a part of the high school curriculum. One hundred and fifty seven girls aged 15 and 16 years, were allocated to under take either mood GYM or their usual curriculum.MoodGYM 's impact on

depressive symptoms, risk of depression, attributional style, depression literacy and attitude towards depression was examined using random effect regressions.

Mood GYM reduces a significantly faster rate of decline in depressive symptoms over the trial period than the condition. Girls with high depression scores before intervention showed strongest benefits on self- reported depression at follow up .The findings suggest that there are benefits from Mood GYM on self- reported depressive symptoms.

SECTION - III

A . Literature related to Cognitive behavior therpy

1. Definition

Cognitive behavior therapy is a set of wide ranging procedures that differ in how they are applied to individuals with various emotional, physical, and psychological difficulties. (Lalitha, 2007).

2. Purpose

To help clients change maladaptive thoughts and behaviors by substituting more adoptive ones.

3. Aspects of cognitive –Behavior Therapy: (Town cent, 2007)

- Cognitive restructuring –Changing negative thoughts by means of behavioral procedures based on the idea that thoughts influence feeling.
- Creating situations in which clients alter their thinking about environmental stimuli previously affected their thinking, ongoing behaviors thought and changes in self –efficiency coping skills.
- Working with clients to directly confront their “inappropriate views” thereby changing the problematic behavior.
- Changing distorted thoughts that participate depression.

4. Therapeutic indication for cognitive behavior therapy

- Anxiety disorders
- Depressive disorders
- Substance related disorders
- Eating disorders
- Personality disorders
- Panic disorders
- Childhood conduct disorders
- Attention- deficit hyper -active disorders
- Excessive fears and phobias obsessive compulsive disorders

5. Pre requisite to choose specific technique (Lalitha, 2007)

- Analysis of the problem
- The resources available to the individual
- The context of the problem behavior

6. Steps to Analyze the Client's Problematic Behavior (Stuart, 2005)

State the behavior problem: Describes the problem in terms of **Observable** quantifiable behaviors with specified limits and contents.

Perform a functional analysis of problem: Related behavior: Analyze the problem behavior in terms of its antecedents and consequences. It includes a detailed description of what occurs immediately before and after the problematic behavior. Complex problems are broken into smaller behaviors that are easier to change and thus promoting progress.

Designate the target behavior.

Formulate behavioral objectives: Develop clear, precise and written behavioral goals. The client and family are active in the process. Client signing in the contract

,and consenting for techniques such as assertiveness skills, learning anxiety reduction skills and using these skills to change problem behavior.

5. Develop an intervention strategy.

6. Implement the intervention strategies : Put the actual strategies into effect.

7. Evaluate the intervention strategy.

SECTION - III

B. Studies related to cognitive behavior therapy for depression and anxiety among adolescents.

Colognori et al (2011) in their study tested the feasibility and potential effectiveness of a cognitive –behavioral intervention in NYU Child study centre ,New York .The adolescents (aged 8-16 yrs) experiencing depression and anxiety were recruited .20 participants aged 11 to 16 with depression and anxiety were randomized to receive CBT.A total of twenty participants completed the pre and post assessments. 17 provided feedback on the intervention .Paired samples t-test demonstrated significant improvements in depression and anxiety .So the study conclude that the CBT provides encouraging preliminary results for the effctiveness and acceceptability with this age group.

A study was conducted in Australia by Keamy and Kang (2009) Canberra, Australia to assess the efficacy of cognitive behavioral therapy for depression and anxiety in adolescents. 157 girls, aged 13 to 16 were randomly enrolled to assess the depressive symptoms. After four months they assessed the effectiveness and found a significant improvement in depression level. They concluded that CBT is more efficacious for treating depressive disorders in youth.

Neil and Batter ham (July 2009) conducted a study on school Based cognitive behavior therapy for depression and anxiety among adolescents in Australia. The first

adolescent sample consisted of 1000 school students who completed the moodGYM program in a class room setting over five weeks as part of randomized control trail. The second sample consisted of 7207 adolescents who accessed the moodGYM program spontaneously and directly through the open access .All users completed a brief survey before the start of the program that measured background characteristics, depression history, symptoms of depression and anxiety, and dysfunctional thinking. Adolescence in the school based cognitive –sample completed significantly more exercises (mean=9.38,SD=6.84) than adolescents in the open access community sample (mean =3.10, SD =3.85; t (1088.62) = -28.39, p<.001). A multiple linear regression revealed that school based setting (p<.001) and female gender (p<.001) were predictive of greater adherence , as were living in a rural area (p<.001) and lower pre-test Anxiety (p=.04) scores for the school –based sample and higher pre-test depression scores (p<.01) for the community sample. A history of depression (P=.33) and pre –test warpy thoughts scores (P=.35) were not predictive of adherence in the school-based or community sample.) So study suggested that the CBT Intervention programme is very effective for reducing depression and anxiety among school students in adolescent period and understanding these differences may improve programme effectiveness and efficiency.

Young et al (2009) in their study assessed the efficacy of cognitive behavioral therapy intervention with 90 adolescents and adults who had recently engaged in self harm for anxious adolescents in Canada. Subjects of participants (aged 12 -35 years) were randomly assigned to treatment as usual plus the intervention. Assessment were complete 3 months. Patients who received cognitive- behavioral therapy in addition to treatment as usual were found to have significantly greater reductions in self harm, suicidal cognitions and symptoms of depression and anxiety, and significantly greater

improvements in self –esteem and problem-solving ability, compared with the control group. This study suggested that Cognitive behavioral intervention is effective to treat anxiety, depression and improvement in self- esteem among children and adolescents.

Monga and Young (2009) conducted a study to evaluate a cognitive behavioral therapy for depression and anxiety among adolescents in University of Toronto, Canada CBT has demonstrated benefits for Anxious School –aged children and adolescents. 25 participants completed an initial assessment followed by await period of approximately 2 months .A series of paired two tailed ' t' test revealed significant reduction in anxiety and depressive symptoms on standardized measures. The study suggested that CBT can be used effectively to treat anxious children and adolescents.

Christensen et al (2009) conducted a study on cognitive behavior therapy for depression in young youth in Australian National University, Canbera, Australia. One hundred and fifty seven students aged 15 and 16 years, were allocated. Symptom changes based on Goldberg anxiety and depression scores recorded upto 5 separate occasions. Approximately 20% of sessions lasted more than 16 minutes. Registrants who completed at least one assessment reported initial symptoms of depression and anxiety that exceeded those found in population based survey and those characterizing a sample of university students. For the web based population both anxiety and depression scores decreased significantly as individual progressed through CBT modules. This study suggested that the cognitive behavior therapy was very effective treatment for the prevention of depression in young people. Both anxiety and depression scores decreased significantly as individual programme and progressed through the module.

Cline Psychol (2007) conducted a study on cognitive behavior therapy in school among adolescents with depressive and anxiety symptoms .CBT was more efficacious then non-CBT treatment .The results strongly suggest that it is more efficacious to reduce anxiety and depression.

Manassis et al(2007) conducted a randomized controlled trial on cognitive behavior therapy for depression and anxiety among adolescents in Canada .In his study forty three adolescents and their parents (14 boys,29 girls ,mean age 16.7) participated. Indices based on child and parent –reported symptoms and impairment were calculated and within sample comparison by age, gender, diagnosis, and initial severity were done using't 'tests. Predictors of symptoms and impairment were also examined. On average adolescents reported moderate level of anxiety related impairment .The results showed that CBT had effectiveness on reducing both depression and anxiety disorders.

Richardson (2011) conduced a study on CBT for depression and anxiety in children and adolescents. These studies reported reduction in clinical symptoms and also improvement in variables such as behavior, self -esteem and cognitions. Satisfaction with treatment which was moderate to high from both children and parents .However preliminary evidences suggest that the CBT is an acceptable and effective intervention for adolescents and understanding these differences may improve programme effectiveness.

A study was conducted by Bjornson et al (2011) in Rhode Island, USA. In this randomized controlled trail cognitive –behavioral group therapy versus group psychotherapy for anxiety disorders among college students was compared .Participants were 45 students at the university of Colorado with a primary anxiety disorders. Each treatment condition comprised eight group sessions lasting 20 minutes

each. There were found statistically little significant differences between group CBT and group psychotherapy. Effect size of CBT (21.7%) and psychotherapy (4.3%) .So the study revealed Group that Cognitive Behavioral Therapy was very effective to reduce anxiety disorders in children.

CHAPTER III

RESEARCH METHODOLOGY

This chapter deals with the description of methodology and various steps adopted to collect and organize data for the study. Research methodology involves the approach, research design, setting of the study, sample and sampling technique, description of the tool, pilot study, data collection procedures and plan for data analysis.

RESEARCH APPROACH

The research approach used for this study consists of two phases

PHASE: I

Survey approach was used to screen the prevalence of depression and anxiety among adolescents in selected schools at Melur. Totally 575 students from 9th standard to 12th standard were screened for prevalence of depression by Kutcher Adolescents Depression (KAD) scale. Those having the possible score of depression and anxiety were included in the second phase.

PHASE: II

An experimental approach was used to determine the effectiveness of school based cognitive behavioral depression prevention programme among adolescents with depression and anxiety in selected schools at Melur.

RESEARCH DESIGN:

A quasi- experimental design with pre- test post- test non-equivalent control group was used in this study.

Group	Pre -Test	Treatment	Post- Test
Experimental group	O_1 O_2	X	O_3 O_4
Control group	O_1 O_2	-	O_3 O_4

Key:

X - School based cognitive behavioral depression prevention programme.

O_1 - Pre -test (Pre assessment of depression among adolescents in the experimental and control group).

O_2 - Pre- test (Pre assessment of anxiety among adolescents in the experimental and control group).

O_3 - Post- test (Post assessment of depression among adolescents in the experimental and control group) .

O_4 - Post -assessment of anxiety among adolescents in the experimental and control group.

VARIABLES:

Dependent Variables - Depression and anxiety

Independent Variable - School based cognitive behavioral depression prevention programme.

SETTING OF THE STUDY:

The study was conducted in two settings namely Government Higher Secondary School at Eriyur and Government Higher Secondary School at Melur.Both the schools are 35kms away from Sacred Heart Nursing College Madurai. The total strength of the school at Eriyur was 1000 and more then 35 teachers are working there and the strength of the school at Melur was 228 and more than 20 teachers are working. Both the schools are situated in the rural area and has got good

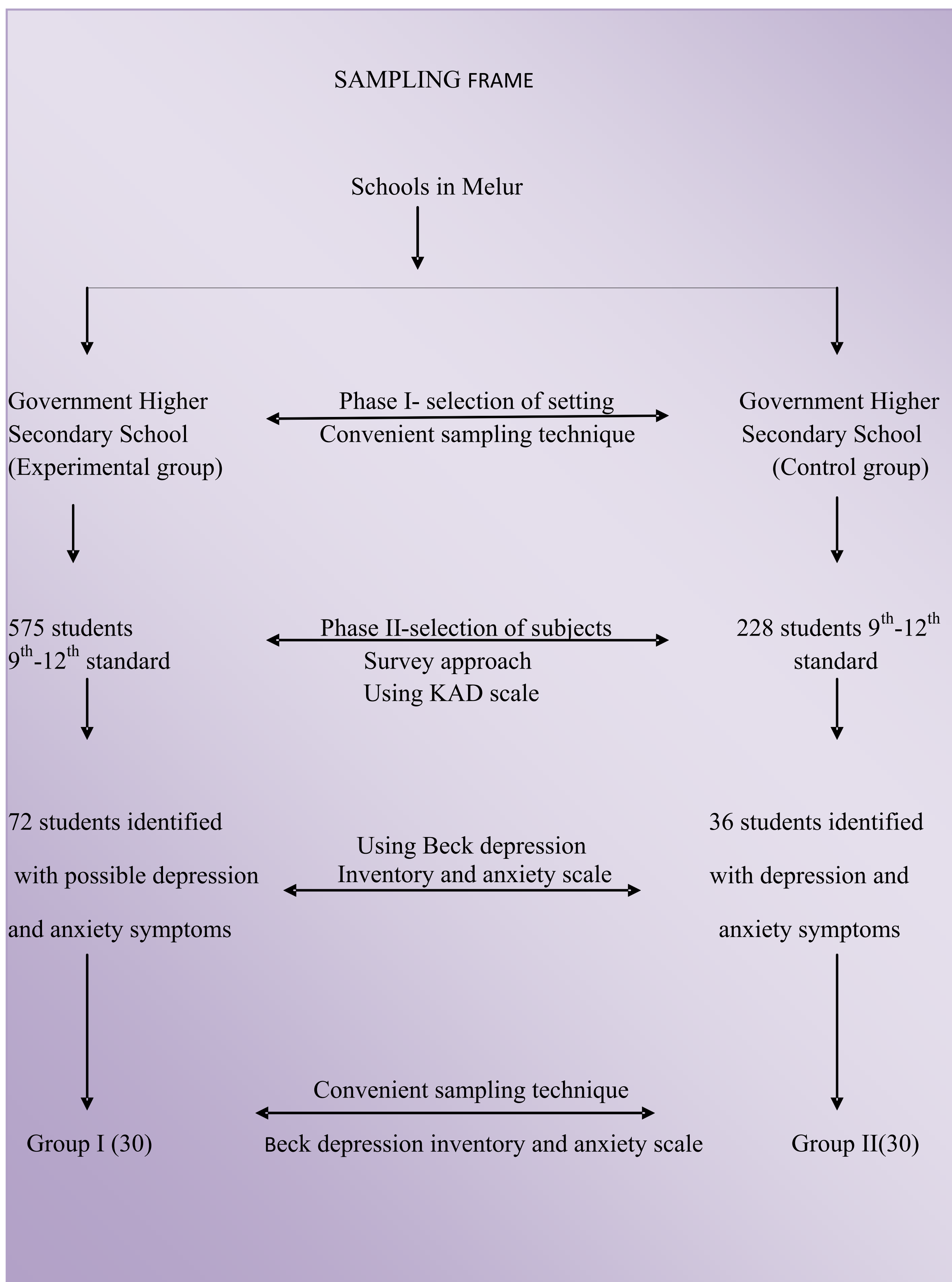
infrastructure, transport and all other facilities. The school provides to education from VI-XII standard. Hostel facilities are available for boys in setting I(experimental setting). The setting was chosen because of the researchers accessibility to the setting and feasibility of conducting the study. Both the schools are away from each other.

STUDY POPULATION:

The target population was school going adolescents in rural schools at Melur. The accessible population was all students from selected Govt Higher Secondary School, teachers and parents.

SAMPLE:

Adolescents (13-17 years) with depression and anxiety symptoms who fulfill the inclusion criteria.


SAMPLING FRAME
Schools in Melur
Government Higher Secondary School (Experimental group)
Phase I- selection of setting
Convenient sampling technique
Government Higher Secondary School (Control group)
575 students 9th-12th standard
Phase II-selection of subjects
Survey approach
Using KAD scale
228 students 9th-12th standard
72 students identified with possible depression and anxiety symptoms
Using Beck depression Inventory and anxiety scale
36 students identified with depression and anxiety symptoms
Convenient sampling technique
Group I (30)
Beck depression inventory and anxiety scale
Group II(30)

Phase I:

Using survey method, all the adolescents were screened for the signs and symptoms of depression and anxiety in the age group of 13-17years by using Kutcher adolescent inventory scale. A Total of 575 students were screened from 9th standard to 12th standard and 72 were identified with possible depression and anxiety in setting I and in setting II a total of 228 students were screened from 9th standard to 12th standard and 36 were identified with possible level of depression and anxiety. .

PHASE II:

Using Beck depression inventory and anxiety rating scale those with moderate to severe level of depression were picked up. Among the 72 adolescents 65 were identified with depression. Due to non willingness 5 were dropped. So a total sample size of 60 with 30 in each group was arrived.

SAMPLING TECHNIQUE:

Using convenient sampling technique was sample who fulfil the inclusion criteria were selected.

CRITERIA FOR SAMPLE SELECTION:

INCLUSION CRITERIA:

- Adolescents in the age group of 13-17 years with the signs and symptoms of depression and anxiety as per Beck depression and anxiety scale and whose physical condition was stable.
- Who could communicate in Tamil.

EXCLUSION CRITERIA:

- Children who have cognitive impairment.
- Subjects who are not willing to participate in the intervention.

RESEARCH TOOL:

The tool used for this study was Beck depression inventory scale for assessing depression and Beck anxiety rating scale for assessing anxiety.

DESCRIPTION OF THE TOOL: (It consists of four parts)

Part I: (Appendix V)

DEMOGRAPHIC VARIABLES

It consists of demographic profile such as age, sex, education, economic status, parent and peer communication, academic performance, difficulty in school, types of family, family disharmony and conflict among parents.

Part II:(Appendix VI)

KUTCHER ADOLESCENT DEPRESSION SCALE

It is a self- report scale specifically designed to screen for adolescent depression.

It is a 6 item scale rating from 0 – 4. The maximum scoring is 18.

INTERPRETATION:

0 – 5	-	Not depressed
6and above	-	Possible depression requiring more thorough assessment.

Part III: (Appendix VII)

BECK DEPRESSION ADOLESCENTS INVENTORY SCALE:

This tool was used to measure the level of depression among adolescents. It consists of twenty one questions

BDI – Scoring:

The BDI was scored by summing the ratings for the 21 items. Each item was rated on a 4 points scale ranging from 0 to 3. The maximum score was 63.

Interpretation:

Score < 15 : mild depression

Score 15-30 : moderate depression

Score > 30 : Severe depression.

Part IV: (Appendix VIII)

BECK ANXIETY RATING SCALE:

It was designed to measure the presence of anxiety among adolescents. It consists of 23 questions.

Scoring:

Beck anxiety rating scale was scored by summing the ratings for the 23 items. Each item was on a 4 point scale ranging from 0-3. The maximum score was 69.

Interpretation:

- 0-16: Mild anxiety
- 17-30: Moderate anxiety
- 31And above: Severe anxiety

INTERVENTION:

School based cognitive behavioral depression prevention programme:

(**Appendix XIV)**

This programme was adopted from the module of Coping with depression course and included depression prevention and counseling session based on cognitive behavioral therapy for students, followed by discussion on adolescents, depression and prevention for parents and teachers.

The duration of each session was 1hour per day.

STUDENTS	TEACHERS	PARENTS
Session I: Depression and social learning. **Session II:**How to design a self change plan. **SessionIII:**Learning to relax **Session IV:** Relaxation in everyday situation. **SessionV:**Pleasant activities and depression. **SessionVI:**Formulating pleasant activities plan. **SessionVII**: Approaches to constructive thinking. **SessionVIII:** Formulating a plan for constructive	**GATE KEEPER TRAINING** It is meant for teachers to facilitate recognition of risk students for anxiety and depression. . **It includes session on;** -How to identify and screen adolescents for depression and anxiety. -How to deal with adolescents depression and anxiety and prevention of teen depression at school level.	It includes; discussion on; -coping with stress. -parent adolescent communication. -Spending time with adolescent . -caring and supporting adolescents at home.

thinking. **SessionIX**: Developing a life plan followed by open discussion and clarification of doubts. **SessionX:** Maintaining gain. Each session was backed up with home work assignments.		

TESTING OF THE TOOL:

VALIDITY:

To evaluate the content validity, the tool and the intervention were submitted to five experts in the field of psychiatric nursing, medical surgical nursing, community medicine, psychology and psychiatry. The tool I and II was validated for adequacy of the content, the sequence of the content and framing of the question. Approval was obtained from all the experts and based on the suggestions of experts the tool got its final form.

RELIABILITY:

Reliability of the measuring instrument is a major criterion of assessing its quality accuracy and adequacy. For the present study the tool was translated in to Tamil and then, the reliability of tool was established by split half method. The spearman's coefficient correlation of depression was r =0.97 and the anxiety was r =1.0. Hence the tool was highly reliable and was used for the study.

PILOT STUDY:

A pilot study is a small preliminary investigation of the same general character of the main study. To assess the feasibility and practicability, a pilot study was conducted on 6 adolescents in a selected school at Madurai. Pilot study revealed that the study was feasible. The sample in the pilot study were not used in the original study.

DATA COLLECTION PROCEDURE:

Before the commencement of the study the researcher underwent counseling course with a CBT.The investigator obtained an approval from the Dissertation committee of Sacred Heart Nursing College to conduct the study. Then a formal permission was obtained from the Principal of the respective schools to conduct the study. The samples were selected and oral consent was obtained from all the study samples. Every day the students gathered between 8-9 AM before the start of their classes at 9.20 AM.

Day-1-3: After establishing rapport with the study subjects, they were explained the purpose of filling the KAD scale. Then each one of them self- rated their level of depression and anxiety symptoms on the scale provided. The tool was administered in their respective class rooms. Out of 575 students 72 had possible depression.

Day 4-5: Pre- assessment of depression and anxiety was done in the experimental group by using Beck depression inventory and anxiety scale. Fifteen subjects were assessed in the morning and other 15 were assessed in the afternoon.

Days 5-6: Pre assessment of depression and anxiety was done in the control group by using the same Beck depression inventory and anxiety scale.

Day 7: Implementation of intervention

All the subjects in the experimental group were gathered in a class room. The researcher introduced about the coping with depression course to the subjects in the experimental group. From then onwards intervention for depression prevention course was initiated. All the sessions were done as a group using discussion, demonstration, assisted with A.Vaids like handout, flashcards and block board. Each session took one hour and was reviewed the next day. **The 1st session of Depression and social learning Commenced**. Subjects were explained regarding the ways of thinking depression and about the skills that change the depression. Home work assignment was given regarding monitoring the daily mood as per work sheet I.

Day 8: Session II .How to design a self - change plan: The researcher reviewed the session 1 and related home work sheet and explained about the main goals of self - change plan.

Day 9: Session III .Learning to relax: In this session some relaxation skills to reduce depression and how to relax in problematic situation were taught. The muscle relaxation procedure and Benson breathing procedure were demonstrated. Then the participants were asked to redemonstrate every step. They were provided with work sheet on daily monitoring relaxation form (2).

Day.10 Session IV: Relaxation in every day situation: This session focused on the practicing relaxation skills (or)using them in everyday situation when they experience stress or tension and then the researcher reviewed the home work sheet (1&2).

Day: 11: Session V: Pleasant activities and depression: This session focused on the relationship between engaging in pleasant activities and not being depressed and then work sheet No 3 was issued.

Day.12 Session VI: Formulating a pleasant activities plan: This session was intended to help them in planning to increase their rate of pleasant activities and the researcher explained how to make a pleasant activities plan..

Day.13 Session VII: Approaches to constructive thinking: This session focused on how to change their way of thinking about problem and difficulties. They were explained about the methods for constructive thinking and work sheet of No 4 was given to write-down their positive thoughts and negative thoughts.

Day.14 Session VIII: Formulating a plan for constructive thinking: This session was intended to help them to develop a plan to begin thinking more constructively. They were explained on the methods of decreasing negative thoughts and increasing the methods for positive thoughts and then work sheet No 5 was given to write the daily dally of positive and negative thoughts.

Day 15. Session IX: Maintaining your gains: This was to help them develop a plan for maintaining the gains and explain the methods for maintaining the gain.

Day.16 : Session X : Developing a life plan: This was to help them to develop a life plan to consolidate the gains they have made and to plan for the prevention of future episodes of depression.

Day 17: Each of the above session was reviewed. All the work sheets were checked. The investigator spent time with each student exploring their problems and provided CBT.

Day.18 to 35: Practice of the above session by the experimental group under researcher supervision was carried out everyday for one hour. In the intervention one to one interaction was made by the investigator to counsel them for the individual problems. With a maximum of three subjects per day in the evening.

Day. 36: Parents of adolescents in the experimental group were asked to come to the school .The investigator discussed on coping with teen, stress, parent adolescent communication, carrying and supporting adolescents at home by using chart. Out of 30 parents, 17 parents only attended and for the remaining parents of 13 the investigator visited them in their houses and discussed the above with them individually.

Day 37: **A session for teachers** was done with total of 35 teachers. Recognition of at risk students for depression and anxiety and how to deal with adolescents were the topics for the discussion. All the teachers actively participated .Hand out were distributed.

Day 38: Post- assessment of depression and anxiety was done for control group.

Day 39; A brief session on coping with depression was done to the adolescents of control group and teachers. Hand out was given regarding how to identify and screen adolescents for depression and how to deal with adolescents for preventing depression.

Day 40 : Post- assessment of depression and anxiety was done for the experimental group.

Those adolescents were further referred to get professional help from psychiatric experts. A teacher was allotted by the principal to continuously monitor them.

The respondents were co-operative both for the teaching session and practice session. Their attendance in these sessions was handed over to principal on the same day. Hence no drop out were there and the researcher thanked them for their cooperation and participation in the study.

PLAN FOR DATA ANALYSIS:

Data analysis was planned according to the objectives of the study by using descriptive and inferential statistics.

Descriptive statistics :

Frequency, percentage and mean were used for the analysis of depression and anxiety.

Inferential statistics: Correlation was used to find out the relationship between depression and anxiety and chi-square test was used to find out the association between depression and anxiety with selected demographic variables.

PROTECTION OF HUMAN RIGHTS:

- Approval for the study was obtained from the Dissertation Committee of the college.
- The consent was obtained from all the study samples and parents. The data obtained was kept confidential. Assurance was given to the study sample that anonymity of each individual would be maintained.

CHAPTER IV

ANALYSIS AND INTERPRETATION

This chapter deals with the description , analysis and interpretation of the data collected and achievement of the objectives of the study .The data collected were tabulated and presented as below.

The data collected were organized under following sections.

Section 1

Frequency and distribution of demographic characteristics of adolescents in the experimental group and the control group.

Section II

Prevalence of depression and anxiety symptoms among adolescents.

Section III

a) Distribution of adolescents in the experimental group and the control group according to their level of depression in the pre –test and post- test.
b) Distribution of adolescents in the experimental group and the control group according to their level of anxiety in the pre-test and post - test.

Section IV

Effectiveness of school based cognitive behavioral depression prevention programme on anxiety and depression.

a. Comparison of mean pre - test and post - test depression score of adolescents in the experimental group and the control group.
b. Comparison of mean - pre test and post - test anxiety score of adolescents in the experimental and the control group.
c. Comparison of mean post -test depression score between adolescents in the experimental group and the control group.
d. Comparison of mean post -test anxiety score between adolescence in the experimental group and the control group.

Section V

Relationship between mean post - test depression and anxiety scores of subjects in the experimental group.

Section VI

Association between pre- test level of depression among adolescents in the experimental group and their selected demographic variables.

Section VII

Association between pre- test level of anxiety among adolescents in the experimental group and their selected demographic variables.

Section I: Demographic variables

Table1 Frequency and distribution demographic characteristics of adolescents in the experimental group and the control group.

N=60

Demographic variables	Experimental group		Control group		Total	
	F	%	F	%	F	%
I. Personal Background						
Age in years						
12-13	3	10	7	23	10	17
14-15	8	27	12	40	20	33
16-17	19	63	11	37	30	50
Sex						
Male	13	43	16	53	29	48
Female	17	57	14	47	31	52
Education						
9th std	8	27	7	23	15	25
10thstd	9	30	9	30	18	30
11th std	7	23	7	23	14	23
12th std	6	20	7	24	13	22
Religion						
Hindu	24	80	18	60	42	70
Muslim	2	7	10	33	12	20
Christian	4	13	2	7	6	10

Type of family						
Joint family	-	-	-	-	-	-
Nuclear family	30	100	30	100	60	100
Birth order						
1st child	18	60	13	43	31	51
2nd child	9	30	15	53	24	41
3rd child	3	10	2	4	5	8
Monthly income(Rs./)						
3000-5000	8	27	9	30	17	28
6000-8000	14	46	7	23	21	35
9000-12000	8	27	14	47	22	37
Alcoholic father						
Yes	9	30	14	47	23	38
No	21	70	16	53	37	62
II.Family background						
Parents living together						
Yes	24	80	27	90	51	85
No	6	20	3	10	9	15
Parents fighting with each other often						
Yes	6	20	7	23	13	22
No	24	80	23	77	47	78

Communication with their parents						
Close communication	20	67	23	77	43	72
Partial communication	10	33	7	23	17	28
Never	-	-	-	-		
Punishment from parents						
Beating	9	30	13	43	22	37
Scolding	21	70	17	57	38	63
Any other	-	-	-	-	-	-
III.School data						
Happiness with school environment						
Very happy	12	40	17	57	29	48
Happy	18	60	13	43	31	52
Academic performance						
Good	18	60	17	57	35	58
Average	12	40	13	43	25	42
Poor						
Students teacher communication						
Close communication	23	77	21	70	44	73
Partial communication	7	23	9	30	16	27

Type of punishment received from school						
Beating	16	53	14	47	30	50
Scolding	6	20	7	23	13	22
Kneeling	8	27	9	30	17	28
Communication with friends						
Close communication	21	70	23	77	44	73
Partial communication	9	30	7	23	16	27
Never	-	-	-	-		
Conflict with friends						
Yes	10	33	7	23	17	28
No	20	67	23	77	43	72
IV.Recreation						
Watching television						
Sometimes	20	67	17	57	37	62
Always	4	13	3	10	7	12
Never	6	20	10	33	16	26
Type of recreational activities						
Television	12	40	13	43	25	42
Sports	12	40	12	40	24	40
Drawing	6	20	5	17	11	18

Table1 Shows that most of the sample i.e. 63% in the experimental group and 37% in the control group) were in the age group of 16-17years. Regarding sex, 57%were females in the experimental group whereas in the control group 47% of samples were male. 30% of the sample in both the groups were studying 10th std and 80% of the sample in the experimental group and 60% of the sample in the control group were Hindus.

Nearly 50% of the subjects in both the groups were getting Rs.6000-8000 and 30% of the samples in the experimental group and 47% in the control group had their father who consumed alcohol. Nearly 80% parents of the sample in the experimental group and 90% in the control group were living together . 20% of the sample in experimental group and 23% in the control group had parents who used to have conflicts.

Most of the sample nearly i.e. (70%) in both the groups were maintaining close communication with their parents , 70% of the sample in the experimental group and 57% of sample in the control group were getting scolds from their parents and nearly 60% of the samples in both the group were feeling happy with the school environment.70% of the sample in the experimental group and 57% in control group were good in their academic performance and 77% of the students in the experimental group 70% of the students in control group had close communication with their teachers. Nearly 70% of the sample in both the groups were having good relationship with their friends. Regarding conflict with friends 33% in the experimental group and 23% in the control group were having conflicts with their friends. Nearly 67% in the experimental group and 57% in the control group were watching television always and 40% in both the groups were involved in sports.

Section II

Table 2 Prevalence of depression and anxiety symptoms among adolescents in selected settings .

N=803

Depression and anxiety symptoms	**Setting 1 n=575**		**Setting 2 n=228**	
	f	**%**	**f**	**%**
Adolescents with depressive & anxiety symptoms	72	13	36	16
Adolescents without Depression & Anxiety symptoms	503	87	192	84

Table 2 reveals that in setting1(experimental group) the overall screened sample of students 72 (13%) had possible level of depressive and anxiety symptoms. In setting 2 (control group) from the over all screened samples of 228 students 36(16%) had possible level of depression and anxiety symptoms .

Section III

Table3 Distribution of adolescents in the experimental and the control group according to their level of depression in the pre-test and post - test.

N=60

Level of depression	experimental group n=30				control group n=30			
	Pre -test		post- test		pre- test		post-test	
	f	%	f	%	f	%	f	%
Mild (<15)	-	-	18	60	8	27	6	20
Moderate (15-30)	16	53	12	40	15	50	15	50
Severe (>30)	14	47	0	0	7	23	9	30

Table 3 reveals that the distribution level of depression in the pre-test and post-test test. In the experimental group 16 (53.3%) of the sample showed moderate level of depression and 14 (47%) showed severe level of depression in the pre- test .In contrasts majority (60%) of the sample had only mild level of depression and 40% of the sample experienced moderate level of depression and none with severe level in the post. But in the control group 27% of the samples showed mild level, 50% of the samples showed moderate level and 23% had severe level of depression in pre - test . In post - test half of them (50%) had moderate, and 20% had mild level of depression and the rest (30%)were in severe level of depression.

Table 4

Distribution of adolescents in the experimental and the control group according to their level of anxiety in the pre-test and post - test.

N=60

Level of Anxiety	Experimental group n=30				Control group n=30			
	Pre -test		post- test		pre- test		post- test	
	F	%	f	%	f	%	f	%
Mild (0-16)	8	27	18	60	12	40	14	47
Moderate 17-30)	16	53	12	40	12	40	10	33
Severe (>31)	6	20	0	0	6	20	6	20

Table 4 shows that in the experimental group 27% of the sample showed mild level of anxiety and 53% of the sample had moderate level and 20% of the samples had severe level of anxiety in the pre - test. In contrasts, majority 60% of the sample had mild level and 40% of the sample had moderate level of anxiety and none with severe level in the post - test. In the control group 20% of the sample had severe level of anxiety and 40% had moderate level in the pre- test .In the post- test 20% continued to have severe level of anxiety.

Section IV

Table 5 Comparison of mean pre - test and post - test depression score of adolescents in the experimental and the control group

N=60

Depression Score	n	Mean	Mean difference	S.D	‘ t’.value	df
Experimental Group						
Pre- test	30	28.2	9.1	9.0	9.02***	29
Post- test	30	19.1		8.0		
Control Group						
Pre- test	30	27.1	0.1	7.43	0.52	29
Post- test	30	27		7.33		

***Significant at ($p<0.001$)

To compare the mean pre- test and post- test score of adolescents the null hypothesis stated was as follows.

H_{01}: The mean post - test depression score of adolescents in the experimental group who had cognitive behavioral therapy will not be significantly lower than their pre - test score.

The hypothesis was tested using paired “t’ test. Table5 Showed that the mean post -test depression score of 1 9.1 was lower than the mean pre- test depression score of 28.2. The obtained “t” value 9.02 was statistically highly significant at P<0.001(df.29). This illustrates that the mean difference of 9.1 was a true difference and has not occurred by chance. So the researcher rejects the null hypothesis and accept the research hypothesis. In control group no significant reduction was noticed.(Fig:3)

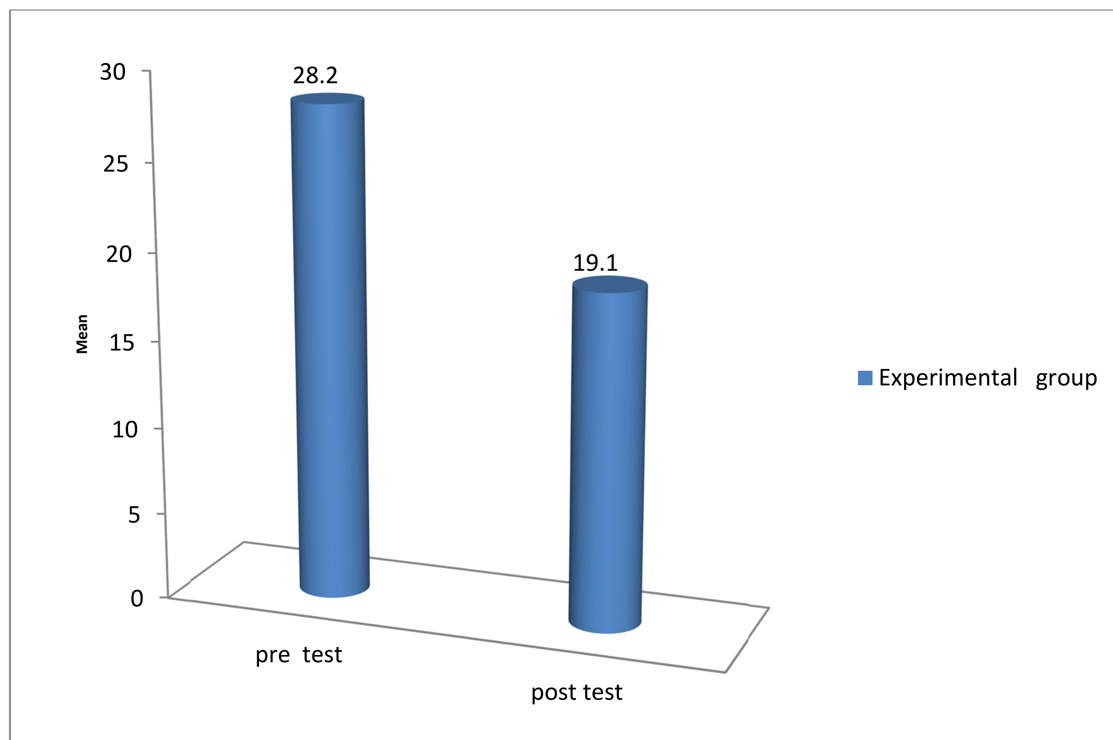


Figure 3: Comparison of mean pre test and post test depression score of adolescents in experimental group.

Table 6 Comparison of mean pre- test and post - test anxiety score of adolescents in the experimental and the control group

N=60

Anxiety Score	**n**	**Mean**	**Mean difference**	**S.D**	**' t'.value**	**df**
Experimental Group						
Pre- test	30	21.3	12.3	9.34	6.4***	29
Post- test	30	9.0		7.4		
Control Group						
Pre- test	30	14.83	1.13	5.46	0.53	29
Post- test	30	13.7		5.03		

*** Significant at (P<0.001)

To compare the mean pre- test and post - test score of anxiety the null hypothesis stated was as follows . H02 : The mean post - test anxiety score of adolescents in the experimental group who had cognitive behavioral therapy will not be significantly lower than their pre- test score.

The hypothesis was tested using paired "t' test. Table 6 Showed that the mean post-test anxiety score of 9.0 was lower than their mean pre test anxiety score of 21.3. The obtained "t" value 6.4 was statistically highly significant at p<0.001 (df =29). This illustrates that the mean difference of 12.3 was a true difference and has not occurred by chance. So the researcher rejects the null hypothesis and accepts the research hypothesis. There was no significant reduction in anxiety score in the control group.(Figure:4)

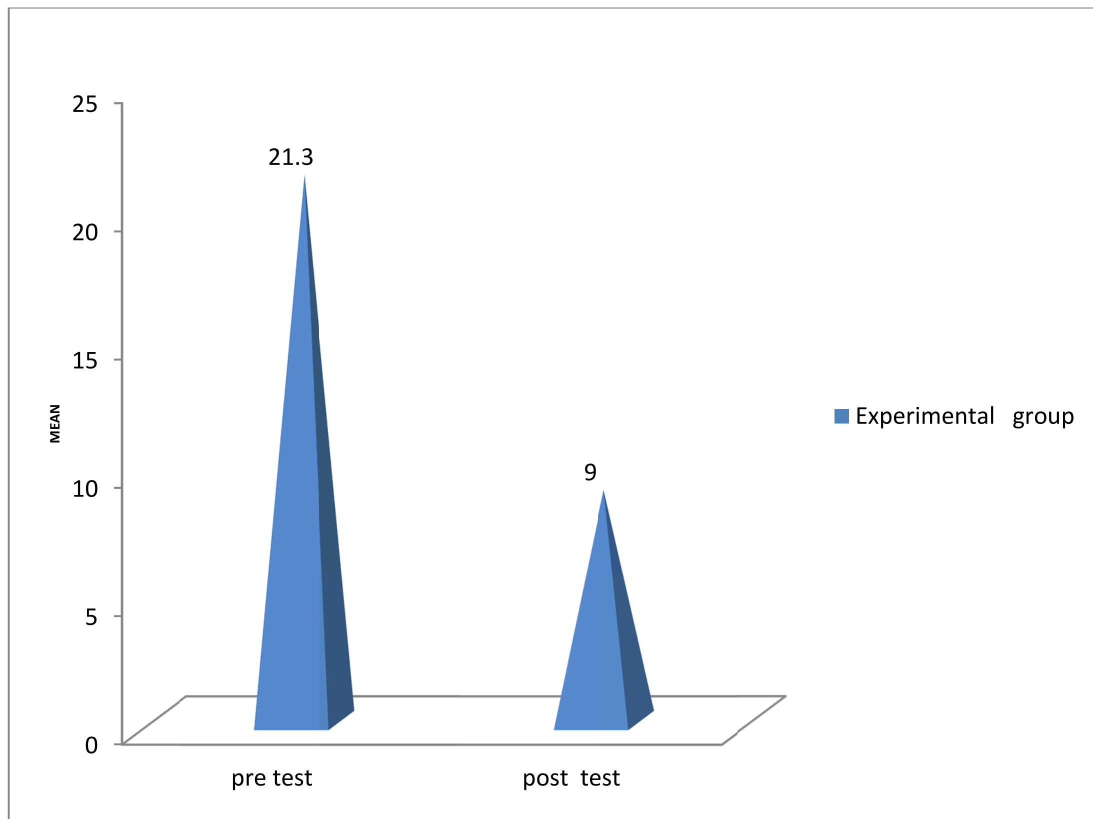


Figure 4: Comparison of mean pre test and post test anxiety score of adolescents in the experimental group.

Table 7 Comparison of mean post- test score of depression between adolescents in the experimental group and the control group.

N=60

Depression Score	**n**	**Mean**	**Mean difference**	**S.D**	**'t'.value**	**df**
Experimental Group	30	19.1	7.9	8.0	3.2***	58
Control Group	30	27		7.33		

***Significant atP< 0.001 level

To compare the mean post- test depression score of the experimental group and the control group the null hypothesis stated was as follows H03: The mean post- test depression score of experimental group who recived cognitive behavioral depression prevention programme will not be significantly lesser than the mean post- test score of control group.

The hypothesis was tested using independent' t'test. The table 7 shows that the mean post- test score of depression in the experimental group was lesser than the mean post test score of control group. The obtained't' value 3.2 was statistically significant at p<0.001 level. This illustrates that the mean difference 7.9 was a true difference and has not occurred by chance .Hence the researcher rejects the null hypothesis and accepts the research hypothesis.(Figure:5)

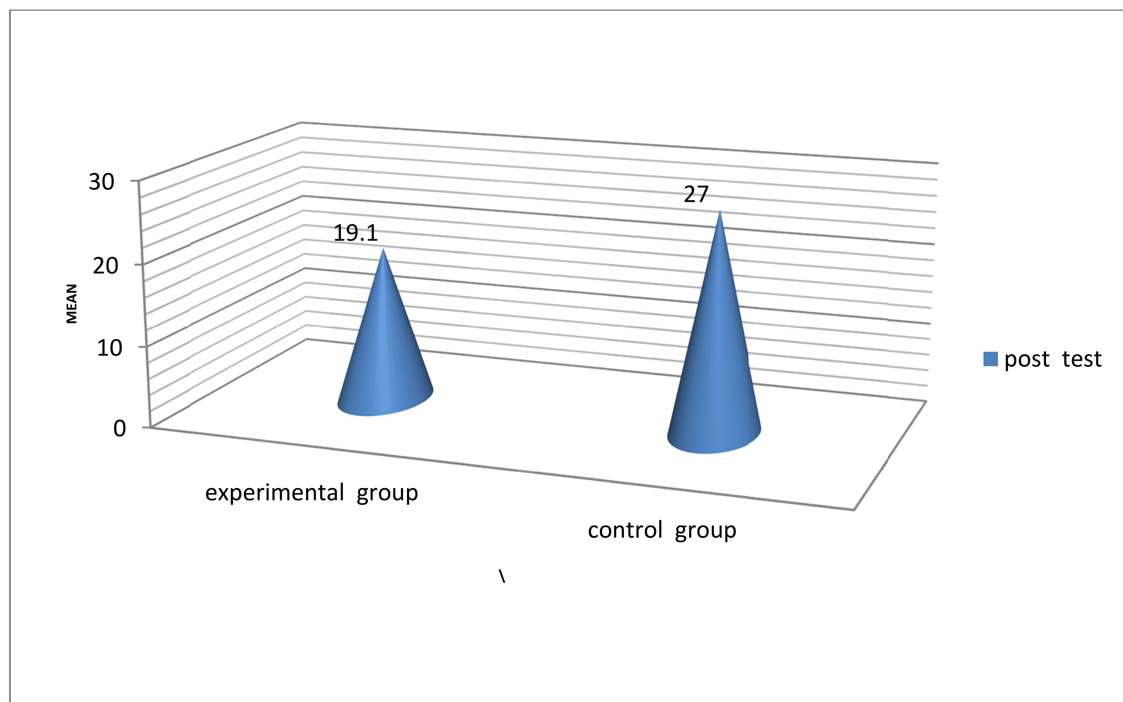


Figure 5 : Comparison of mean post test score of depression between adolescents in the experimental and the control group.

Table 8 Comparison of mean post -test score of anxiety between adolescents in the experimental group and the control group.

N=60

Anxiety Score	**n**	**Mean**	**Mean difference**	**S.D**	**'t'.value**	**df**
Experimental Group	30	9.0	4.7	7.4	5.25***	58
Control Group	30	13.7		5.03		

***Significant at P< 0.001 level

To compare the mean post- test anxiety score of the experimental and the control group the null hypothesis stated was as follows.

H_{04}: The mean post- test anxiety score of the experimental group who received cognitive behavioral depression prevention programme will not be significantly lesser then the mean post- test score of the control group.

The hypothesis was tested using independent' t'test. The table 8 shows that the mean post- test score of anxiety in the experimental group is lesser than the mean post- test score of the control group. The obtained 't" value 5.25 was statistically highly significant at P < 0.001 level. This illustrates that the mean difference of 4.7 was a true difference and has not occurred by chance .So the researcher rejects the null hypothesis and accepts the research hypothesis.(Figure:6)

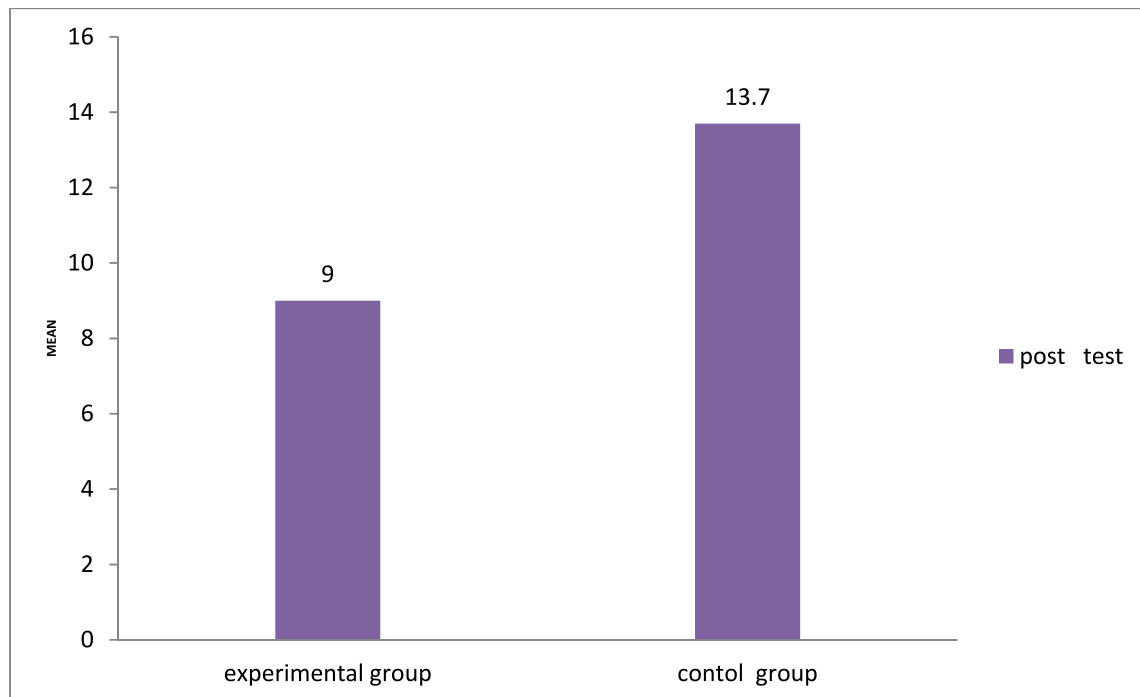


Figure 6: Comparison of mean post test score of anxiety among adolescents in the experimental and control group.

.SECTION V

Table 9 Relationship between mean post test depression and anxiety scores of subjects in the experimental group.

n=30

Variables	mean	S.D	“r’value
Depression	19.1	8.0	0.9***
Anxiety	9.0	7.4	

*** Significant at p<0.001

To find out the relationship between depression and anxiety the null hypothesis was stated as follows .

H05: There will not be a significant positive relationship between anxiety and depression.

Table 9 shows that there was a significant positive relationship between depression and anxiety (r=0.9) at p<0.001 level of significance. Therefore the researcher accepts the research hypothesis and rejects the null hypothesis.

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SECTION VI

Table 10 Association between pre- test level of depression among adolescents in the experimental group and selected demographic variables.

n=30

Demographic Variables	Above mean	Below mean	Total	chi square	df
I. Personal data					
Age in years					
12-13	4	4	8		
14-15	7	2	9	0.190#	2
16-17	8	5	13		
Sex					
Male	9	4	13	0.78#	1
Female	10	7	17		
Education					
9th std	4	2	6		
10th std	7	2	9	0.18#	3
11th std	5	2	7		
12th std	4	4	8		
Religion					
Hindu	16	8	24		
Muslim	1	1	2	0.08#	2
Christian	2	2	4		

Type of family					
Joint family	-	-	-	-	-
Nuclear family	16	14	30	100	1
Birth order					
1st child	6	12	18		
2nd child	5	4	9	0.22#	2
3rd child	2	1	3		
Monthly income(Rs./)					
3000-5000	5	4	9		
6000-8000	12	4	16	0.35#	2
9000-12000	2	3	5		
Alcoholic father					
Yes	6	3	9	0.38 #	1
No	13	8	21		
II.Family data					
Parents living together					
Yes	15	6	21	0.38#	1
No	4	5	9		
Parents fighting with each other often					
Yes	4	3	7	0.1#	1
No	15	8	23		

Communication with their parents					
Close communication	12	6	18		
Partial communication	7	5	12	0.80#	2
Never	-	-	-		
Punishment from parents					
Beating	4	4	8		
Scolding	15	7	22	0.18#	2
Any other	-	-	-		
III.School data					
Happiness with school environment					
Good	7	4	11		
Somewhat	9	5	14	0.10#	2
poor	2	3	5		
Academic performance					
Good	11	6	17		
Average	6	3	9	0.95#	2
Poor	2	2	4		
Students teacher communication					
Close communication	10	7	17	0.07#	1
Partial communication	9	4	13		

Type of punishment received from school					
Beating	4	2	6		
Scolding	10	7	17	0.06#	2
Kneeling	5	2	7		
Communication with friends					
Close communication	13	8	21	0.12 #	1
Partial communication	6	3	9		
Never		-	-	-	-
Conflict with friends					
Yes	5	4	9	0.06#	1
No	14	7	21		
IV.Recreation					
Watching television					
Sometimes	11	7	18		
Always	5	2	7	0.14#	2
Never	3	2	5		
Type of recreational activities					
Television	6	5	11		
Sports	8	3	11	0.14#	2
Drawing	5	3	8		

Not Significant at P<0.001 level

To find out the association between the mean pre test depression score and selected demographic variables the null hypothesis was stated as follows.

H_{06}: There will not be a significant association between the pre-test depression score of adolescents in the experimental group and their selected demographic variables.

Table 10 describes that there is no significant association between mean pre-test score of depression and selected demographic variables. Hence it is inferred that there was no significant association between pre-test depression score and selected demographic variables. So the researcher accepts the null hypothesis and rejects the research hypothesis.

SECTION VII

Table 11 Association between pre- test score of anxiety among adolescents in the experimental group and selected demographic variables.

n=30

Demographic Variables	Above mean	Below mean	Total	chi square	df
I.Personal data					
Age in years					
12-13	3	5	8		
14-15	6	4	10	1.38#	2
16-17	12	0	12		
Sex					
Male	9	4	13	0.35#	1
Female	8	9	17		
Education					
9th std	2	6	8		
10^{th}std	4	5	9	0.91#	3
11th std	4	3	7		
12th std	6	0	6		
Religion					
Hindu	13	11	24		
Muslim	2	1	3	0.03#	2
Christian	1	2	3		

Type of family					
Joint family	-	-	-	-	-
Nuclear family	17	13	30	100	1
Birth order					
1st child	6	12	18		
2nd child	5	4	9	0.22#	2
3rd child	2	1	3		
Monthly income(Rs./)					
3000-5000	5	3	8		
6000-8000	6	8	14	0.21#	2
9000-12000	5	3	8		
Alcoholic father					
Yes	6	3	9	0.192#	1
No	10	11	21		
II.Family data					
Parents living together					
Yes	15	6	21	0.38#	1
No	4	5	9		
Parents fighting with each other often					
Yes	10	2	12	0.2#	1
No	3	15	18		

Communication with their parents					
Close communication	13	12	25		
Partial communication	4	1	5	0.180#	2
Never	-	-	-		
Punishment from parents					
Beating	4	43	7		
Scolding	13	10	23	0.05 #	2
Any other	-	-	-		
III.School data					
Happiness with school environment					
Good	17	8	25		
Somewhat	3	2	5	0.32 #	2
poor	-	-	-		
Academic performance					
Good	11	6	17		
Average	6	3	9	0.38#	2
Poor	2	2	4		
Student teacher communication					
Close communication	11	8	19	0.89#	1
Partial communication	6	5	11		

To find out the association between the mean pre test anxiety score and selected demographic variables, the null hypothesis was stated as follows.

H_{07}: There will not be a significant association between the pre - test anxiety score of adolescents in experimental group and their selected demographic variables.

Table 10 describes that there is no significant association between the mean pre- test score and demographic variables. Hence it is inferred that there was no significant relationship between mean pre - test anxiety score and selected demographic variables. So the researcher accepts the null hypothesis and rejects the research hypothesis.

CHAPTER V

DISCUSSION

This study evaluated the effect of depression prevention programme in terms of reducing the depression and anxiety symptoms among adolescents in selected rural schools of Melur. The study findings are discussed in this chapter with reference to the objectives and hypothesis stated in chapter-1

MAJOR FINDINGS OF THE STUDY

1. Characteristics of the participants

The majority of the participants i.e., 63% in the experimental group and 37% in the control group belonged to the age group of 16-17 years. With regard to sex, 57% of the experimental groups were females and 47% of the samples in the control group were males. With regard to educational status, 30% of the samples in both the groups were studying 10th standard and 80% of the sample in the experimental group and 60% of the sample in the control group were Hindus.

2) Family data

Nearly 50% in both the groups were getting Rs.6000-8000 and 30% of the sample in the experimental group and 47% in control group had fathers who consumed alcohol .Parents of most of the subjects nearly 80% of the sample in experimental group and 90% in the control group were living together .Nearly 20% of the sample in the experimental group and 23% in the control group had conflict with their parents. Nearly 70% in both the groups were maintaining a close communication with their Parents and 30% of the sample in experimental group and 43% of sample in the control group used to get beating as a punishment from their parents.

3. School Data

Nearly 50% of the sample in both the groups were satisfied with the school environment and 60% of the sample in the experimental group and 57% in the control group were good at their academic performance. Nearly 73% of the sample in both the groups were having a good relationship with their friends.

4. Recreation

Nearly 67% in experimental group and 57% in control group were watching television always and 40% in both the groups used to get involved in sports.

1. The first objective of the study was to find out the prevalence of depression and anxiety symptoms among adolescents in selected settings.

In order to identify the prevalence of depression and anxiety symptoms survey was carried out at Government Higher Secondary Schools at Eriyur and Melur .They were screened for the possible level of depression by KAD scale. In setting I (Experimental group) from the overall screened sample of 575, 72 (13%) students had possible level of depression and anxiety symptoms. In setting II (control group) from over all screened sample of 228 students 36 (76%) had possible level of depression and anxiety symptoms .

A higher prevalence of depression and anxiety was evident in a study conducted by Mohanraj, and Subbaiah (2010) among nine hundred and sixty four adolescents in two schools of Chennai. Results showed that 338 (37%) were mildly depressed, 187 were (19.4%) moderately depressed and 41 94.3%) were severely depressed.

Another study done by Sahoo and Khess (2010) among adolescents in Ranchi city of India showed a prevalence of depression in18.5%and anxiety in 24.45 of adolescents. There was a good response among the subjects when screening was done among them and the verbatim quoted by the subjects were as follows.*" Screening of depressive and anxiety symptoms helps us to know our mental status which we have not taken care of before and the school principal said it was very helpful for us to know our students, mental status to guide them."*

2. The second objective of the study was to assess the pre-test and post- test level of depression among adolescents in the experimental group and the control group.

Table 5 shows that in the experimental group 16 (53%) adolescents had moderate level of depression and 14 (47%) had severe level of depression in the pre-test, whereas in control group 15 (50%) adolescents had moderate and 7 (23%) had severe and 8(27%) had mild level of depression in the pre- test.

In post -test, in the experimental group 18 (60%) subjects had mild level, 12 (40%) had moderate level of depression and none had severe level of depression. Whereas in the control group there was no change in their level of depression compared to the pre - test.

3. The third objective of the study was to assess the pre-test and post- test level of anxiety among adolescents in the experimental group and the control group.

In the experimental group 8(27%) subjects had mild level of anxiety, 16(53%) had moderate level of anxiety and 6(20%) had severe level of anxiety in the pre- test. Whereas in the control group 12 (40%) subjects had mild level,12 (40%) had moderate level and 6 (20%) had severe level of anxiety.

In the post- test, in the experimental group 18 (60%) subjects had mild level and 12 (40%) had moderate level of anxiety and none had severe level of anxiety. Whereas control group there was no reduction in their severe level of anxiety compared to the pre -test.

4. The fourth objective of the study was to evaluate the effectiveness of school based cognitive behavioral depression prevention programme on depression among adolescents.

In the experimental group the mean post- test depression score 19.1 was lower than their mean pre-test depression score 28.2. The obtained't' value was statistically highly significant at P<0.001 level (MD=9.1, t=9.02).This illustrates that the mean difference was a true difference and has not occurred by chance.

Apart from that there was a significant difference between the control group and the experimental group. The mean post- test depression score of the experimental group was lower than the mean post- test depression score of the control group .The obtained 't' value was statistically highly significant at P< 0.001 level (MD=7.9, t=3.2).This illustrates that mean difference was a true differences. So the researcher rejected the null hypothesis and accepted the research hypothesis.

The children who received the school based depression prevention programme were found to have significantly greater reduction in depression and the findings support the existing evidence that the intervention was effective.

A similar study was conducted by Bidwell et al (2011) in USA, in which 17646 inhabitants of 13-18yrs of age were screened for the presence of possible depression and they were counseled using cognitive behavioral depression prevention programme and the findings revealed that the baseline measurements for

developing depressive symptoms was low and their behavior changed by means of the intervention .This study supports the above findings.

5. The fifth objective of the study was to evaluate the effectiveness of school based cognitive behavioral depression prevention programme on anxiety among adolescents.

In the experimental group the mean post- test anxiety score 9.0 was lower than their mean pre-test anxiety score 21.3. The obtained 't' value was statistically highly significant at P<0.001 level (MD=12.3, t=6.4).This illustrates that the mean difference was a true difference and has not occurred by chance.

There was a significant difference between the experimental and the control group. The mean post- test anxiety score of the experimental group was lower than the mean post -test anxiety score of control group .The obtained 't' value was statistically highly significant at P< 0.001 level (MD=4.7, t=5.25).This illustrates that the mean difference was a true difference. So the researcher rejected the null hypothesis and accepted the research hypothesis. It shows that there was a significant reduction of anxiety symptoms due to the intervention.

The above findings were supported by a study that tested the effectiveness of cognitive behavioral prevention programme in reducing anxiety among adolescents by Garnefski et al (2008) in Netherlands, in which they had selected 90 adolescents with the symptoms of depression and anxiety. Participants were randomly assigned to treatment as usual plus the intervention. Assessments were completed. The children who received cognitive behavioral therapy were found to have significantly greater reduction in symptoms of anxiety, depression and suicidal cognition. These findings extend the evidence that a time –limited Cognitive Behavioral intervention is effective for adolescents with anxiety and depression.

6. The sixth objective of the study was to find out the correlation between depression and anxiety among adolescents in the experimental group.

Table 9 portrayed that the mean post- test score of depression was 19.1 and anxiety score was 9.0 the obtained “r’value of 0.9 was statistically highly significant at P<0.001 level. The researcher accepted the research hypothesis and rejected the null hypothesis since there was a significant positive relationship between depression and anxiety .So all those with depression are likely to have anxiety too. This is supported by the following study.

A study was conducted by Axelson and Birmaher (2001) to find out the relationship between Anxiety and Depressive disorders among adolescents in Pennsylvania, USA. The study indicated that there was a strong relationship between anxiety disorders and depression. Assessment measures showed high rates of correlation between Depression and Anxiety. Anxiety and depression are frequently co morbid in children and adolescents. About 25-50% of depressed youth has co morbid anxiety disorders and about 10-15%of anxious youth has depression. It shows that there was a positive relationship between depression and anxiety. So it can be concluded that when depression increases anxiety also increases.

7. The seventh objective of the study was to find out the association between selected demographic variables (such as age, sex, education academic performance, difficulty in school, family disharmony, conflict among parents) and pre- test score of depression among adolescents in the experimental group.

In this study the researcher found that there was no significant association between the demographic profile and depression. i. e, demographic variables did not have any impact on the depression level. Since there was no significant association

between depression and demographic variables, the researcher accepted the null hypothesis and rejected the research hypothesis.

But in another study in south India Mohanraj and Subbaiah (2010) found that there was a significant association between age and depression. Adolescents aged 15years had the lowest mean score and adolescents aged 18 years had the highest mean score experiencing more depressive symptoms than younger adolescents.

8. The eighth objective of the study was to find out the association between selected demographic variables(such as age, sex, education, academic performance, difficulty in school, family disharmony, conflict among parent, depressive symptoms) and pre -test score of anxiety among adolescents in the experimental group.

An analysis on whether the variable in the study exerts any influence in the anxiety score was done. The researcher found that there was no significant association between the demographic profiles and anxiety.

Since there was no significant association found between anxiety and demographic variables the researcher accepted the null hypothesis and rejected the research hypothesis.

CHAPTER VI
SUMMARY, CONCLUSION, IMPLICATION AND RECOMMENDATION

This chapter deals with the summary of the study, conclusion , implication and also recommendation for the different areas like nursing practice, nursing education, nursing administration and the research.

The study was undertaken to determine the effectiveness of school based cognitive behavioral depression prevention programme on reduction of depression and anxiety symptoms among adolescents.

All hypotheses were tested at 0.001 level of significance.

An experimental approach and the quasi- experimental pre- test and post -test non equivalent control group design was chosen for the study .The population chosen for the study was adolescents of 13 to 18 years of age who were at the risk of depression and anxiety. The study subjects were selected using convenient and purposive sampling techniques.

The tool used for the data collection consisted of four sections.

Section I: Contains screening of adolescents by KAD

Section II: Includes demographic variable

Section III: Contains Beck Depression inventory

Section IV: Includes Beck Anxiety rating scale

Variables

Independent variables: School based cognitive behavioral depression prevention programme.

Dependent variables: Depression and Anxiety.

Descriptive statistics, inferential statistics, chi-square test were used to analyze the data and to test the hypothesis. Content validity was established by submitting the tool to five experts in the field of Nursing, Community Medicine, Psychology, and Psychiatry.

MAJOR FINDINGS OF THE STUDY

I. Background profile

a) Personal Data

- Among the sample 63% in the experimental group and 37% in the control group belonged to the age group of 16 to 17 years.
- In the experimental group 57% were females and 47% of the subjects in the control group were male. 80% of the participants in the experimental group and 60% in the control group were Hindus.
- Nearly 37% of the sample in both the groups were studying 10th standard. Half of the subjects (50%) in both the groups were getting RS.6000-8000 per month.30% of the sample in the experimental group and 47% in the control group had their father who consumed alcohol.
- Nearly 80% of the samples of the experimental group and 90% of control group had their parents living together.
- In this study, 20% of the sample in the experimental group and 23% in the control group reported that their parents had conflicts. Most of the sample (nearly 70%) in both the groups were maintaining close communication with parents.

b) School data

- With regard to their experience at school 60% in the experimental group and 57% of control group were happy with the school environment. Nearly 60% of the subjects had good academic performance.
- Most of the sample ie (77% in experimental group and 70% in control group) was maintaining close communication with teacher. With regard to punishment from school 53% of the sample in the experimental group and 47% in the control group experienced beating as a punishment and 33% of the samples in the experimental group and 23% in the control group were having conflict with their friends.

c) Recreation

More than 67% in the experimental group and 57% in control group were watching television. 40% of the experimental group and 43% of the control group were involved in sports activities.

II. Findings related to depression and anxiety.

- Half of the sample in the experimental group (53%) was at moderate and (47%) were at severe level of depression in the pre- test.
- The mean post- test score of depression of the experimental group 19.1 was lower than their mean pre- test score 28.2. The obtained 't' value 9.02 was significant at $P< 0.001$ level. The mean difference between the score could be due to the effect of School Based Cognitive Behavioral Depression Prevention Programme. But in the control group there was no significant difference in the depression score (Md.=0.1 and 't' value 0.52).

- When compared to the control group, the mean post- test score of depression of experimental group was lesser than the post- test score of the control group. (Md= 7.9 & 't' value 3.2 , at $P < 0.001$ level). It showed that there was a significant reduction in the depressive symptoms due to the intervention.
- The mean post- test anxiety score of the experimental group was 9.0 which was lower than their mean pre- test score 21.3. The mean difference was 12.3 and 't' value 6.4 significant at $P < 0.001$ level. The mean difference between the scores could be due to the effect of School Based Cognitive Behavioral Depression Prevention Programme. But in the control group there was no significant difference in the anxiety score.(Md=1.13, 't' value 0.53 at $P<0.001$ level).
- When compared to the control group the mean post- test score of anxiety in the experimental group was lesser than the post- test anxiety score of the control group (Md=4.7 &'t' value5.2 at $P< 0.001$ level).It showed that there was a significant reduction in anxiety symptoms which proved the effect of intervention. .
- There was a significant positive relationship between depression and anxiety ($r=0.9$) at $p<0.001$ level of significance.
- There was no significant association found between the demographic profiles of the subjects and their pre -test level of depression and anxiety among adolescents.

Conclusion:

The following conclusions were drawn from this study: Depression and anxiety are considered to be one of the most common emotional problems in adolescents. The School Based Cognitive Behavioral Depression prevention

programme substantially contributed to the improvement of depressive and anxiety symptoms among adolescents. It is a cost effective, simple, feasible and much applicable intervention for school children. School health nurses should routinely screen for depression, anxiety and continue this programme and sustain the changes in behavior and suicidal attempts.

Implications for Nursing

The findings of the present study supports that the School Based Cognitive Behavioral Depression Prevention Programme was effective in reducing developing Depression and Anxiety.

The findings of the study have several implications in the following fields.

Implication for nursing practice

- Nurses are in the best position to focus on the primary prevention.
- The nurse can arrange for awareness programmes to the teachers in various schools regarding the effectiveness of cognitive behavioral depression prevention programme.
- The community health nurse needs to take the responsibility of helping children and their parents in the regulation of their interaction and communication in order to minimize the depressive and anxiety symptoms.
- The school health nurse can plan and carryout counselling sessions for the students with depression and anxiety periodically to prevent suicidal attempts.

Implication for nursing education

- There should be a greater emphasis in nursing curriculum about the impact of depression and anxiety on the adolescents.

- The nursing personnel working in various health setting should be given inservice education to improve their competency in identifying the at risk adolescents.

Implications for nursing administration

- The nurse administrator should prepare adequate learning materials for capacity building of Nurses towards prevention of depression and anxiety. The module adopted in the study can be used for training nurses.
- The nurse administrator can focus on primordial and primary prevention strategies so that the risk can be postponed or delayed.

Implication for nursing research

- It is essential to develop evidence based strategies for preventing depression and anxiety.
- This study also brings about the fact that more studies are needed to be done in different settings using other depression prevention strategies.

LIMITATIONS

- The setting of the study was chosen using convenient sampling and not by random sampling technique.
- The data collection period was limited to 6 weeks. The Post- test was done within a short time. The effect on a longer duration could not be measured due to limited data collection period. Cognitive behavioral depression programme was limited to only 10 sessions with selected techniques only. The impact of training on teachers and parents was not evaluated.

RECOMMENDATION

Based on the findings of the study, the recommendation for future studies are as follows:

- Similar study can be conducted for a large group.
- This study can be done as a comparative study between the urban and rural populations.
- Similar study can be conducted with a post- test after one month, six month, and at one year interval to evaluate the impact as a longitudinal one.
- Effect of the School Based Cognitive Behavioral Depression Prevention Programme on academic performance, peer and parent child relationship can be estimated.   .

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APPENDIX – I

Copy of the Letter Seeking Experts Opinion for Tool and Content Validity

From

II Yr. M.Sc., (Nursing)
Sacred Heart College of Nursing
Madurai – 20

To

Dear Madam/ sir,

Sub : requesting opinion and suggestion of experts for tool and content validity in

I am a final year M.Sc., (N) student in Sacred Heart Nursing. In partial fulfillment of Master degree in Nursing, I have selected the topic mentioned below for the research project to be submitted to the Tamilnadu Dr.M.G.R. Medical University, Chennai.

Problem statement

"A study to assess the effectiveness of School Based Cognitive Behavioral Depression Prevention Programme on depression and anxiety symptoms among adolescents in selected rural schools melur".

I request you to kindly validate the content and give your expert opinion for necessary modification and I would be happy if you could refine the problem statement and the objectives.

Place: Thanking you. Your' faithfully,
Date

APPENDIX – II

SACRED HEART NURSING COLLEGE

ULTRA TRUST

4 / 235, COLLEGE ROAD,
THASILDAR NAGAR,
MADURAI - 625 020.
TAMILNADU, INDIA.
PHONE : 0452 - 2534593

Ref: UT: SHNC: 2012 **Date:** 20.06.2012

To

The Headmaster
Govt. Hr. Sec. School,
Eriyur, Thiruppathur Tk
Sivagangai Dt.

Sub: Sacred Heart Nursing College, Madurai – project work of II year M.Sc(N) student - Permission requested - reg.

Respected Sir / Madam,

We wish to state that **Mrs. G. BHARATHA SELVI**, final year M.Sc(N) student of Sacred Heart Nursing College, Madurai has to conduct a Research Project, which is to be submitted to the Tamil Nadu Dr.M.G.R. Medical university, Chennai as a partial fulfillment of University requirements.

The Topic of research project is "A study to assess the efficacy of cognitive behavioural depression prevention programme on depression and anxiety symptoms among adolescents in selected schools at Madurai".

We therefore request you to kindly permit her to do the research work in selected schools under your valuable guidance and suggestions.

Thanking you,

permitted to conduct the project
18/7/2012

HEAD MASTER,
Govt. Higher Secondary School,
ERIYUR - 630 212.
SIVAGANGA DIST.

yours faithfully

PRINCIPAL
SACRED HEART NURSING COLLEGE
ULTRA TRUST, MADURAI.

Dr. NALINI JEYAVANTH SANTHA
PRINCIPAL
SACRED HEART NURSING COLLEGE
MADURAI 20

APPENDIX – III

Copy of Letter seeking permission to conduct study in Government Higher Secondary School, Melur.

Sacred Heart Nursing College
Ultra Trust, Madurai

Ref: UT: SHNC: 2012

4/235, COLLEGE ROAD,
THASILDAR NAGAR,
MADURAI -625020
TAMILNADU, INDIA.

To
The principal,
Government Higher Secondary School,
Melur.

Respected sir/madam,

Sub: Sacred Heart Nursing College, Madurai – project work of M.Sc. (N) student – permission requested – reg.

We wish to state that …………………, second year M.Sc. (Nursing) student of this college has to conduct a Research Project, which is to be submitted to the Tamilnadu Dr.M.G.R. Medical University, Chennai in partial fulfillment of university requirements.

The topic of research project is **“a study to assess the effectiveness of School Based Cognitive Behavioral Depression Prevention Programme on depression and anxiert symptoms among adolescents in selected rural schools, Melur”.**

We request you to kindly permit her to do the research work in your school under your valuable guidance and suggestions.

Thanking you,

Your’s faithfully,
For Sacred Heart Nursing college
Ultra trust

APPENDIX -IV

LIST OF EXPERTS CONSULTED FOR THE CONTENT VALIDITY

1. **Dr. M. Joy Patricia Pushparani**, **MD,**
   Associate Professor of community Medicine,
   Coimbatore Medical College,
   Coimbatore.

2. **Dr. M. Kartikeyan, MD.,**
   Govt Rajaji Hospital,
   Madurai.

3. **Mrs.Devakirubai,M.Sc(N), Ph.d**
   Professor,
   Sacred Heart Nursing College,
   Madurai.

4. **Mrs. Jesinda Vedanayagi, M.Sc., (N)**
   Asst. Professor,
   Sacred Heart Nursing College,
   Madurai.

5. **Dr. B. Ananthavalli, Ph.D,**
   Director,
   Valliammal Institution,
   Madurai.

APPENDIX - V

DEMOGRAPHIC VARIABLES

Personal Background:

1. Age in Years (Completed) :

2. Sex : a. Male b. Female

3. Educational Status :

4. Habitant : a. Rural b. Any other

5. Religion : a. Hindu b. Muslim c. Christian d. Any other

6. Type of Family : a. Joint family b. Nuclear family

7. Birth order : a. 1st child b. 2nd child c. 3rd child d. More

8. Monthly Income : a. Rs.3000-5000 b. Rs. 5000 – 8000 c. Rs. 8000 – 12000 d.Above Rs. 12000

9. Alcoholic Father : a. Yes b. No

10. Academic performance : a. Good b. Average c. Poor

FAMILY BACKGROUND:

11. Are your parents living together : a. Yes b. No

12. Are you having happy parent relationship: a. Yes b. No

    If no specify the reason : __________________________

13. How close you will communicate with Your parents : a. No communication b. Close communication c. Partial communication

14. What kind of punishment you will get
    from your parents in case of any unhappy
    events : a. Beating b. Scolding
    c. No punishment

SCHOOL:

15. Are you happy with your school environment : a. Yes b. No
16. Do you have happy communication with your
    Teachers : a. Yes b. No
    If no specify the reason : ___________________
17. What kind of punishment will you receive
    From your school in case of any : a. Beating b. Scolding
    disobedience c. Kneeling c.Any other

FRIENDS:

18. Do you have cardial relationship with your friends : a. Yes b. No
    If no specify the reason :
    ____
19. Are you having any conflict with your friends : a. Yes b. No
    If no specify the reason :
    ____

RECREATION:

20. How often you will see television : a. Timely b. Always
    c. Never
21. What type of recreation activities will you like more? : a. Television b. Sports
    c. Playing d. Any other

APPENDIX – VI

6-ITEM Kutcher Adolescent Depression Scale: KADS-6

NAME: ____________________ CHART NUMBER: ____________________

DATE: ____________________ ASSESSMENT COMPLETED BY: ____________________

OVER THE LAST WEEK, HOW HAVE YOU BEEN "ON AVERAGE" OR "USUALLY" REGARDING THE FOLLOWING ITEMS:

1. **Low mood, sadness, feeling blah or down, depressed, just can't be bothered.**

   ☐ 0 - Hardly Ever ☐ 1 - Much of The Time ☐ 2 - Most of The Time ☐ 3 - All of The Time

2. **Feelings of worthlessness, hopelessness, letting people down, not being a good person.**

   ☐ 0 - Hardly Ever ☐ 1 - Much of The Time ☐ 2 - Most of The Time ☐ 3 - All of The Time

3. **Feeling tired, feeling fatigued, low in energy, hard to get motivated, have to push to get things done, want to rest or lie down a lot.**

   ☐ 0 - Hardly Ever ☐ 1 - Much of The Time ☐ 2 - Most of The Time ☐ 3 - All of The Time

4. **Feeling that life is not very much fun, not feeling good when usually (before getting sick) would feel good, not getting as much pleasure from fun things as usual (before getting sick).**

   ☐ 0 - Hardly Ever ☐ 1 - Much of The Time ☐ 2 - Most of The Time ☐ 3 - All of The Time

5. **Feeling worried, nervous, panicky, tense, keyed up, anxious.**

   ☐ 0 - Hardly Ever ☐ 1 - Much of The Time ☐ 2 - Most of The Time ☐ 3 - All of The Time

6. **Thoughts, plans or actions about suicide or self-harm.**

   ☐ 0 - Hardly Ever ☐ 1 - Much of The Time ☐ 2 - Most of The Time ☐ 3 - All of The Time

TOTAL SCORE: ☐

1

© Dr Stan Kutcher, 2006

APPENDIX – VII

BECK DEPRESSION INVENTORY

The Beck Depression Inventory is a self-rating scale that measures depression. The patient can complete the questionnaire in about 10 minutes. The total score provides an estimate of the degree of severity of the depressed mood.

QUESTIONS:

1. Sadness

    0 I do not feel sad.

    1 I feel sad

    2 I am sad all the time and I can't snap out of it.

    3 I am so sad or unhappy that I can't stand it.

2. Hopelessness

    0 I am not particularly discouraged about the future.

    1 I feel discouraged about the future

    2 I feel I have nothing to look forward to

    3 I feel that the future is hopeless and that things cannot improve.

3. Failure

    0 I do not feel like a failure

    1 I feel I have failed more than the average person

    2 As I look back on my life, all I can see is a lot of failures

    3 I feel I am a complete failure as a person

4. Loss of pleasure

    0 I get as much satisfaction out of things as I used to

    1 I don't enjoy things the way I used to

    2 I don't get real satisfaction out of anything anymore

    3 I am dissatisfied or bored with everything

5. Guilty feelings

   0 I don’t feel particularly guilty

   1 I feel guilty a good part of the time.

   2 I feel quite guilty most of the time

   3 I feel guilty all of the time

6. Punishment feelings

   0 I don’t feel I am being punished

   1 I feel I may be punished

   2 I expect to be punished

   3 I feel I am being punished

7. Self Dislike

   0 I don’t feel disappointed in myself

   1 I am disappointed in myself

   2 I am disgusted with myself

   3 I hat myself

8. Self Blame

   0 I don’t feel I am worse than anybody else.

   1 I am critical of myself for any weaknesses or mistakes

   2 I blame myself all the time for my faults

   3 I blame myself for everything bad that happens

9. Suicidal Thoughts

   0 I don’t have any thoughts of killing myself.

   1 I have thoughts of killing myself, but I would not carry them out.

   2 I would like to kill myself.

   3 I would kill myself if I had the chance.

10. Crying

0 I don’t cry any more than usual.

1 I cry more now than usual

2 I cry all the time now

3 I used to be able to cry, but now I can’t even though I want to

11. Irritability

0 I am no more irritated by things than I ever am

1 I am slightly more irritated now than usual

2 I am quite annoyed or irritated a good deal of the time

3 I feel irritated all the time now

12. Loss of interest in activities

0 I have not lost interest in other people.

1 I am less interested in other people than I used to be

2 I have lost most of any interest in other people

3 I have lost all of my interest in other people

13. Indecisiveness

0 I make decisions about as well as I ever could

1 I put off making decisions more than I used to

2 I have greater difficulty in making decisions than before

3 I can’t make decisions at all anymore.

14. Worthlessness

0 I don’t feel that I look any worse than I used to

1 I am worried that I am looking old or unattractive

2 I feed that three are permanent changes in my appearance that make me look unattractive.

3 I believe that I look ugly

15. Loss of Energy

    0 I can work about as well as before

    1 I take an extra effort to get started doing something

    2 I have to push myself very hard to do anything

    3 I can't do my work at all

16. Changes in sleep pattern

    0 I can sleep as well as usual

    1 I don't sleep as well as I used to

    2 I wake up 1-2 hours earlier than I used to an cannot get back to sleep

    3 I wake up several hours earlier than I used to and cannot get back to sleep

17. Tiredness (or) Fatigue

    0 I don't get more tired than usual

    1 I get tired more easily than I used to

    2 I get tired from doing almost anything

    3 I am too tired to do anything

18. Changes in appetite

    0 My appetite is no worse than usual

    1 My appetite is not as good as it used to be

    2 My appetite is much worse now

    3 I have no appetite at all anymore

19. Agitation

    0 I haven't lost much weight, if any, lately

    1 I have lost more than 5 pounds

    2 I have lost more than 10 pounds

    3 I have lost more than 15 pounds

20. Physical changes

   0 I am no more worried about my health than usual

   1 I am worried about physical problems such as aches and pains, or upset stomach, or constipation.

   2 I am very worried about physical problems and it's hard to think of much else.

   3 I am so worried about my physical problems that I cannot think about anything else.

21. School work

   0 Performing expected love

   1 Disinterest in school level work

   2 Doing poorly in most subjects

   3 Incapable of doing school work

SCORING:

The BDI scored by summing the ratings for the 21 items. Each item is rated on a 4 points scale ranging from 0 to 3. The maximum scoring is 63.

INTERPRETATION:

Score < 15	:	Mild depression
Score 15-30	:	Moderate depression
Score > 30	:	Severe depression

APPENDIX - VIII

BECK ANXIETY RATING SCALE

S. No	Items	Never 0	Seldom 1	Occasionally 2	Frequent 3
1.	I felt sad and depressed				
2.	I felt I had lost interest about everything				
3.	I felt that life wasn't worth living				
4.	I couldn't experience any positive feeling at all				
5.	I felt I am a person of low self esteem				
6.	I feel guilty				
7.	I found my self helpless				
8.	I felt difficult to get along with others				
9.	I found myself distructed				
10.	I found myself anxious				
11.	I found that I was very irritable				
12.	I felt interference with my physical activities				
13.	I felt interference with my school work				
14.	I found difficult in doing things				
15.	I found changing in my sleeping pattern				
16.	I felt I had a diurnal mood variation				
17.	I find I can't concentrate on anything				
18.	I feel I am having suicidal				

APPENDIX - IX

kf;fspay;j ut[

Ra tptuk;:

1/ taJ (tUlj;jpy;) :

2/ ghypdk; : m/ Mz; M/ bgz;

3/ fy;tpj; jFjp :

4/ trpf;Fk; ,lk; : m/ fpuhkg;g[wk; M/ efh;g[wk;

5/ kjk; : m/ ,e;J M/ K!yPk;

,/ fpwp!;jth; </ kw;wit

6/ FLk;g mikg;g[: m/ jdp FLk;gk; M/ Tl;L FLk;gk;

7/ gzpg[hpa[k; epiy : m/ murhq;f CHpa;h;

M/ jdpahh; CHpa;h;

,/ Rar; bjhHpy;

8/ khj tUkhdk; : m/ U/3000?5000 M/ U/5000?8000

,/ U/8000?12000 </ U/12000 nkYk;

9/ jpUkzkhdtuh? : m/ Mk; M/ ,y;iy

10/ FHe;ij tsh;g;g[: m/ bgw;nwhh; M/ jhj;jh ghl;o </ kw;wth;

FLk;g tptuk;

11/ bgw;nwhUld; ,Uf;fpwPh;fsh? : m/ Mk; M/ ,y;iy

12/ bgw;nwhUld; nrh;e;J thHtpy;iy

,Uf;fpwPh;fsh? : m/ Mk; M/ ,y;iy

,y;iybadpy; Fwpg;gpl;lhy; : ????????????????????????????????????

13/ bgwnwhUI d;vej mstpwF : m/ bj hI hg[, yi y

beUf fkhf ngRtPf s;? M/ beUf fkhd bj hI hg[

, / guht hapyyhky;bj hI hg[

14/ xU , ffI I hd R{Hypy;vej : m/ motb' Fj y;

ti fahd j z Ii di a M/j pI L th' Fj y;

bgwnwhpI k;bgWtPf s;? , /j z Ii d , yi y

gssp tptuk;

15/ gssp RwWR{Hypy;

renj hc&khf , Uf fpwPf sh?: m/ Mk; M/ , yi y

16/ Mrphpahf spI k;ngRkbghGJ

renj hc&khf , Uf fpwPf sh?: m/ Mk; M/ , yi y

, yi ybadpy; Fwpj j fhuz k; ??????????????????????????????

17/ eP f s;fHgoahj R{Hypy; : m/ motb' Fj y;

vt ti fahd j z Ii z i a M/j pI L th' Fj y;

gsspapypUe;J bgWtPf s;? , / KI ognghLj y;</ kwwi t

ez ghf s;

18/ c' f s;ez ghf SI d;kdk; : m/ Mk; M/ , yi y

beUf fkhd cwt[cz I h?

, yi ybadpy; Fwpj j fhuz k; ??????????????????????????????

19/ eP f s;c' f s;ez ghf SI d;: m/ Mk; M/ , yi y

nkhj y;VwgI Lssj h?

, yi ybadpy; Fwpj j fhuz k; ??????????????????????????????

, i HgghUj y;neuk;(m) bghGJ nghf;F neuk;

20/	bj hi yf hl rpi a ghhggj wF :	m/ F wpggpl l neuk;
	vt;tst [neuk; brytpL tPf s?;	M/ vgnghJ k; , / , yi y
21/	vej ti f ahd bghGJ nghfi f	m/ bj hi yf hl rp
	mj pf k; tpUkg[tPf s;?	M/ tpi sahl L
		, / tpi sahLj y;</ kwwi t

APPENDIX – X

, staj py;VwgLk;kd mGj j j j pwfhd mst[nfhy;(fl rh)

bgah;: nj j p:

nfs;tpfs;:

1/ tpUggkpdi k. J }ffk; j hH;thf epi dj j y; kdrnrhh;t[ahUk; fz L bfhssh j epi y

m/ 0? vgnghJ k;, yi y M/ 1?rpy neu' ;fspy;

, / 2? Mj pf neu' ;fspy; </ 3?vgbghGJ k;

2/ kj pggpdi k. ekgpf i f , yyhj vz z ' ;fs; kwwthf i s j hH;thf epi dj j y;j di dj j hnd j hH;thf epi dj j y;

m/ 0? vgnghJ k;, yi y M/ 1?rpy neu' ;fspy;

, / 2? Mj pf neu' ;fspy; </ 3?vgbghGJ k;

3/ nrhh;thd vz z k;j sh;thd vz z k; rj ;J f Fi wt[CfF tpggj py;f tdk; twgl;Wj j pnti y braj y;

m/ 0? vgnghJ k;, yi y M/ 1?rpy neu' ;fspy;

, / 2? Mj pf neu' ;fspy; </ 3?vgbghGJ k;

4/ vgbghGJ k;vdf F cl yepi y rhpapyi y vd;Wk;kfpHrrp , yi y vd;Wk;vz z k;cUthFj y;

m/ 0? vgnghJ k;, yi y M/ 1?rpy neu' ;fspy;

, / 2? Mj pf neu' ;fspy; </ 3?vgbghGJ k;

5/ fti yahd vz z ' ;fs; gj l;l k; eLf fk; kdmGj j k;kwWk; nfhgk;

m/ 0? vgnghJ k;, yi y M/ 1?rpy neu' ;fspy;

, / 2? Mj pf neu' ;fspy; </ 3?vgbghGJ k;

6/ j wbfhi y vz z k; Kawrp j di dj j hnd tUj j pbfhs;tJ

m/ 0? vgnghJ k;, yi y M/ 1?rpy neu' ;fspy;

, / 2? Mj pf neu' ;fspy; </ 3?vgbghGJ k;

APPENDIX – XI

kd mGj j k;mwpF wpgl pay;

kd mGj j mwpF wpgl pay; vdgJ j di dna mwpe;J bfhs;Sk; mst[hfhy;/ khz thf;s; bfhL f;f ggl ; nfs;tpf S f;F gj ;J epkpl j ;J f;F s; gj py; mspf;f ntz ;Lk;/ , ej kj pgbgz ; Kyk; kd mGj j j j pd;epi yi a mwpe;J bfhs;syhk;/

nfs;tpfs;

1/ J f;f kpdi k

0 ? J f;f khf ehd;cz u khl ;nl d;

1 ? J f;f khf cz h;ntd;

2 ? vyyh neu' ;f sp;Yk;J f;f khf , Ug;ngd; kw;Wk; mi j cl nd tpl khl ;nl d;/

3 ? ehd;J f;f khf , Ug;ngd;(m) kf;pHr;rpahf , Uf;f khl ;nl d;/

2/ ekgpf;i f aPd;i k

0 ? ehd;Kf;f pakhf vj pH;f hyj i j gw;wp ekgpf;i f , yyhky;, Uf;f pnwd;/

1 ? vj pH;f hyj i j gw;wp ekgpf;i f , yi y

2 ? gpd;dhy;el ggi j gw;wpa f ti y , yi y

3 ? vdf;F vj pH;f hyj i j gw;wpa ekgpf;i f , yi y/ mi j vd;dhy;j pUj j pf;bfhs;s t[k;, aytpy;i y/

3/ nj hy;tp

0 ? ehd;nj hy;tpi a cz u khl ;nl d;

1 ? vdf;F nj hy;tp Vwgl ;l hy;ruhrhp kdpj i dg;nghy; tUj j ggL ntd;/

2 ? mj dhy;vdJ thH;f i fi a j pUkgp ghh;g;ngd; ehd; ghhj j J epi wa nj hy;tp

3 ? ehd;KGtj pYk;nj hy;tpa[w;w kdpj dhf , Uf;f pnwd;/

4/ , Hej kfpHrrp

0 ? ehd;braf;pdw tpca' ;fs;mtDf;F kdepi wt[fpi l ggJ

1 ? ehd;braf;pdw tpca' ;fs;vej tpj j j pYk;kfpHrrp mspggj pyi y

2 ? cz i kahd kdepi wt[fpi l f;f tpyi y

3 ? mej brai fapy;kdepi wt[, yi y/ vyyhnk bore-Mf , Uf;F/

5/ j hH;t[kdgghdi k

0 ? Kf;fpakhf tUj j ggl khI nI d;

1 ? tUj j ggLntd;Mdhy;eyy tpca' fSf;F tUj j ggLntd;

2 ? mj pf neuk;j hH;t[kdgghdi kapy;tUj j ggLntd;

3 ? vej neuKk;tUj j ggLntd;

6/ j z I i d cz hrrp

0 ? vdf;f j z oj j hYk;fti yggl khI nI d;

1 ? vdi d j z oj j hy;ehd;tUj j ggl khI nI d;

2 ? j z I i di a vj phgghhgngd;

3 ? j z I i d bfhLj j ggpd;tUj j ggLntd;

7/ j di dna gpof;fhj epi y

0 ? vdi dggwwp f ti yggl khI nI d;

1 ? vdi d gwwp f ti yggLntd;

2 ? vdf;Fs;nfs;tp nfI ngd;

3 ? vdi d ehnd btWgngd;

8/ j dj dna Fi wthf epi dj j y;

0 ? kwywthf;fi s tpl kl jl khf , Uej hYk;ehd; tUj j ggl khl;nl d;

1 ? vd;ndhl Fi w. Fwyw' ;fi s ehnd mwpn;td;

2 ? ehd;bra;f;pd;w j tWfSf;f vdj d ehnd j pl;Lntd;

3 ? Vnj Dk;bfl l jl j hf el ej hYk;vdj dna ehd; j pl;of;bfhs;ntd;/

9/ j wbf hi y vz z ' ;fs;

0 ? vdj d ehnd bf hyy epi dj j j pyj y

1 ? ehnd j wbf hi y gz z ntz ;Lk;vd epi dgnd; Mdhy;braygLj j Koatpyj y

2 ? vdj d ehnd j wbf hi y bra;J bf hss tpUkgi;td;

3 ? xU thagg[f pi l j j hy;vdj d ehnd j wbf hi y bra;J bf hs;ntd;

10/ mGj y;

0 ? vgbghGJ k;mGtJ nghy;mGntd;/ mj pf khf mHkhl ;nl d;

1 ? vgbghGJ k;mGti j tpl . , gbghGJ mj pf khf mGntd;/

2 ? , gbghGJ neuKk;mGntd;

3 ? vd;dhy;mH Koa[k;/ Mdhy;vd;dhy;mGfntz ;Lk; vd epi dj j hYk;Koatpyj y

11/ nf hg Kl ;Lj y;

0 ? , dpnky;nf hg Kl ;Lti j vd;dhy;bghUj ;J f; bf hss KoahJ /

1 ? tHf;fj j pwF khwhf ehd;rpwpj st[nf hgg; gLj j ggl ;nl d;

2 ? xU eyy neuj j py;vdj d nf hgggLj j p tpl ;l hhf;s;

3 ? vyyh neuKk;ehd;nf hggl ;nl d;

12/ brayj pl l j j py;Mh;t k;, yi y

0 ? kwywthf shy;vdDi l a Mh;t j i j ehd;
, Hf f t pyi y

1 ? vgbghGJ k;, Uggi j tpl kwywthf spl k;rpwgj st[
Mh;t k;f hl Lnt d;

2 ? kwywthf shy;vdDi l a Mh;t j i j mj pf khf
, He;J tpl nl d;

3 ? kwywthf shy;vdDi l a Mh;t j i j KGi kahf
, He;J tpl nl d/

13/ Kot pyyhi k

0 ? vd;dhy;Koej i j kl Lk;Kobt Lgngd;

1 ? vd;dhy;Koej i j tpl mj pf khf Kobt Lgngd;

2 ? Kot [vLggj wnf f c;l khf cssJ

3 ? , dpky;vd;dhy;Kont vLf f KoahJ /

14/ kj pgg[, yyhi k

0 ? ehd;vggt k;, Uggi j tpl kj pggpyyhj i j gwwp
f ti yggl khl nl d;

1 ? vdDi l a mGf pdi ki aak;taj hti j ak;
epi dj ;J f ti yggLnt d;

2 ? mHf pyyhj j di k KdW cssJ / mJ bts gj ;
nj hwwj j py;kj pgg[, yyhky;, Uf Fk;

3 ? ehd;mrp' f khf , Uggj hf ekg Fpnwd;

15/ rf j p, yyhj epi y

0 ? vgbghGJ k;nghy vdDi l a nti yi a branj d;

1 ? ehd;nti yi a braaj ;J t ' Fk;nghJ rpwpJ Kawrp
vLj ;J brant d;

2 ? ehd;braf pdw nti yi a twg Wj j p brant d;

3 ? vd;dhy;vd;nti yi a braa Koat pyi y

16/ J}ff;j;jpy;khw;wk;

0 ? ehd;vg;bghGJk;nghy J}';Fntd;

1 ? ehd;vg;bghGJk;nghy J}';fkhl;nld;

2 ? 2 kz pneuj;jpw;F Kd;tpHpj;J tpLntd;/ mjdhy; J}ff;k;tutpy;iy

3 ? gykz pneuj;jpw;F Kd;vGe;J tpLntd;/ mjdhy; J}ff;k;tutpy;iy

17/ nrhh;t[

0 ? ehd;vg;bghGJk;, Ugg;J nghy;, Ugnd;/ fi;yggi;la khl;nld;

1 ? buhkg rP;f;pukhf fi;yggi;lntd;

2 ? vej xU nti;y braj;hYk;fi;yggi;lntd;

3 ? rpwpa nti;y braj;hYk;buhkg fi;yggi;lntd;

18/ grp khw;wk;

0 ? tHf;fk;nghy;grpf;Fk;

1 ? tHf;fkhf grpgg;J nghJ , y;iy

2 ? grpapdi;k buhkg , Uf;F

3 ? grp vd;gnj , y;iy/

19/ fti;y

0 ? fti;y bfhz;l hy;cl;kg[Fi;wa[k;

1 ? fti;yggl;lj;hy;5 fpnyh Fi;we;J tpl;nld;

2 ? fti;yggl;lj;hy;10 fpnyh Fi;we;J tpl;nld;

3 ? fti;yggl;lj;hy;15 fpnyh Fi;we;J tpl;nld;

20/ cly;py;khw;wk;

0 ? vJ el;ej;hYk;, dpky;vd;cl;ki;g gw;wp fti;yg; gl;khl;nld;

1 ? ji;ytyp cl;kg[typ taw;Wtyp tej;hy;fti;yg; gLntd;/

2 ? cl;kg[cghi;j fs;, Uej;hYk;kw;wi;j ggw;wp nahrpgnd;

3 ? cl;kg[cghi;j fs;rhpapy;iy vd;why;kw;wi;j gw;wp nahrpf;f khl;nld;

21/ gss,pnti y

0 ? vj pd;ghh;f;Fk; mstpw;F vd;nti yi a Koj ;J tpLntd/ mi dthpd; KK;mdg;hf ele;J bfhs;ntd;

1 / gss,pnti yapy; Mh;tk;, yi y

2 ? ghl j j py; mj pf kej khf epi yapy;, Uf;f pnwd;

3 ? gss,pnti yi a bra,a Koatpy;i y

APPENDIX - XII

fti yg;gwwpa mst[nfhs;(bgf)

t/vz ;	nfs;tpfs;	vgnghJ k; , yi y 0	rpy neu' fspy; 1	Mj pfkhf , Ujj y; 2	vgbghGJ k; 3
1/	KrRj j pz wy;				
2/	, ut [neuj j py;J }' Ftj py;rpukk;				
3/	kaf;fk;(m) kgj khd j i ytyp				
4/	Kfk;rptj j y;				
5/	j i y Rwwy;				
6/	, wggi j fz ;L gak;				
7/	j ti w epi dj ;J gak;				
8/	R{l hd vz ;z k;				
9/	KrR mi l ggJ nghy;cz h;t[				
10/	j dj d fl ;LggLj ;J tj py;rpukk;				
11/	i ffs;eL f;fk;				
12/	, j a J ogg[mj pfhpj j y;				
13/	brwpkhdkpki k (m) tapwWf;nfhshU				
14/	gj l l ;k;				
15/	kj kj gg[				
16/	fi l rpj Uz j j y;				
17/	XLk;vz ;z ' f;s;				
18/	mi rf;fggLj y;				
19/	tpahj j y;				
20/	btWgghd vz ;z k;				
21/	Xa;t[vLggj py;fodk;				
22/	epi yFi yj y;				
23/	fhy;fs;kWj ;J nghj y;				

ti fgghL

0?16 ? kgj khd nfhgk;

17?30 ? mj pfkhd nfhgk;

31f;F nky; ? kpf mj pfkhd nfhgk;

APPENDIX - XIII

COPING WITH DEPRESSION COURSE

SESSION – I

DEPRESSION AND SOCIAL LEARNING

GOALS:

This session presents an outline of the social learning view of depression. This course is intended to teach you the skills you will need in order to learn to become "undepressed". The goals are,

1. To become familiar with the social learning approach to depression
2. To understand what the implications of the social learning approach to depression are for you and how this knowledge can help you to care with depression.

AGENDA:

1. Business:
2. Introduction and ground rules
3. Get acquainted exercise
4. The social learning approach
5. Homework assignment session
6. Review session 2 and assign homework

BUSINESS:

- ❖ Introduce class members to each other
- ❖ Draw a small seating chart to help remember names.
- ❖ Make sure everyone has the participant work book for the coping with depression course.

INTRODUCTION:

It is always difficult to get started on something now. Congratulations you have taken the first step by enrolling in this course and coming to the first session.

- ❖ The benefits that you receive from this course are largely determined by your willingness to keep an open mind and try new things.
- ❖ You can learn to control your depression and improve your mood.

- ❖ Depression is the result of problems in living
- ❖ The coping with depression course is skill and task oriented.
- ❖ Homework assignments are required
- ❖ Students are responsible for learning new skills
- ❖ The instructor is a teacher and facilitator
- ❖ This course is an opportunity for you to learn new and useful skills to control your mood.
- ❖ At the end of the course the skills that work for you will be used to develop a life plan.
- ❖ The course is not therapy or counseling.

GROUND RULES:

- ❖ Avoid depressive talk
- ❖ Be supportive avoid criticizing others try to reward others by finding the positive aspects of what they are saying.
- ❖ Provide equal time-everyone should have an opportunity to share ideas ask questions and discuss difficulties that they may encounter in applying the techniques.
- ❖ Confidentiality – Important to honor the confidentiality of personal information that is offered in group sessions.

EXERCISE:

- ❖ Share information about their backgrounds and areas of interest.
- ❖ The first exercise is to get to know each other. The class will be divided into smaller groups so that you will feel more comfortable.

RATIONALE AND OVERVIEW OF THE SOCIAL LEARNING:

A. Ways of thinking about depression.

- ❖ Depression is a disease
- ❖ Depression is due to some underlying pathology.
- ❖ Depression is related to problems in living.
- ❖ Depression is a signal that there is something lacking or off balance.
- ❖ There are multiple roads to depression

- Interactions that were a source of positive outcomes are no longer available (someone close to you dies (or) moves.

B. People who are depressed have learned to behave think and feel

- Behaviour thinking and emotions.
- How we interact with our environment (for e.g. how we interact with others)
- Depressive behaviour are those behaviours associated with unpleasant (or) dissatisfying outcomes (i.e. behaviours that have negative consequences).

B. Thinking – Thoughts regarding our interactions with our environment is a very important factor (thoughts that one is useless, boring, unattractive, stupid, incompetent and so on).

C. Emotions – Feelings give us a global index of how our life is going.

C. The depressive cycle may start anywhere in this triad.

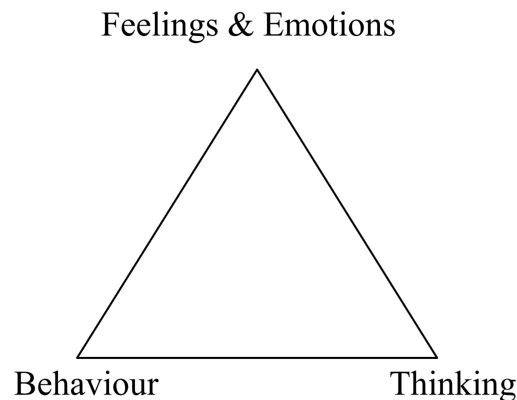
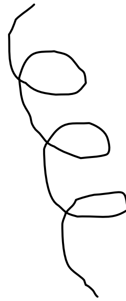


Illustration:

When we feel bad we are loss likely to initiate behaviorus and we have doubts about our ability to engage successfully in the behaviour. When we are successful at something we feel good and gain self confidence. When we feel that we can do something well we are more likely to initiate the action.

3. The depressive spiral

Feel Depressed



Engage in few interaction with positive

Outcomes

Feel more depressed

Become less active

Feel even more depressed

Do even less

The skills that can change this depressive spiral:

1. The skills area related to behaviour are,
    a. Pleasant activities
    b. Social skills
2. The skill area related to thinking are,
    a. Constructive thinking
    b. Balancing positive and negative thoughts
3. The skill area related the feeling is relaxation.

HOME WORK ASSIGNMENT:

- ❖ Complete the pleasant events schedule
- ❖ Monitoring daily mood rating form

B. MOOD MONITORING:

- ❖ Problems remembering by doing at the same time each night.
- ❖ Remember to record your average mood for the day.

SESSION – 2

HOW TO DESIGN A SELF CHANGE PLAN

GOALS:

This session focuses on the basic steps for designing a self change plan. The goals are,

A. To learn how to develop a systematic self change plan.
B. To learn how to apply those basic self change methods in order to alleviate specific problems that you may be experiencing.

AGENDA:

1. Introduction
2. Review session 1 and related homework
3. Rationale for session 2
4. Lecture: self change skills
5. Review session 2 home work
6. Review session 3 and assign homework

INTRODUCTION:

- ❖ Your expectations are important
- ❖ Your expectations must be kept within realistic limits.

REVIEW SESSION 1 AND RELATED HOMEWORK:

- ❖ Depression is a problem in living
- ❖ Three facts of a mutually interactive system are behavior thinking and feeling each influences the others.
- ❖ The two spirals, negative and positive
- ❖ Skill building is the focus in general.
- ❖ Specific skills
    - o Relaxation
    - o Pleasant activities
    - o Constructive thinking
    - o Social skills

RATIONALE:

Today you will learn step by step self change skills your can use to change the problems you have identified self control is different from will power self control is a skill that you can learn.

LECTURE: SELF CHANGE SKILLS:

There are seven steps

a. Pinpointing the problem

- ❖ Pinpoint a behaviour (or) thought (not a feeling)
- ❖ The behaviour (or) thought must be specific observable and countable.

b. Base lining (or) gathering information keeping track of your progress.

- ❖ Set a reasonable goal for change

C. Discovering antecedents:

- ❖ It occur before we engage in given behaviour

There are 4 types of antecedents

1. Social situations
2. Your own feelings and thoughts
3. Physical circumstances
4. The behaviour of other people

You can control antecedents in three ways

1. Avoid them
2. Change them
3. Not respond to them

D. Discovering consequences:

1. Consequences are events that happen after we engage in a behavior.

There are two main kinds of consequences

- ❖ Reactions from other people
- ❖ Our own reactions that is things we say to ourselves.
- ❖ To increase a behavior you want the behavior to be followed by many positive consequences and few negative ones.

- ❖ To decrease a behavior, you don't want the behavior to be followed by positive consequences.

E. Setting goals – Your goals should be alterable and attainable.

F. Contracting – Reward yourself if your accomplish certain steps towards goals.

G. Choosing reinforces – Reinforces should be

- ❖ Make you feel good
- ❖ Be accessible
- ❖ Be powerful
- ❖ Be under your control
- ❖ Be as close in time as possible to goal achievement

REVIEW SESSION 3 AND ASSIGN HOMEWORK REVIEW:

- ❖ Tension gets in the way of doing things that are necessary to overcome depression.
- ❖ Relaxation is a skill that takes practice to develop.
- ❖ The common procedure are Jacobson's progressive deep muscle relaxation.
- ❖ Continue to monitor your daily mood.
- ❖ Fill out the daily monitoring relaxation form each day.

SESSION – 3

LEARNING TO RELAX

GOALS:

This session teaches some basic relaxation skills.

The goals are,

A. To determine your current base level of relaxation. This will allow you to evaluate your progress as you learn to relax more.

B. To identify particular situations and (or) times of the day when you are the most tense.

AGENDA:

- Introduction
- Review session 2 and related homework
- Rationale for session 3
- Lecture – Progressive relaxation
- Review session 3 homework
- Review session 4 and assign homework

INTRODUCTION:

a. Change – It can be scary make change in your life.

b. Helping others – I hope that in this class you will be supportive helpful and understanding with each other.

c. Process comments – This is a good time for discussion.

REVIEW SESSION 2 AND RELATED HOMEWORK:

- Basic self change skills are the foundation for the course.
- Steps for making a self change plan
- You should understand that self control is not the same as will power.

RATIONALE:

a. Tension gets in the way of overcoming your depression.

- Tension interferes with enjoying things that you might otherwise enjoy.
- Tension causes fatigue and tension headaches.
- Expectations of complete relaxation are unrealistic. A certain adaptive level of tension is necessary in order to function effectively.

LECTURE: PROGRESSIVE RELAXATION:(using AV aids)

A. The Jacobson progressive deep muscle relaxation procedure.

1. Tense and relax major muscle groups:

a. First major muscle group.

1. Hands out arms – make a tight fist.
2. Biceps – push down on the arm of a chair with your elbow, or pull your elbows in toward your body, or bring your forearm up against your biceps.

b. Second major muscle group.

1. Forehead – lift your eyebrows or produce a “knit brow”.
2. Upper cheeks and nose – squint your eyes and wrinkle your nose.
3. Lower cheeks and jaws – clench your teeth and pull back the corners of your mouth.
4. Neck and throat – pull your chin down or press your neck against the back of the chair.

c. Third major muscle group.

1. Chest – take a deep breath and hold it.
2. Shoulders and upper back – move your shoulders into an exaggerated shrug or touch your shoulders together behind your back.
3. Stomach – tighten your stomach as if you were going to hit yourself.

d. Fourth major muscle group.

1. Thighs – press your heels into the ground or lift your legs slightly off the ground or press your knees together.
2. Calves – push your toes into the ground or point your toes away from your head or point your toes toward your head.
3. Feet – turn your feet inward and curl your toes under.
3. Bring participants back to attention slowly.

V. LECTURE:

B. The Benson relaxation Procedure.

1. Preliminary steps.
    a. Choose a quiet, comfortable environment.
    b. Choose a quiet time a day, for example, two hours after a meal.
    c. Choose a word or phrase to repeat to yourself (e.g. “one”).
    d. Develop a passive attitude.
    e. Choose a comfortable position.
2. Description of the procedure
    a. Sit quietly in a comfortable position.
    b. Close your eyes
    c. Progressively relax your muscles.
    d. Breathing – say “one” as your breathe out.

e. Do this for 10 to 20 minutes – then sit quietly for a few minutes.

VI. REVIEW SESSION 3 HOMEWORK:

In small groups or in the whole group, help participants calculate their weekly average tension level for their most relaxed time, their least relaxed time, and their overall average.

1. In small groups, have participants generate their own problem situation lists so that they will be prepared for the next homework assignment.
2. In the whole group, it is suggested that a list of problem situations be listed on the blackboard.

VII. PREVIEW SESSION 4 AND ASSIGN HOMEWORK:

A. Preview: Relaxation in problem situations.

1. Relaxation skills become particularly important when they are used before or during anxiety-producing situations. This session is aimed at helping you become more relaxed in general and in specific problem situations.
2. Continue to monitor your daily mood
3. Practice relaxation procedures for at least 30 minutes daily using the Jacobsen procedure, the Benson procedure, or some combination.
4. Evaluate your progress by filling out the entire Daily Monitoring – Relaxation form each day.
5. Complete the Daily Monitoring – Relaxation in Problem Situations form each day.

SESSION – 4

RELAXATION IN EVERYDAY SITUATIONS.

GOALS:

This session will focus on practicing relaxation skills or using them in everyday situations when your experience stress (or) tension.

The goals are,

- ❖ To learn become more relaxed by practicing a relaxation technique.
- ❖ To identify particular situations and when your are the most tense.

AGENDA:

1. Introduction
2. Review session 3 and related homework.
3. Rationale for session 4
4. Lecture – Relaxation in everyday situations
5. Review session 4 homework.
6. Review session 5 and assign homework.

INTRODUCTION:

You have now had a few days to practice using the first skill for controlling depression – relaxation. You have also collected some baseline information about your overall tension level and about tension in problem situations. All of this new input and homework may feel somewhat overwhelming. Don't feel discouraged, try to "hang in there" and keep up the good work.

REVIEW SESSION 3 AND RELATED HOMEWORK:

A. Review Session 3: Progressive Relaxation

- ❖ Tension gets in the way of overcoming depression
- ❖ Anxiety and tension are survival responses with evolutionary value.
- ❖ Relaxation is a skill that takes practice
- ❖ Two common procedures are Jacobson's progressive deep muscle relaxation and Benson's relaxation procedure.
- ❖ You should be practicing one of the relaxation procedures (or a combination of them) daily in order to lower their average daily tension level.
- ❖ Progressive deep muscle relaxation is useful because it allows you to get a running start on relaxation by helping you to distinguish between tension and relaxation states.
- ❖ The Benson procedure is useful because it is portable and less conspicuous.

B. Review homework:

- ❖ How is your relaxation practice going? Any problems? Stress the importance of regular practice for mastering the skill.
- ❖ Check on tracking (Daily Monitoring – Relaxation form). Reinforce successes and trouble-shoot problems.

RATIONLE:

Finding out what situations are particularly tension-producing for you is an important step toward using relaxation skills efficiently. After identifying problem situations, you can schedule your relaxation practice to help you approach these situations in a more relaxed mood, or your can use "portable" relaxation techniques when you notice yourself becoming tense.

LECTURE: RELAXATTION IN EVERYDAY SITUATIONS:

Applying relaxation skills in everyday situations requires some creativity.

- ❖ To identify situations that are accompanied by high levels of tension, look at your Daily Monitoring – Relaxation form.
  - o Do your tension levels follow any particular pattern?
  - o Are there specific times of day situations in which you tend to feel more tense?
- ❖ Try to schedule relaxation practice sessions just before these tension-producing situations. Even a few minutes of practice is better than none.
- ❖ Try imagining yourself acting in a calm manner as you enter a stressful situation.

REVIEW SESSION 4 RELATED HOMEWORK:

A. Note patterns of tension from your Daily Monitoring – Relaxation form.

1. Times of day
2. Good or bad situations (antecedents)

B. Discuss relaxation practice

1. Relaxation ratings
2. Successes or failures.

C. Review your Daily Monitoring – Relaxation in Problem Situations form.

1. Are the problem situations pinpointed enough/too much?
2. Expand your list if necessary.
3. Prioritize the Problem Situations list.

PREVIEW SESSION 5 AND ASSIGN HOMEWORK:

A. Preview: Pleasant Activities.

1. The frequency with which you engage in pleasant activities has an impact on depression.
2. Plan to work on increasing your participation in pleasant activities and se how it relates to your mood.
3. Give out personalized lists of pleasant activities.

B. Assign homework

1. Continue to monitor your daily mood.
2. Practice using relaxation in problem situations and monitor your progress by completing the Daily Monitoring – Relaxation in Problem Situations form each day.
3. Monitor your daily rate of pleasant activities, using the Activity Schedule.
4. Graph your mood and level of pleasant activity.

SESSION – 5

PLEASANT ACTIVITIES AND DEPRESSION

GOALS:

This session will focus on the relationship between engaging in pleasant activities and being depressed. The goals are

- ❖ To determine your level of pleasant activities.
- ❖ To assess the degree to which your frequency of pleasant activities and the extent to which you are enjoying them may be contributing to your depression.

AGENDA:

I. Introduction

II. Review session 4 and related homework

III. Rationale for session 5

IV. Lecture: Pleasant activities

V. Review session 5 homework

VI. Preview session 6 and assign homework

I. INTRODUCTION:

You can't expect to feel good all of the time. Everyone has his or her bad days. You won't be able to eliminate them completely. It is important for you to set realistic goals ("I want to feel good most of the time" or "I would like to be more in control or my mood"). Depression often results when people set unrealistically high goals. You need to learn to establish limited, achievable goals.

REVIEW SESSION 4 AND RELATED HOMEWORK:

A. Review: Relaxation in everyday situations

- ❖ Take a deep breath and focus on your breathing for a few minutes.
- ❖ Repeat your special relaxation word to yourself for a couple of minutes.
- ❖ Picture yourself relaxing in your favorite place.
- ❖ Relax the muscles that feel the most tense.

B. Review Homework

- ❖ Review your Daily Monitoring – Relaxation in Problem Situations form.
- ❖ Note changes in tension levels across the same situations before and after intervention.
- ❖ Reinforce any successes, no matter how small they may be

RATIONALE:

A. Research has shown that the rate of pleasant activities and occurrences of depression are reciprocally related. This gives you a powerful tool for learning how to control your depression.

- ❖ When you are depressed, you are less motivated to do things. This results in a decrease in pleasant activities (and activity level in general).
- ❖ When your rate of pleasant activities falls below a critical level, your are very likely to become depressed.

LECTURE: PLEASANT ACTIVITIES:

A. There is a subset of pleasant activities that is especially important in determining depression, i.e. mood related activities. These are starred items on the Pleasant Events Schedule.

- ❖ Pleasant social interactions – interactions with others that are experienced as positive and pleasurable (e.g. expressing affection, frank and open conversations with friends).
- ❖ Competency experiences-experiences that make us feel skilled or competent (e.g. successfully learning to do something new, performing a task well).
- ❖ Incompatible responses – activities that are incompatible with feeling depressed (e.g. calling a good friend, sleeping well, laughing, being relaxed).

B. The information obtained from the Pleasant Events Schedule is scored as follows:

- ❖ Frequency score- how often you engaged in pleasant activities in general at the time of the test.
- ❖ Potential enjoy ability score-this is an index expressing how pleasant a particular activity was at the time of the test.
- ❖ Cross-product score-this is a measure of the pleasure obtained from the activities that you were engaged in.

C. Some general antecedents for problems with pleasant activities.

- ❖ Pressure from activities (Type A) that are not pleasant but must be performed (e.g. homework interferes with dancing on Friday night).

  Solution: Use time management to make sure that homework is completed before Friday night.
- ❖ Lack of care in choosing activities, resulting in a poor match between what one likes to do and what one actually does (e.g. spend the weekends working around the house instead of going fishing).

  Solution: Try to make time for the things you like to do.

- Sometimes a change will take place that removes the availability of a pleasant event (e.g. someone dies, you move, you get a divorce).

  Solution: Work on finding substitute pleasant activities.
- Anxiety and discomfort interfere with enjoyment (e.g. lack of social skills causes a person to be anxious at parties).

  Solution: Identify the source of interference (e.g. tension, lack of social skills) and work on removing it.

REVIEW SESSION 5 HOMEWORK:

A. Any problems monitoring pleasant activities each evening?

B. Check pleasant activities graph and activities schedule

- Check for patterns between mood and pleasant activities.
- Does there seem to be a critical number of pleasant activities associated with an acceptable mood score for you?
- Are there particular activities that seem to have a powerful impact on your mood?

PREVIEW SESSION 6 AND ASSIGN HOMEWORK:

A. Preview: Writing a pleasant activities plan.

1. It is important to get started right away on writing a plan for increasing pleasant activities.
    a. Set a goal that strikes a balance between pleasant and unpleasant activities.
    b. Plan ahead by filling out the schedule.
    c. Select activities that are potentially pleasant for you, make sure to select activities that are available.
    d. Set modest goals; an increase of one to five pleasant activities per day over baseline rate is appropriate.
    e. Reward yourself for achieving your goals.
    f. Evaluate your progress.

B. Assign homework

1. Have the students turn to session 6 in their workbooks.
    a. Continue to monitor your daily mood.

b. Formulate a written plan for increasing your daily rate of pleasant activities.
c. Begin to implement your pleasant activity plan. Evaluate your progress by continuing to monitor your daily rate of pleasant activities on the Activities Schedule.

SESSION – 6

FORMULATING A PLEASANT ACTIVITIES PLAN

GOALS:

This session is intended to help you in planning to increase your rate of pleasant activities. The goals are,

- ❖ To become aware of the importance of specific activities that are especially related to your daily mood.
- ❖ To design and implement a self change plan aimed at increasing pleasant activities.

AGENDA:

1. Introduction
2. Review session 5 and related homework
3. Rationale for session 6
4. Lecture: Pleasant activities plan
5. Review session 6 homework
6. Preview session 7 and assign homework

INTRODUCTION ;We can help each other learn and make the class enjoyable. Whether or not your maintain the gains that you achieve in class, however, will depend upon your own individual efforts.

REVIEW SESSION 5 AND RELATED HOMEWORK:

A. Review: Pleasant activities

- ❖ The number of pleasant activities your engage in is related to your mood.
- ❖ If the number of pleasant activities falls below a critical level, your mood is likely to become increasingly depressed.

- It is important to achieve a balance between neutral or unpleasant activities, and pleasant activities.

B. Review homework

- Any problems monitoring activities?
- Check graphs. Is there a relationship between mood and pleasant activity level?
- Have you noticed any changes in your mood since you began to work on increasing pleasant activities?

RATIONALIE:

A. Pleasant activities give you a "handle" on your mood. You can control your mood by attending to the balance between pleasant activities and neutral or unpleasant activities and by planning to keep your rate of pleasant activities at an adequate level.

LECTURE: MAKING A PLEASANT ACTIVITIES PLAN

A. A good plan is one that you will be able to follow consistently.

B. Objective: To achieve a modest increase in your rate of pleasant activities from baseline level. This can be accomplished by increasing the rate of activities that you have enjoyed before, or by engaging in some new activities.

C. Some general considerations to keep in mind.

- The following can contribute to a low rate of pleasant activities.
    - Pressure from outside activities.
    - Choosing activities that are not highly pleasant.
    - Excessive anxiety or discomfort can interfere with your enjoyment of pleasant activities.
- Commitment – You must commit yourself to putting the plan into effect. In order to do this, you must be willing to make choices, establish priorities and rearrange your life a bit.
- Balance-the goal is to achieve a balance between the things that you must do and the things that you want to do.
- Planning-try to anticipate any problems or circumstances that might interfere with completing your plan. How will you take care of demands

on your time that might prevent you from engaging in pleasant activities?

- ❖ You will achieve a feeling of control over your life to the extent that your stick to your plan. By controlling your time, you are controlling your life.

Planning ahead:

a. Commit yourself to engaging in more pleasant activities.

- ❖ Schedule your pleasant activities at least one day in advance.
- ❖ Don't let yourself back out or give excuses.
- ❖ Specify the time and place.

b. Anticipate problems and try to prevent them (e.g. unplug the telephone, arrange for a babysitter, make dinner reservations).

Setting a specific Goal:

a. Look at your baseline rate and decide what level would represent a modest increase. Make sure that the increase is reason able and attainable.

Reward yourself for attaining goals:

a. Include a contract for rewarding yourself. This will increase your chances for success.

Check your progress – you may want to adjust your plan if it is too ambitions or not ambitious enough.

PREVIEW SESSION 7 AND ASSIGN HOMEWORK:

A. Preview: Thinking and depression

1. Two approaches to controlling your thoughts.

- ❖ Increasing positive thoughts and decreasing negative thoughts.
- ❖ Constructive thinking: the ABC method.

2. You will be required to choose one of the two techniques.

B. Assign homework. Again, have the students open their workbooks and follow along.

1. Continue to monitor your daily mood.
2. Continue to implement your pleasant activities plan and evaluate your progress.

SESSION – 7

APPROACHES TO CONSTRUCTIVE THINKING

GOALS:

- ❖ To develop a working knowledge of two different approaches to more constructive thinking
- ❖ To make an informed choice as to which of these two approaches you will utilize to help you to think more constructively.

AGENDA:

1. Introduction
2. Review session 6 and related homework
3. Rationale for session 7
4. Lectures: Controlling your thoughts; constructive thinking
5. Review session 7 homework
6. Preview session 8 and assign homework

INTRODUCTION:

You have made it half way through the course. Congratulations! You have learned how to relax and how to monitor and increase your pleasant activities. Techniques for improving your thinking and social skills are yet to come. Keep up the good work.

REVIEW SESSION 6 AND RELATED HOMEWORK:

A. Review: Following a pleasant activities plan.

- ❖ Because pleasant activities are an important "handle" on mood, the main goal is to achieve an increase in your pleasant activities by developing a self-change plan.
- ❖ A balance is needed between Type A and Type B activities.
- ❖ Plan ahead by committing yourself to engage in more pleasant activities, anticipating problems, and filling out a schedule.
- ❖ Set a specific goal that represents a modest increase in rate over baseline.
- ❖ Reward yourself for attaining your goals.

B. Review homework. Take out your Pleasant Activities form whether you've done the assignment or not so you can follow along.

- Did you succeed in carrying out your plans? If not, have the members of the group help you to problem solve. Did you remember to reward yourself?
- Are there any volunteers who are willing to show their graphs?
  - Is there a noticeable rise in mood, pleasant activities, or both?
  - Is there a noticeable relationship between mood and pleasant activities?

RATIONALE FOR SESSION 7:

A. Thoughts can have a profound effect on mood.

B. There are several advantages to working with thoughts.

- They are always with you
- They are under your control.

C. However, these characteristics can sometimes be disadvantages.

- Thoughts seem automatic and it's easy to take them for granted; you must learn to become aware of them and take them seriously.
- Thoughts cannot be observed by other people. You must be particularly conscientious when implementing these techniques because only you will know whether you are properly applying what you learn.

D. You will learn two approaches for changing negative thoughts.

- Techniques for increasing positive thoughts and decreasing negative thoughts.
- Techniques for developing more constructive thoughts.

LECTURE: CONTROLLING YOUR THOUGHTS:

A. Self-assessment of thinking problems

- Compute your rate of positive and negative thoughts to decide if you need to work on thoughts, if your ratio is less than 2, then this approach is very important for you. In general, it is very useful for people who tend to think negatively.

- Identify important thoughts by noticing some of your positive and negative thoughts for a day and writing them down.
- Make a list of positive and negative thoughts on the inventory of thoughts form.

B. Managing thoughts. Instruction should give many examples and use the blackboard to illustrate the main points.

- Reducing negative thoughts
  - Thought interruption. Stop the negative thought by interrupting it with another thought.
    - Yell "stop!" and then fade the overt word "stop" into a covert word "stop".
    - Say "I'm not going to think that now" and then fade this to a covert statement.
    - Employ the rubber band technique. Wear a rubber band on your wrist and snap it whenever you think a negative thought.
  - Worrying-time schedule. If you need to think about certain negative things, then schedule a time to do so (no more than 30 minutes per day). Limit your negative thoughts to that time period.
  - Blow-up technique. Take your negative thought to a ridiculous extreme. What is the worst that you can imagine?
- Increasing positive thoughts
  a. Primary. Carry 3x5 cards with positive self-statements
  b. Using cues. Pair positive thoughts with behaviors that occur frequently. (e.g. eating or brushing your teeth).
  c. Notice what you can accomplish rather than what you do not accomplish by making a list of daily successes (e.g. getting to work on time).
  d. Positive self-rewarding thoughts. Reward yourself with positive thoughts (e.g. "I did a good job on that").

e. Time projection. Think forward to an easier time. It is O.K to feel down; it is becoming demoralized and losing hope that causes problems. Try to imagine a time when your current problem will be gone.

C. Evaluating your efforts. Pay attention to:

- ❖ Antecedents – places, people, time of day.
- ❖ Consequences – are there rewards for thinking negative thoughts?

LECTURE:

D. Constructive thinking

- ❖ Introduction. This technique is very useful for people who tend to overreact to problems and difficulties. The goal is to change the way you think about problems and difficulties.
- ❖ Some situations that lead many people to overreact.
  - o Being rejected by someone.
  - o Being disapproved of, or criticized
  - o Feeling unappreciated.
  - o Doing more than your share of the work without receiving credit.
  - o Failing, making a mistake, or performing poorly.
- ❖ The ABC Method (Albert Ellis, RET) for constructive thinking.
  - o There is a strong connection between how you think and how your feel. It may not be what happens to you that causes you to become depressed, but what you tell yourself about what happens.

    A = Activating event

    B = What you believe or say to yourself about A

    C = Emotional consequences
  - o Learn to identify beliefs and / or attitudes that cause you to overreact: B, what you say to yourself about an event, A, causes the emotional reaction, C.
  - o There are three relatively reliable indicators of non-constructive self-talk

        - Highly evaluative words: should, must.
        - Catastrophizing words: it's awful, terrible.
        - Over generalizing: I'll never, nobody ever.
    - The assignment is to track ABC for one situation per day for a week. Solicit examples from the group.
    - Methods for disputing non-constructive self-talk.
        - Argue against irrational beliefs or self-talk.
        - Argue against "should" and "ought" thoughts with "why should I?....."
        - Question words like terrible and awful with "I would have liked, …." "But is it really awful?...."
        - Challenge overgeneralizations with "just because this time …. Does it really mean always?"
        - If you choose this technique you will begin to write down disputing statements for your irrational negative thoughts.
- ❖ Concluding remarks
    - Both techniques take practice
    - No one is content or happy all of the time
    - The idea is to keep negative feelings at a more reasonable level so we can deal with life's difficulties more constructively.

REVIEW SESSION 7 HOMEWORK:

The positive-negative thought group tasks are:

Make sure you have an inventory of thoughts. If not, have the members of your group help you to generate a list or give your suggestions about how you can generate one.

Review your baseline data – any problems?

You should choose one technique for decreasing negative thoughts and one technique for increasing positive thoughts and write them down on your tally sheet.

The ABC group tasks are:

Review your baseline data – any problems?

Each of you should give an example of at least one ABC sequence. Help each other to problem solve and discriminate rational from irrational beliefs.

PREVIEW SESSION 8 AND ASSIGN HOMEWORK:

- ❖ Preview: formulating a plan for constructive thinking.
  - Continue to monitor your daily mood.
  - Read Chapter II in CYD.
  - Do the appropriate thinking assignment.
    - Utilize the cognitive technique that you have chosen and monitor your progress
    - Dispute your non constructive self-talk and complete the Daily Monitoring form each day.

SESSION – 8

FORMULATING A PLAN FOR CONSTRUCTIVE THINKING

GOALS:

- This session is intended to help you to develop a plan to begin thinking more constructively.

The goals are to learn either

- New ways to channel your thoughts

(or)

- New ways to think about problems so that you will be less upset by them and thus be more able to deal with effectively.

AGENDA:

I. Review session 7 and related homework

II. Rationale for session 8

III. Lecture: Self – Instruction

IV. Small group task: Positive self-statements

INTRODUCTION:

This part of the course should help you realize how much your thoughts an influence your mood, and we hope, how much you can influence and control how you think.

REVIEW SESSION 7 AND RELATED HOMEWORK:

A. Review: Controlling you thoughts and constructive thinking.

1. Controlling your thoughts.
    a. Identify thoughts – keep track of both positive and negative thoughts.
    b. Count thoughts – generate a "master list" of your most important thoughts. Keep track of how many positive and how many negative thoughts you have each day (base lining).
    c. Manage thoughts
        i. Methods for decreasing negative thoughts
            1. Thought interruption. STOP technique-being by saying it out loud, then fade to a covert statement such as, "I'm going to stop thinking that now". Rubber band technique-slap your wrist to punish no constructive thoughts.
            2. Blow-up technique. Exaggerate your negative thought until it becomes ridiculous and funny.
        ii. Methods for increasing thoughts
            1. Use cues. Pair positive thoughts with behaviors that occur frequently (e.g. eating, brushing your teeth, answering the telephone).
            2. Notice what you accomplish
            3. Positive self-rewarding thoughts (e.g. "I did a good job on that").
2. Constructive thinking
    a. The ABC method helps you to focus on how you think about problems and difficulties. The theory is that feelings of being

upset come more from what you say to yourself about what happens in your life than from the actual events.

A = Activating Event

B = Beliefs or thoughts

C = Emotional Consequences

b. Learn to identify beliefs and attitudes that cause you to overreact
    i. Self-observe by filling out an ABC form when you become upset.
    ii. Identify your self-talk. What do you say to yourself?
    iii. Identify nonconstructive self-statements
        1. Over evaluating (should, must).
        2. Catastrophizing (awful, terrible)
        3. Overgeneralizing (always, never)

c. Dispute non constructive statements (e.g. Why should I? Is it really terrible? Am I really always?....)

RATIONALE:

Often people known what they should do, and they know it would be effective if they did it, but somehow they seem unable to actually follow through. Self-instruction techniques can be "the missing link" that helps you to actually do the things that you know you should do.

LECTURE: SELF – INSTRUCTION TECHNIQUES

A. Benefits of internal self-talk

- ❖ Makes goals more concrete.
- ❖ Focuses attention on the situation at hand
- ❖ Activates your memory
- ❖ Has a distancing effect; allows you to be more objective
- ❖ Helps you to anticipate problems and plan for handling them
- ❖ Keeps you calm and on tract.
- ❖ Provides motivation

B. Using self-instruction

- ❖ Understand what you want to accomplish. Be specific

- Understand how you plan to accomplish it.
- Write down your instruction
- Practice your instructions
    - Do it
    - Imagine it
    - Imagine someone else doing it.
- Modify your self-instructions if necessary
- Make your self-instructions into a routine.
- Reward yourself for using self-instructions

SMALL GROUP TASK; POSITIVE SELF-STATEMENTS

Have the group help generate a list of positive self statements for each individual member. Group members should tell each individual good things they have noticed about him or her; each person should write down these comments for future use (priming).

SESSION – 9

MAINTAINING YOUR GAINS

GOALS:

This session is intended to help you develop a plan for maintaining the gains that you have made during the course.

The goals are,

- To assist you in integrating what you have learned
- To encourage you to monitor your depression level periodically so that you can recognize recurrence quickly
- To alert you to certain stressful events that often cause depression.

AGENDA:

I. Review session 8 and related homework

II. Rationale for session 11

III. Lecture: Maintaining your gains

INTRODUCTION:

Feeling better during the 5 weeks of the course is important. More important, however, is what happens after the course ends. You should be actively planning ahead now so that you will maintain the gains that you have achieved and continue to use the skills that you've learned in the course.

REVIEW SESSION 8 AND RELATED HOMEWORK:

RATIONALE:

- ❖ Now we have completed the skill components of the course and it is time to plan for the future by reviewing what you have learned and begin working on a "life plan".
- ❖ You will be continuing on your own to practice and apply the skills that you have learned.
- ❖ It is important to see the end of the course as the beginning of your "life plan".

LECTURE: MAINTAINING YOUR GAINS:

A. Review the material already covered.

- ❖ Depression is viewed as a problem in living that is characterized by dysphoria, low level of activities, problems interacting with others, guilt, physical problems, and anxiety.
- ❖ The three-facet model of depression. We have covered skills for each facer.
  - o Thinking: positive / negative thoughts and the ABC method
  - o Behaving: pleasant activities, and social skills.
  - o Feeling: relaxation and mood.

C. A review of what you have achieved by participating in the course.

- ❖ Most of you have experienced a decrease in your level of depression.
  1. Compare your score on the Beck Depression Inventory (BDI)

2. If you would like to share the changes that you have noticed in your BDI scores with the group, please feel free to do so.

- A better understanding about the symptoms of depression
- The ability to recognize depression in yourself.
- A greater awareness of the situations, behaviors and thoughts that can cause depression
- The ability to design and implement a self-change plan.

C. Methods for maintaining your gains

- Take time to integrate what you've learned
  - What contributes to your depression?
  - Assign priorities to your problem areas.
  - Describe your methods of coping with your problem areas.
  - Decide how to remind yourself to use intervention strategies if you feel yourself becoming depressed again.
- Monitor your mood on a regular basis. This is extremely important.
  - Prevention is far easier and less painful than treatment
  - Try to recognize the early signs of depression

D. Major life events and life changes that often lead to depression

- Situational changes can change the positive outcomes of your behavior and can change the quality of your interactions.
- Possible life events that may lead to depression
  - Social separations
  - Health related problems
  - New responsibilities and adjustments
  - Work-related events
  - Financial and material changes
- Major events happening to those close to you can also affect you, they might begin to act differently toward your (e.g. be available less often, less sympathetic, and so on).

E. Anticipate and plan for stressful life events.

- ❖ Anticipate specific ways in which the stressful life event will affect your behavior and your interactions.
- ❖ Prepare for stressful events by developing a self-change plan
- ❖ Observe your depression level more closely during stressful times.

PREVIEW SESSION 12 AND ASSIGN HOMEWORK

A. Preview: Developing a Life Plan.

- ❖ The next session will help you think about who you are and who you might become.
- ❖ We will discuss how to plan the direction in which you would like to change and provide guidelines for developing a strategy to help these changes take place.

SESSION – 10

DEVELOPING A LIFE PLAN

GOALS:

This session is intended to help you develop a life plan to consolidate the gains you have made and to plan for the prevention of future episodes of depression.

The goals are,

- ❖ To assist you in actively planning for future including a consideration of your individual and interpersonal life goals.
- ❖ To encourage you to think preventively and to make a plan for positive mental health.

AGENDA:

I. Introduction

II. Rationale for session 10

III. Lecture: Making a life plan

IV. Final pep talk, closing remarks

INTRODUCTION:

I expect that many of you have noticed that you have made significant gains in your ability to improve your mood. Ofcourse, your mood will always

fluctuate. There will be times when you feel up and times when you feel down-that is simply part of being human. However, all of you should now have some skills that you can use to prevent depression, or to help yourself feel better if you do become depressed.

REVIEW: MAINTAINING YOUR GAINS:

- ❖ Carrying out regular assessments of your state of well-being will allow you to recognize the beginning stages of depression so you can work on feeling better.
- ❖ Identify your own individual problem areas and the techniques for dealing with them.
- ❖ Prevention is easier and less painful than treatment.

RATIONALE:

This is an opportunity for you to think about who you are and who you might become. Plan the direction in which you would like to change.

LECTURE: MAKING A LIFE PLAN

A. Often people are afraid to change. Some reasons for this include:

- ❖ Fear of breaking away from the status quo.
- ❖ Fear of inconsistency
- ❖ Fear that change is an admission of failure.
- ❖ Fear of losing spontaneity. (We become spontaneous by choosing well and wisely, not by refusing to make choices).
- ❖ Fear of experimenting. Making changes can be exciting, particularly when the changes are planned. You can choose to make changes.

B. Creating yourself. There is no one good way to be. I have suggested that you create a role sketch for yourself that includes goals, style, types of relationships, and values. Describe who you are and "improve" that by suggesting some possible modification. Describe the changes that you will need to make to become an "improved" person.

C. Maintaining your gains. People often react to a crisis by putting new ideas into practice, but when the crisis passes they return to their old patterns. To prevent this, I want to emphasize:

- ❖ Think preventively, in terms of positive mental health.
- ❖ Learn to recognize and make room for “high points” in your life.
    - o Plan for positive mental health. Try not to wait until you already feel bed and then plan to do something about it.
    - o Try to view changes as opportunities for growth rather than as threats to your well-being.

D. Goals are specific ends toward which you direct your efforts.

- ❖ Your goals take their meaning from your values.
- ❖ It is good to deliberately arrange social support systems that reinforce and strengthen your values and goals.
- ❖ Goals fall into several categories.
    - o Individual goals: Life-style (your “image”), economic pursuits, educational plans, vocational choices, physical activity level, spiritual beliefs, recreational and creative activities.
    - o Interpersonal goals: family life-style, sharing time with friends, developing romantic relationships, making group commitments, and assuming leadership roles.
    - o Short-term vs. long-term goals.
    - o Super ordinate goals give meaning to life.

REVIEW SESSION 10 HOMEWORK:

- ❖ Review your Life Plan
    - o Outline your most critical problem areas and ways to continue to work on them.
    - o Design a way to check your depression level regularly.
    - o Consider what you need to change to be more the way you’d like to be.
    - o Outline your goals, both long term and short term.

FINAL TALK AND CLOSING REMARKS:

This is an important talk to tailor to the participants. The content of the pep talk is probably less important than the process itself. The issues to address are: Do the participants have a sense of hope and optimism? Are their

goals specific and realistic? Do they have a sense of clarity about what they've learned? Have they had a chance to share their feelings about the class experience? Is there a sense of closure?

- ❖ Beginnings and endings are important times. Among other things they provide an opportunity to plan and reflect.
- ❖ I have formed a cohesive, supportive group, and probably each of us depends on the group and its regular meetings in some way. Perhaps you should expect somewhat of a let-down as the course ends, and therefore plan what you can do to deal with that. For instance, you might want to attend carefully to your rate of pleasant activities, particularly social activities.

APPENDIX - XIV

HOW CAN TEACHERS HELP CHILDREN WITH DEPRESSION

"Being a teacher can be fun and rewarding, but can also be challenging"

ADOLESCENTS:(11-19 years)

Adolescents is a transitional stage of physical and psychological development generally occurring from the onset of puberty to adulthood.

ADOLESCENT DEPRESSION:

Depression is a condition of mental disturbance typically with lack in energy and difficulty in concentration (or) interest in life.

CAUSES AND RISK FACTORS:

The most common teen depression causes and risk factors are outlined below.

1. ABUSE AND TEEN DEPRESSION:

Children (or) adolescents who have been the victim of verbal, physical (or) sexual abuse are at an increased risk of depression.

2. BEING BULLIED AT SCHOOL:

- ❖ A teen who is being bullied will likely experience fear and anxiety.
- ❖ Victims of bullying may also develop a strong sense of worthless.

3. CONFLICT AT HOME:

- ❖ Conflict at home can be a great source of stress in the life of a teen.
- ❖ This is especially true if he finds school a stressful place as well. He may feel like he has nowhere to go to escape the pressure of life.

4. INSOMNIA AND FATIQUE:

- ❖ Lack of sleep will lead to depression.
- ❖ Restless and less able to cope with the stressors of life.

5. NUTRIENT DEFICIENCIES:

- ❖ Poor eating habits place a teen at a greater risk of depression.
- ❖ Teenagers often make unhealthy food choices and don't get the nutrients their bodies need.

6. PRESENCE OF UNDERLYING DISORDERS:

- ❖ Teens with anxiety disorders
- ❖ Behavioural problems (e.g. steeling, lying)
- ❖ Learning disabilities are at a greater risk for depression.

7. SUBSTANCE ABUSE:

Alcohol and illicit drugs have been linked to an increased risk of depression.

FEW TIPS TO HELP CHILDREN WITH DEPERSSION:

As a teacher, you serve as a strong influence in the student's life. Depression is real to many students. Depressed students may become destructive to themselves and others and can even become violent. Here are a few tips on how you, as a teacher, can help children with depression.

Understand the symptoms of depression:

- ❖ The symptoms include being sad
- ❖ Anxious or feeling empty
- ❖ Hopelessness

- Guilt
- Worthlessness
- Decreased energy level
- Insomnia
- Eating problems (eating too much or not enough)
- Thoughts of suicide or pains and aches that are not helped with treatment.

Talk to the Student:

- If you notice that a student is exhibiting depression-like symptoms, don't just stand by.
- Pull the student aside in private and share your concern.
- Talk to the student to try to understand what he is feeling and how you can help.
- Express your concern for the well being and future of the student.

Find success in the Student:

- Often students suffering from depression will feel inadequate, pessimistic and lack self esteem
- Help build the student's self esteem and self confidence by praising her when she does a job well.
- Find out where to student excels in her studies and build on it.
- Helping the child to build her self esteem may help her to recover from depression.

Get the School Counselor Involved:

- ❖ If you have a depressed student, don't address the issue by yourself, involve the school counselor.
- ❖ A school counselor can talk to the child and help him recognize his feelings and how to deal with them.
- ❖ The school counselor is also an excellent resource for your when it comes to working with depressed child.

Get the Parents Involved:

- ❖ During the day, the child is at school much of the day and the parent may not be aware that their child is depressed.
- ❖ Share your concerns with the child's parents and work as a team to help the child.
- ❖ Give the parents frequent updates on the progression of the student in the classroom.

APPENDIX – XV

PARENTING SESSION FOR TEEN DEPRESSION AND ANXIETY

ADOLESCENTS:(11-19 years)

Adolescents is a transitional stage of physical and psychological development generally occurring from the onset of puberty to adulthood.

ADOLESCENT DEPRESSION:

Depression is a condition of mental disturbance typically with lack in energy and difficulty in concentration (or) interest in life.

CAUSES AND RISK FACTORS:

The most common teen depression causes and risk factors are outlined below.

1. ABUSE AND TEEN DEPRESSION:

Children (or) adolescents who have been the victim of verbal, physical (or) sexual abuse are at an increased risk of depression.

2. BEING BULLIED AT SCHOOL:

- ❖ A teen who is being bullied will likely experience fear and anxiety.
- ❖ Victims of bullying may also develop a strong sense of worthless.

3. CONFLICT AT HOME:

- ❖ Conflict at home can be a great source of stress in the life of a teen.
- ❖ This is especially true if he finds school a stressful place as well. He may feel like he has nowhere to go to escape the pressure of life.

4. INSOMNIA AND FATIQUE:

- ❖ Lack of sleep will lead to depression.
- ❖ Restless and less able to cope with the stressors of life.

5. NUTRIENT DEFICIENCIES:

- ❖ Poor eating habits place a teen at a greater risk of depression.
- ❖ Teenagers often make unhealthy food choices and don't get the nutrients their bodies need.

6. PRESENCE OF UNDERLYING DISORDERS:

- ❖ Teens with anxiety disorders
- ❖ Behavioural problems (e.g. steeling, lying)
- ❖ Learning disabilities are at a greater risk for depression.

7. SUBSTANCE ABUSE:

Alcohol and illicit drugs have been linked to an increased risk of depression.

SYMPTOMS OF ADOLESENTS DEPRESSION:

- ❖ Frequent nonspecific physical complaints
- ❖ Absence from school
- ❖ Poor school performance
- ❖ Take (or) actions of running away.
- ❖ Boredom of lethargy
- ❖ Outbursts of crying (or) moody behavior
- ❖ Irritable angry (or) hostile demeanor
- ❖ Lack of interest in friends
- ❖ Alcohol (or) drug use
- ❖ Decreased interaction and communication
- ❖ Fears of death

- Lack of interest in usual hobbies, sports (or) recreational activities.
- Sensitivity to rejection (or) failure.
- Restless risk-taking behavior
- Relationship problems
- Changes in appetite accompanied by weight fluctuations.
- Changes in sleeping patterns
- Low self-esteem feeling of worthlessness.

MANAGING TEENS DEPRESSION:

Teen depression prevention begins with parentral support.

- As a parent you can play a key role in depression prevention and detection by listening to and watching your teen carefully.

HOW CAN PARENTS PREVENT TEEN DEPRESSION:

Parents may be able to help prevent teen depression by promoting your child's physical and mental health.

The following steps can make a difference.

- Praising your child's skills
- Encouraging physical activity
- Providing parental and family support
- Communicate openly
- Encourage positive activities
- Be aware of events in your teens life.
- Promoting participation in organized activities.

I. PRAISING YOUR CHILD'S SKILLS:

- ❖ Praise your teens strengths and be sensitive when addressing weakness, self esteem can be very fragile particularly during the teenage years.
- ❖ Meet with teachers to find out how your child is doing in school.
- ❖ If your child is having trouble in school be sure to praise his (or) her other strengths – whether in music, athletics relationships (or) other areas.

II. ENCOURAGING PHYSICAL ACTIVITY:

- ❖ Physical activity may slightly reduce teen depression and anxiety.
- ❖ Physical activity can improve your child's over all health.
- ❖ Adolescents must get one hour (or) more of physical activity a day.
- ❖ Physical activity can be as effective as medications (or) therapy for depression so get involved in sports (or) dance class. Even a short walk can be beneficial.

III. PROVIDING PARENTAL AND FAMILY SUPPORT:

- ❖ Higher level of parental support seemed to offer protection from depressive symptoms.
- ❖ Remind your child that you care by listening showing interest in his (or) her problems and respecting his (or) her feelings.
- ❖ Spending quality time with the child can help your child and give the perspective need.

IV. COMMUNICATE OPENLY:

Most teens go through periods of depression during adolescence but you can keep it from spiraling into something more serious by establishing an open and honest connection with your teen.

- ❖ Let him know that he can come and talk to you about anything if he needs to and that you won't judge him (or) try to manage him if he has a problem.
- ❖ Be ready to listen as much as talk and to express your support for him regardless of the circumstances.
- ❖ The earlier you can establish good patterns of communication the less likely your teens depression will become worse.
- ❖ Talk with your teen and listen attentively. Let your child know that you are there and to listen when something is wrong. Don't be discouraged if it takes some time before your child begins to confide in you.

V. ENCOURAGE POSITIVE ACTIVITIES:

- ❖ It can be tough for parents to steer a teen toward a particular outlook (or) activity.
- ❖ Anything a parent does is by definition, monumentally uncool. But at the same time it helps to nourish positive goals in your teen and encourage him to pursue activities that he finds fulfilling.
- ❖ Regular exercise can keep energy levels high while creative endeavors even if its just writing in a diary (or) blog-encourage expressiveness instead of just bottling up emotions.

- Encourage healthy eating habits too often a teen who is given too much freedom in food selection chooses to eat junk food. This can result in nutritional deficiencies that can in turn become a risk factor for depression.

VI. BE AWARE OF EVENTS IN YOUR TEEN'S LIFE:

- Depression can reverberate through all aspects of a teenager life.
- School performance may suffer, she may undergo radical changes in mood (or) dress style, interest in previously enjoyable activities may drop and there may be an unusually high amount of defiance even criminal behavior such as steeling can end up committing a suicide. So watch the teen closely.
- While you should not smother her (or) fallow her everywhere she goes teens require a certain amount of independence it helps to be aware of the activities she's involved in and take an interest in what's happening in her life.
- If you can spot early warning signs you may be able to prevent a slip into serious depression.

APPENDIX – XVI

gphpt [? 1

kdrnrhh;t [kwWk;rKf fy;tp

moggi l bfhsi ffs;

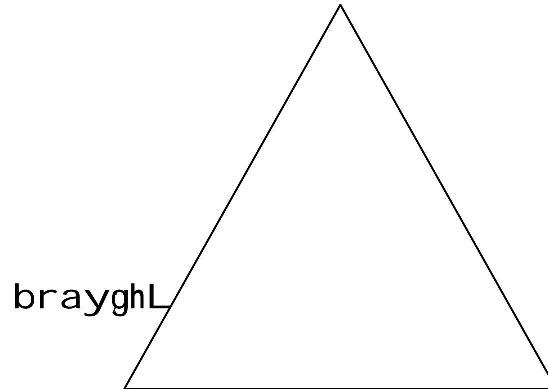
- ❖ kdrnrhh;t [kwWk;kd mGj j j i j cUthf;Fk;brayfi s ngrhj pUj j y;
- ❖ Mj uthf ngRj y;
- ❖ kwwthfi s , Hpt[ggLj ;J tJ nghdw brayfi s braahj pUj j y;
- ❖ mthfs;braak;eyy brayfi s ghuhl p ngRj y;
- ❖ mi dtUf;Fk; rkkhd neuk; bfhLj ;J mthfSi la j pwi kfs; kwWk; mthfSi la kdffti yfi s gwwp fye;J i uahLj y;
- ❖ mthfi s gwwpa j ftyfi s kwwthfSl d; gfpe;J bfhsshky;, ufrpakhf mthfSl d;ci uahLj y;

kdrnrhhi tggwwp epi dggj wfhd tHpKi wfs;

- ❖ kdrnrhh;t [vdgJ xU neha;
- ❖ gy ti fahd nehafs;j hf;Ftj pdhy;kdrnrhh;t [VwgLfpwJ
- ❖ kdrnrhh;t [vdgJ ekKi la thH;tpy; rpy Kf;fpa j Uz ' fi s , Hf f f;T oa neha;
- ❖ kdrnrhh;t [vdgJ gyti f fhuz ' fshy; cUthff f;T oaJ /
- ❖ ekKi la thHfi faply;rpy Fi wghLfs;, Uf;FknghJ ehk; kdrnrhh;t [mi l fpnwhk;/

kdrnrhhj tggwwpa Kfnfhz rpej i d

rpej i d



braygh Lfs;

ehk;vggo kwwthf SI d;R{Hepi yfF Vwwth W xj ;J nghj y;

rpej i d

ehk; RwWgf w R{Hepi ya[Dk; kwwthf SI Dk;

xj j pUf F knghJ ekKi l a kdj py;Vwgl f ;T oa vz z ' f s/

cz h;t[

ekKi l a kdj py;vHf ;T oa cz hrrpf s/

kdrnrhhj t gwwpa RUs;

kdrnrhh;thd cz h;t[	eyy brayf SI d;ekj k , i z j ;J bfhsSj y;
mj pf khd kdrnrhh;t[	RWRWgg[j dj k Fi wj y;
kpf mj pf khd kdrnrhh;t[	kpf t [k;RWRWgg[j dj k Fi wj y;

kdrnrhh;t[gwwpa RUi s khwwf;Toa j pwi kfs;

brayghl owf;hd j pwi kfs;

- , dgkhd brayf;s;
- rKf j pwi kfs;

rpej i df;f;hd j pwi kfs;

- rpej i di a cUthf;Fk;j pwd;
- rkkhd nehkki w kwWk;vj pphki w rpej i dfs;

cz h;tf;f;hd j pwi kfs;

- Xa;t[vLj j y;

gphpt [? 2

j di d nehkki wahf khwwf;Toa j pwi kfs;

- gpurrpi df;i s Fwpggpl;L brhy;Yj y;
- moggi l f; fUj ;J f;f;i s bj hpe;J bfhz ;L mj wnfwwthW el e;J bfhsj y;
- c' f;Si l a Fwpf;nfhs; nehkki wahf , Uf;f ntz ;Lk;/ vj phki wahd Fwpf;nfhsf;i s j tph;f;f ntz ;Lk;/
- xU brai y bra;tj wF Kd; mj wF Kdd;hy; el ej rkgt' f;i s gwwp Muhae;J bry;Yj y;
- brayghl od;Kf;f;paj ;J tj i j edF cz Uj y;
- c' f;Si l a Fwpf;nfhsf;i s nehkki wahf ephz apj j y;
- j hk;braak;eyy brayf;i s Fwpj ;J bgUkpj k;bfhsSj y;
- j di d gyggLj ;J tj wf;hd brayf;i sj ;nj h;ebj Lj j y;

gjhpt [? 3

KrRggapwrp

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1/ mi kj pahd R{Hepi yi a nj hebj Lffftk;

2/ bj sptthd kdggfFtj i j cz Ihfftk;

3/ bj sptthd vz z ' fi s cz utk;

braKi w tpsfffk;

1/ mi kj pahd epi yapy;cl fhhe;J c' fs;fz fi s Kl tk;

2/ , gbghGJ c' fSi l a j i rfi s Xa;tgLj j tk;

3/ thaggFj pi a edwhf Kofbfhz L Kffpd; tHpahf 4 q behofs;Kri r edwhf csns , Gff ntz Lk/

4/ mj dgpd; 7 behofs; Kri r edF gpoj ;J i tj ;J f; bfhssntz Lk/

5/ gpd;8 beho ti u Kri r tha;tHpahf btsptpl tk;

6/ 10 Kj y; 30 epkpl k; bj hl he;J braatk/ mj d; gpd; l e;J epkpl k;mi kj pahf cl fhutk;

j i rggapwrpfs;

moggi l tgj pKi wfs;

1/ mi kj pahd R{Hepi yi a nj hebj Lfftk;

2/ kdi j mi kj pggLj j pftdk;bfhss ntz Lk;

3/ j i rfSfF Xa;t[bfhLffk; nghJ c' fSi l a cl y; ghf' fi s ftdj j py;bfhz Ltu ntz Lk;

4/ xtbthU Ki w braakghJ k; xnu khj pphpahd tHpKi wi a gpdgwwtk;

5/ gapwrp braakghJ ntfkpyyhky;bkJ thf braak;

braKi w tpsffk;

fhy;j i rfi s Xa;tg;gLj ;J j y;

- mi kj ;pahd R{Hepi yapy; i f. fhyfi s ePl;oathW cl;fhut;k;
- c' ;fSi l a fhy;j i rfi s 5 Kj y;7 behofs;ti u , Wf;fp gpoj ;J gpd;j sh;thf tpl;t;k;
- mj dgpd; c' ;fSi l a fhy; ghj j i j nkyp;nehf;fp cahj j p gpof;f t;k; 5 behofs; fHpj ;J fhy; ghj j i j fPH; nehf;fp tpl;t;k;gpd; rpwpJ neuk; Koej gpdg[mi j Xa;thd epi yf;F bfhz ;L tut;k;
- , nj nghy; c' ;fSi l a bj hi l j i rfs; kw;Wk; KH' ;fhy; j i rfi sa;k;, Wf;fp gpoj ;J gpd;dh;mi j Xa;thd epi yf;F bfhz ;L tut;k;
- , gbghGJ c' ;fSi l a fhyfi s gpd;dhy;kl f;fp bkJ thf gi Ha epi yi kf;F fPH bfhz ;L tut;k;/ c' ;fSi l a fhy; j i rfs; mi dj ;j ak; KGi kahf Xa;tg;gLj j t;k; , gbghGJ c' ;fSi l a fhy; j i rfs; KGi kahf Xa;t[vLj j cz hj ; t c' ;fshy;cz u Koak;/

khhgf j i rfi s Xa;tg;Lj ;J j y;

, gbghGJ c' ;fSi l a KJ Fj z ;i l neuhf i tj ;J khhgfj ;i j cahj j p khhgfk; tap;W kw;Wk; fGj ;J j i rfi s , Wf;fpg; gpof;f t;k; gpd;dh; 5 behofs; Koej gpd; mi j j sh;thd epi yf;F bfhz ;L tut;k; , t;thW bra;tj d; Kyk; c' ;fSi l a tap;W. khhgfk;kw;Wk;fGj ;J j i rfs;Xa;thd epi yapy;, Uggi j cz u Koak;/

Kfjji rfi s Xa;t[gLj;Jjy;

, gbghGJ c' ;fSi la Kfjji rfs; bewwp kwWk; fz ; ji rfi s 7 tpehofs; , Wf;fg; gpoj;J rpwpJ neuk; Koej gpdg[Xa;t[gLjjt[k; gpd;dh; tha; fd;dk; kwWk; jhi lfspy; css ji rfi sa[k; , Wf;fg; gpoj;J gpd;dh; 5 behofs; Koej gpd;dh; Xa;t[gLjjt[k;/ , gbghGJ c' ;fSi la kd mGjjk;Fi we;J xU g[;Jz h;rrp bgwwJ nghy;c' ;fshy;cz u Koa[k;/

i ffspy;css ji rfi s Xa;t[gLj;Jjy;

, gbghGJ c' ;fSi la i ffs; kwWk;fhy;tpuy;fspy;css ji rfi s 5 Kjy;7 epkpl k;ti u ed;whf , Wf;fp gpoj;J gpd;dh;30 epkpl' ;fs; Koej gpdg[Xa;t[gLjjt[k;/ , ggo bra;tjpd; Kyk; c' ;fSf;F kdf;fti y kwWk; kdrnrhh;t[vyyhk; Fi we;J xU g[;Jz h;thd vz z ' ;fs; njhd;Wk;/

fi lrpahf c' ;fSi la thaggFjpi a ed;whf Kof;bfhz ;L Kff;pd; tHpahf Kri r ed;whf csns , Gj;J mjd;gpd; Kri r tha; tHpahf btsp tpl tt[k;/ , gbghGJ c' ;fshy; eyy bjspthd vz z ' ;fi sa[k; cz h;t[fi sa[k;bgw Koa[k;/

gphpt[? 4

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3/ r{Hei yfF VwywthW Xa;t[vLggj wfhd gapwrpi a xU fhy mI} ti z nghI;L mi j j pdKk; 5 epkpI ' fs; j twhky; gapwrp gz z ntz ;Lk/

4/ kd mGj j j j pwfhd rej hggk; VwgLk; nghJ c' fi s eP fns mi kj pggLj j p bfhz } J nghy;epi dj ;J f;bfhss ntz ;Lk/

5/ mj dgpdg[edywhf tha;tHpahf Kri r css;pGj ;J gpdpdh; bkJ thf btspptpI ntz ;Lk/ gpdpdh; mi kj p mi kj p vdW c' fs;kdj pwFs;brhyy ntz ;Lk/

6/ gpurri dfi s j uf;T oa R{Hepi y VwgggI} hy; eP fs; mej g; gpurrpi di a kpf t[k; bghWi ka[Dk; ftdj ;J I Dk; vj ph; bfhss ntz ;Lk/

gphpt [? 5

, dgkhd brayj pwd;kwWk;kdrnrhh;t[

kdrnrhhj t ephz apggj py; , dgkhd epfHrrpfs; kpf t[k; Kffpakhdj hFk/ (vLj ;J f;fhI} hf kdepi y rkkej ggI} rkgt' fs)/

1/ , dgj i j j uf;T oa nehki wahd brayfSI d; kwywthfnshL rKf cI dghLI d;fye;J i uahLj y;
(vLj ;J f;fhI} hf mdj g btspggLj ;J j y; ez ghfSI d; btspggi I ahd ngrRfspy;fye;J i uahLj y)

2/ c' fSi I a cz h;t[fi s c' fSfF Vwwhhnghy; mDgtkhffp bfhsSj y;

(vLj ;J f f hl ǀ hf. gJ[pa tpc&a' fi s bj sptthf gfipe;J bfhsSj y; kwWk; c' f s; f l i kfi s j pwdgl bra;J Koj j y)

3/ eP f s; kdrnrhht[d; , Uf F knghJ c' f S f F khwwj i j j uf;T oa brayfi s braj y/

(vLj ;J f f hl ǀ hf c' f s; ez ghf S l d; f ye;J i uahLj y; edwhf J }' Fj y; rphj j y; kwWk; Xa;t[vLj j y)/

gphpt [? 6

, dgkhd brayfi s cUthf Fk;j pd ǀ k;

1/ eyy j pd ǀ j ;J l d; c' f Si l a brayfi s mj wnf wwthW Fwpggpl L braj y;

2/ c' f Si l a moggi l brayfs; , dgkhdj hf , Uej hy; eP f s; braanghFk; brayfspy; kpFej Mh;tKl d; c' fi s , i z j ;J f bf hz L eyy gJ[pa brayfi s fwWf bf hs;tPf s/

c' f Si l a brayfs; , dgkhdj hf , Uf f rpy bghJ thd fUj ;J f fi s c' fs;kdj py;i tj ;J f bf hss ntz Lk/

❖ c' f Si l a j pd ǀ ' fi s epi wntwWknghJ eP f s; kpf t[k; bghWgg[d; el e;J f bf hss ntz Lk; kwWk; mej j pd ǀ ' fi s thpi rggLj j p mj wnf wwhh; nghy; c' f Si l a thHf i f j pd ǀ ' fi s khwwpai kf f ntz Lk/

❖ c' f Si l a Fwpf nf hsfs; eP f s; vi j f l ǀ hakhf braantz Lk; kwWk; vi j tpUkgp braa ntz Lk; vdw , uz L f F k;rkkhd Koi t j Ukgo mi ka ntz Lk;

- c'fSila gpurrpid dfis R{Hepi yfF Vwwhhnghy; jpl;lkpl;L ifahSjy; kwWk; mij jLggjwfhd tHpKiwfis jpl;lkpl;L ifahSjy;ntz;Lk;/
- c'fSila thHfif jpwid fhyjjpwF Vwwhh; nghy; jpl;lkpl;L mjwFhpa jpwik kfis ifahSjy;ntz;Lk;/

, dgkhd bray;fspy; kpf;t[k; bghWgg[d; c'fis ,idj;J bfhs;tJ vggo

- c'fSila ,dgkhd bray;fis xU ehisff Kd;dj;hfnt jpl;lkpLjy;
- mej jpl;lj;jpy; , Ue;J gpd;th'fhj pUjjy; (m) kd;dpgg[nfl;ly;Tl;hJ /
- mjwfhd ,lk;kwWk;fhyj;ij jpl;lkpl;L FwpggpLjy;
- c'fSila Fwpf;nfhs; kpf;t[k; bjspthdjhft[k; vspjpy; mila;f;Toajhft[k;, Uff ntz;Lk;/
- c'fSila Fwpf;nfhis mileJgwF c'fis ePf;fns bgUikggLjjpbfhss ntz;Lk;/ (vLj;J f;fhl;lhf ehd;xU eyy fhhpaj;ij bra;J Koj;Jsnsd; mij epidj;J vdi d ehnd bgUikgLjjpf;bfhsf;pnwd; vdW epi dff ntz;Lk;/
- c'fSila Fwpf;nfhSf;hd jpl;ljjpd; tshrrpia fz;lwpe;J mjwnfwwhhnghy; c'fspd; thH;tpy; eP;fs; Kdndwp bryy ntz;Lk;/

gphpt [? 7

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- Fwpf nf hsf s;kpf t[k;gaDss j hf , Uf f ntz Lk;/
- R{Hepi yf F Vwwt hW c' f Si l a f tdk;mi ka ntz Lk;
- c' f spd;" hgf rfj pi a mj pf gLj j ntz Lk;
- c' f spd;Fwpf nf hsf s;c' f Si l a kdk; vz z k;cz h;r;rp , i tf nshL xj ;J nghf f;T oaj hf , Uf f ntz Lk;/
- c' f Si l a gpur;rpi df spd; vj pHghhgi g fz l wpe;J mj wnf wy ti f apy;i f ahs ntz Lk;/
- mi kj pahd tHpapy;braygl ntz Lk;
- braa[k;brayf Sf F Cf f k;bf hLf f ntz Lk;/

j dpj d khwwf;T oa j pwi kfi s vggo gadgLj ;J tJ

- eP f s; vej brai y epi wntwy ntz Lk; vdW gh pe;J bf hz L mi j Fwpgg pl L braygLj ;J j y;
- vggo mej j pl l j i j epi wntwy nghf pnwhk; vdgi j ed whf gh pe;J braygLj y;
- c' f Si l a brayj pwd f i s vGj p i tj ;J f bf hss ntz Lk;
- mi j j pdKk;gapwrp gLj j ntz Lk;/ (vLj ;J f f hl L hf .
  - ehd;bra ntd;
  - mi j fwgi d bra ntz Lk;
  - kwwthf s;mej brai y bra;t J nghy;fwgi d bra;J ghhf f ntz Lk;/

❖ j di d khwwf;Toa eQqff' fi s c' fs; nji tfF Vwwhhnghy; khwwpf ;bfhssyhk;

❖ c' fSi la Ra EQqff' fi s jpdKk; tHffggLjjp bfhss ntz ;Lk;

❖ Ra EQqff' fi s braygLjjpa gpd; c' fi s ePfns bgUi kggLjjp bfhss ntz ;Lk;/

gphpt [?8 &9

j ' fs;vz z ' fi s guhkhpj j y;

❖ kdrnrhhtp[vdgJ ek; thHf;i fapy; VwgI f;Toa xU gprrpi dj hd; , J VwgI ;hy; ekKi la brayjpwi kfs; Fi we;J kwwthfnshL ehk; ngRknghJ gprrpi dfs; VwgI ;L mJ xU Fwwkhf khwp tUk; kwWk; ekKi la clkgpy; gprrpi dfs; cUthfp mJ xU kdfftfi yahf khwptpL k;

❖ kdrnrhhtpy; , Ue;J c' fi s khwwpf bfhss c' fSi la brayfs; jpwdfs; kwWk; cz h;tfi s mwpe;J bfhz ;L mj wnfwwthW el e;J bfhss ntz ;Lk;/

❖ c' fs; kdjpy; VwgI f;Toa khww' fi s kwwthfSI d; gfpHe;J bfhss ntz ;Lk;

❖ kdrnrhhtpwfhd mwpFwpfi s edwhf gHpe;J bfhss ntz ;Lk;/

❖ c' fspd; kdrnrhhi t gwwp ePfns mi lahsk; fz ;L bfhssntz ;Lk;/

❖ mj wfhd fhuz j i j mwpe;J bfhz ;L mj wnf wpw R{Hepi y brayf s; kwWk;vz z ' fi s khwwp mi kff ntz ;Lk/

❖ mj wnf wpwhhnghy; c' fi s nehki wahf khwwf;T oa Ra j pd ;' fi s mkygLj j ntz ;Lk/

ti ffs;

❖ c' fSi l a gpurr pi dfi s thpi rggLj j p bfhsst [k;

❖ mej g; gpurr pi df SfF vej khj phpahd j Pt[vLff ntz ;Lk;vdgi j gphpe;J bfhss ntz ;Lk;

❖ j Pt[f fhd j pd ;j ej pu' fi s "hgf ggLj j p mj wfhd tHpKi wfi s i fahs ntz ;Lk;

❖ c' fSi l a kdepi yi a j pdKk;gl ;oaypl ntz ;Lk;

❖ kdrnrhhj t j LfFk; Ki wfs; kpf t [k; vspi kahdJ kwWk; , J rwWk;tHpFi wej i tj j pa Ki wahFk/

❖ kdrnrhh;tpwfhd mwpF wpfi s F wpj j fhyj j pwFs; fz ;l wpe;J mi j KwwpYkhf khwwpai kf f ntz ;Lk/

kdrnrhhj t VwgLj j f;T oa thHf;i f brayf s;

❖ rKfj j py;, Ue;J gphpe;J j dpi kapy;, Uj j y;

❖ cl yhP pahd gpurr pi dfs;

❖ gz ;i a bghWggf s;kwwk; thHf;i f khww' fs;

❖ nti y rkkej khd brayf s;

❖ gz k;kwWk;brabghUs;rkkej khd khww' fs/

gphpt [? 10

thHf;i f j pl;l j i j cUthf;Fj y;

1/ j di; dj j hnd j pl;l kpLj y;

2/ j ' ;f s;vz z ' ;fi s guhkhpj j y;

- nehf;fi wahd vz z ' ;fs; bfhz ;l brayf;fs; kw;Wk; kdeyj i j cz hpe;J bfhs;Sj y;
- c' ;fSi l a thHf;i f f ;f;pw;fhd cahj ; uj i j bj hpe;J bfhz ;L mj w;fhd brayf;fi s fw;Wf;bfhs;Sj y;
- eyy xU kdepi yi a cUthf;f f;T oa j pl;l ' ;fi s j P;Lj y;
- Koej mst[c' ;fs; thHf;i f apy; Kd;ndwf;T oa rej hg' ;fi s fz ;Lgpoj ;J c' ;fs; thH;tpy; j i l ahf , Uf;F k;mrR;Uj j yf;i s khw;w ntz ;Lk;
- c' ;fSi l a Fwpf;nfhs;fs; c' ;fs; thHf;i fi a eyy ti fapy; tHpel j j p bry;tj hf mi ka ntz ;Lk; kw;Wk; c' ;fs; thHf;i f f;F xU kj pgi g VwgLj j p j uf;T oaj hf mi ka ntz ;Lk;
- c' ;fspd; Fwpf;nfhs;fs; eyy tpc;a' ;fi s epi wntw;wp j Utj hf mi ka[khW eP;fns fwgi d bra;J bfhss ntz ;Lk; (vLj ;J f;fhl;lhf. fy;tpf;fhd j pl;lk; fwgi d j pwi d nkkgLj j y; fl t[s;nky;ekgpf;i f i tj j y; kw;Wk; bj hHpY f;fhd j pl;l k; cl wgapw;rp nghdw eyy Fwpf;nfhYl d; j pwdgl brayg;Lj y;
- mnj nghy; c' ;fspd; FLkgj j py; eyy xU thHf;i f j uj i j a[k; ez ghf;fSl d; kdk; tpl;L ngRj y; kw;Wk; c' ;fSi l a bghWgg[fi s j pwdgl bra;J Koj j y; nghdw eyy Fwpf;nfhs;fi s bfhz ;L braygl ntz ;Lk

APPENDIX – XVII

, sk;gUtj j py;VwgLk;kdmGj j j i j j tpizgj py;

bgwnwhhf sp d;g' F

, sk;gUtk;

, sk;gUtk; vdgJ cl y;hP pahf t [k; kdhP pahf t [k; Vwgl f;T oa khwwk; gUtki l j Yf Fk; thf Fhpi k bgwf;T oa taJ f Fk; , i l ggl l gUtk/

, skgUtj j py;Vwgl f;T oa kdmGj j k;

kdmGj j k; vdgJ . kdi j ghj pf f f;T oa f tdf; Fi wghL. Mwwy;, di k. Mh;tkpd i ki a F wpf Fk;neha/

fhuz ' fs;kwWk;Mgj ;J fhuz pfs;

bghJ thf , skgUtj j py; tUk; kdmGj j j j pd; fhuz ' fs; gpd;t UkhW

cl bfhsSj y;kwWk;, staJ kdmGj j k;

tukg[tRpa ngrRk; Ghypapypy; <LgLj Yk; , sk;taJ FHei j fi s kdmGj j i j VwgLj ;J k/

gssp gUtj j py;twgWj ;J j y;

- twgWj ;J j yhy; gssp f Fr; bry;Yk; gpsi sf Sf F gaKk; gj wwKk; , Uf Fk/
- twgWj ;J j yhy;j hd; vj wfhf xU brai y braf pd nwhk; vdW mhj j k;mwwj hf Mf pt pLk/

tPoy;gMurri dfs;

- kd mGjj Jjj pwF tPL gMurri dfs; Kffpa fhuz khf cssJ/
- tPL gMurri d fhuz khf gsspapy; ftd brYjj Koahky; nghf pwJ/

J}ffkpdi k kwWk;nrhhtt[

J}ffkpdi k kdmGjjjij VwgLj;Jk; vjphbfhsSk;jpwd; Fi we;J tpLk;/

Jdpi k

kd mGjjjjhy; , sk; taJ gpsi sfs; gsspi a jdpi k , I khf epi dffpwhhfs/ , j dhy; eyYwtpd; MWj yfi s , off pwhhfs/

Fi wej jdpdkgpfi f

kd mGjjjjhy;j dpdkgpfi f Fi wak;/

Cl I rrj;J Fi wghL

- Cl I rj;J Fi wghl I hy;kdmGjj k;Vwgl thaggssJ/
- , skgUt gpsi sfs; rj;J ss cz i t cl bfhsshjjhy; Cl kgpfF Vww Cl I rj;J fpi I ggjpyi y/

fHfz I Fi wghLfs;cssjhy;kdmGjj k;tUk;

- gj wwk;
- el tofi f khwwk;
- gogghwwy;Fi wghL

- kUe;J fs;(Myf;twhy; nghi j bghUs;)

mwpFwpfs;

- Fwpggpl Koahj cl yepi y khw;wk;
- gss;pf;F bry;yhj pUj j y;
- Fi wthd Kd;ndwpw Fwpgngl
- brai y bra;ahJ eGt[y;
- nrhh;t[
- rj j j ;J l d;mGj y;
- nfhgk;(vhpr;rYl d)
- el gf;[bfhs;Sj ypy;Mh;tkpdi k
- Myf;twhy; nghi j kUe;J mUe;J j y;
- Fi wthd ngrR
- kuz gak;
- ei l Ki wr;braypy;Mh;tkpdi k
- xU brai y bra;ahj pUj j y;(m) nj hypy;tpai l j y;
- vej Mgj j hd braypy;<LgLj y;
- cwtpfSf;fpi l na gpur;ri d
- grpapdi k
- J}f;fkpdi k
- Fi wej j d;dkgpf;i fahy;mhj j kpy;yhj thH;fi f thGj y;

bgwnwhhf;fs; vt;thW j d; FHej; j fspd; kd mGj; j j; i j j ;j tpnf;f ntz;Lk;

- c' ;fs; FHej; j fspd; j pwi kfi s ghuhl ;Lj y;
- cl wgapw;rp bra;ti j Cf;Ft pj; j y;
- bgwnwhh; kwWk; FLkgj; j pd h; Mj ut [fhl ;Lj y;
- FHej; j fspd; k; bt spgi l ahf ngRj y;
- eyy bray;fi s Cf;Ft pj; j y;
- , skgUtj; j py; VwgLk; thHf;i f ep;fH;t ;fi sg; gw;wp mwpj; y;
- xU' ;fpi z ej bray;fspy; g' nfwgi j Cf;Ft pj; j y;

APPENDIX – XVIII

DAILY MOOD RATING FORM

Very depressed ——— 1 2 3 4 5 6 7 8 9 ——— Very happy

Monitoring Day	Mood Score	Monitoring Day	Mood Score
1		31	
2		32	
3		33	
4		34	
5		35	
6		36	
7		37	
8		38	
9		39	
10		40	
11		41	
12		42	
13		43	
14		44	
15		45	
16		46	
17		47	
18		48	
19		49	
20		50	
21		51	
22		52	
23		53	
24		54	
25		55	
26		56	
27		57	
28		58	
29		59	
30		60	

DAILY MONITORING — RELAXATION

Relaxation Rating: 0 = Most relaxed you have ever been
10 = Most tense you have ever been

Date: __________ to __________

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Average Score (add your scores and divide by 7)
Average Score for the Day								______
Least Relaxed Time								
Score								______
When								
Where								
Situation								
Most Relaxed Time								
Score								______
When								
Where								
Situation								
Occurrence of Tension Symptoms H = Headache SA = Stomachache SP = Sleep problem								
Relaxation Practice								
When								
For how long								
Score before								______
Score after								______

DAILY MONITORING — RELAXATION IN PROBLEM SITUATIONS

Relaxation Rating: 0 = Most relaxed you have ever been
10 = Most tense you have ever been

Date: __________ to __________

Problem Situations	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

CHART FOR RECORDING DAILY PLEASANT ACTIVITIES AND MOOD SCORES

Daily Mood Score

Best

9
8
7
6
5
4
3
2
1

Worst

Number of Pleasant Activities

25
20
15
10
5

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

● Daily Mood Score
■ Number of Pleasant Activities

INVENTORY OF THOUGHTS

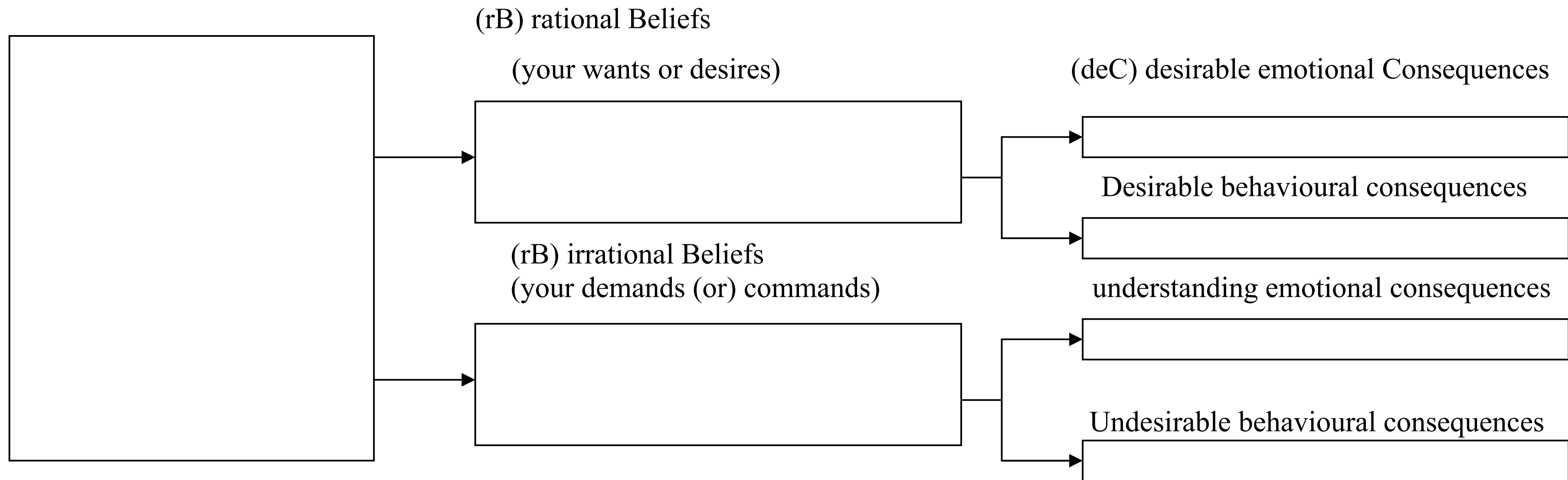
NEGATIVE	POSITIVE

DAILY TALLY OF POSITIVE AND NEGATIVE THOUGHTS

	Number of Negative Thoughts	Number of Positive Thoughts
Day 1	________	________
Day 2	________	________
Day 3	________	________
Day 4	________	________
Day 5	________	________
Day 6	________	________
Day 7	________	________
Total for the week	________	________
Average (Total ÷7)	________	________

Day 8	________	________
Day 9	________	________
Day 10	________	________
Day 11	________	________
Day 12	________	________
Day 13	________	________
Day 14	________	________
Total for the week	________	________
Average (Total ÷7)	________	________

APPROACHES TO CONSTRUCTIVE THINKING



APPENDIX – XIX

THE VALLIAMMAL INSTITUTION (TVI)

11/6 B.B. Road 2nd St., Pankajam Colony , Madurai-625 009.

✆ 98942 49630 email: ananthibetsy@rediffmail.com

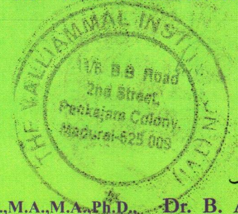
Certificate Course in Counselling and Cognitive Behavioural Therapy for Depression

Reg. No. PTCC/26/June 2012/189 Date: 26/06/2012

This is to certify that **Ms. G. BHARATHA SELVI**

has completed our **CERTIFICATE COURSE IN COUNSELLING AND COGNITIVE BEHAVIOURAL THERAPY FOR DEPRESSION** *(24hrs Part-time Education Programme designed and offered by experts) by effectively participating in theory & practical classes and successfully completing all the exercises.*

She has been placed in **FIRST CLASS**..



26/06/2012

Prof. Dr. S. Jeyapragasam M.Sc.,M.A.,M.A.,Ph.D.,
Director
Rajarajan Institute of Science (RISE)

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The Valliammal Institution (TVI)