

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

This chapter provides a summary of this research study and is divided into three parts. The first part focuses on conclusions based on the research results. The second part shows the limitations of this study and, finally, implications of the study is presented in the third part.

Conclusions

Using repeated measures multivariate analysis of covariance (MANCOVA) on the subjects' BDI and HRS scores within and between groups and at different times, the findings indicated that the brief cognitive-support treatment was effective in reducing depression not only in BDI scores, but also in HRS scores. Adolescent students in the treatment group showed a significant decrease in self-reported and clinician-reported depression scores and these improvements were maintained from the time of the immediate post-treatment assessment to the 6-week and 12-week follow-up assessments. Conversely, adolescent students in the control group showed no significant change in their psychological well-being across these four time points.

Additional item analysis of BDI and HRS scores in only the treatment group were used to test for specific symptom sensitivity to the effects of brief cognitive-support treatment. The results revealed significant pre-treatment to 12 weeks after post-treatment reductions in sadness, hopelessness, past failure, anhedonia, punishment, self-dislike, self-blame, crying, agitation, loss of interest in activities,

indecisiveness, insomnia, and appetite. The items showing the largest reductions in severity were feelings of punishment, crying, and agitation respectively.

In the HRS, the items addressing suicide, early insomnia, late insomnia, work and activities, agitation, psychological anxiety, somatic anxiety, somatic symptoms both gastrointestinal and general, and sexual dysfunction/menstrual dysfunction all showed significant reductions in severity from pretreatment to 12 weeks after post-treatment. Items pertaining to psychomotor retardation, hypochondrias, weight loss, and insight were not endorsed by subjects at any time, and thus had no change in severity. The largest reductions were observed in items addressing sexual dysfunction/menstrual dysfunction, gastrointestinal symptoms, and psychological anxiety, respectively. The findings of this study confirmed the improvement in mental health among depressed adolescent students after the brief cognitive-support treatment. The effects of the treatment effectively continued for at least 12 weeks. These results provide preliminary evidence of the effective treatment for depression among Thai adolescent students.

In addition, using repeated measures multivariate analysis of variance (MANOVA) on the perception of treatment effectiveness of parents/guardians, teachers and adolescent students of only the treatment group across different points in time. Depressed adolescent students perceived their treatment for depression positively and their parents and teachers were satisfied with the useful and positive effect of the treatment. The results indicated that all three groups agreed that the brief cognitive-support treatment in decreasing depressive symptoms in risk students was effective, and that its benefits lasted 6 and 12 weeks after treatment.

Thus, as hypothesized, the findings support the idea that a three-session dose

of brief cognitive interventions combined with three-weeks of supportive interpersonal interactions delivered during the school day was more effective than usual care in reducing mild to moderate cognitive, physical, and emotional symptoms of depression among Thai adolescent students. The treatment indicated a reduction in both the self-rated and the provider rated symptoms of depression. Furthermore, adolescent students who received the brief cognitive-support treatment, their parents/guardians, and their teachers rated brief cognitive-support treatment as effective for reducing depressive symptoms. Based on these findings, the brief cognitive-support treatment aimed at reducing adolescent depressive symptoms would be appropriate for Thai adolescent students.

Limitations

To the researcher's knowledge, this study is among the first to investigate brief cognitive intervention with support environment in the school to reduce depressive symptoms among adolescent students with mild to moderate depression. As a consequence, notable among these was the timeframe in this study; it was too short to evaluate the potential preventive effects of the treatment. Normally, tests of the preventive effectiveness of cognitive treatment would require at least 6 to 12 months of follow-up assessment data (Thase et al., 1992). However, the data suggests that brief treatment may have promoted more realistic thinking, and thus respond to upsetting problems (Galaif et al., 2003, Turner & Butler, 2003).

Brief cognitive-support treatment appeared to be most effective in reducing the severity of feelings of punishment, crying, agitation, sexual dysfunction/menstrual

dysfunction, gastrointestinal symptoms, and psychological anxiety. This combination of symptoms is consistent with mixed depression and anxiety, yet the study only assessed symptoms of depression. However, the cognitive symptoms of feelings of punishment are highly consistent with unrealistic adolescent performance expectations.

Although the aim of this study was to compare the effectiveness of brief cognitive-support treatment to the usual problem-focused counseling offered in Thai secondary schools, no direct comparisons between the two treatments can be made. Treatment effectiveness was assessed as post-treatment reduction of symptoms only. Other treatment outcomes that should also be tested in future studies include the duration of symptom reduction and impact on psychosocial functioning.

Interestingly, although the brief cognitive-support treatment tested in the study reduced the symptoms of depression assessed in the study, one cognitive symptom, feelings of punishment, showed more post-treatment decline. Returning to the culturally context of depression in Thai adolescents previously presented, perceived feelings of punishment could be culturally consistent with increased risk of depression in Thai adolescent students. Thai adolescents who internalize what they may perceive as conflicting and frustrating cultural messages may respond with perceptions of psychological punishment that cognitive-supportive treatment can effect.

Finally, although the two treatments tested in the study were delivered at two different schools, this researcher speculates that treatment expectations might nevertheless have been a factor not accounted for in the current analyses. It is noteworthy that the treatment and control groups differed in monthly family income. Although both groups had extremely low family incomes, the income difference may

be representative of a fundamental difference between the two schools and this might have contributed to the differences in treatment outcomes observed. Although the students who participated in the study were assessed twice to ensure that they had mild to moderate symptoms of depression and/or no history of depression, symptoms of this magnitude can be associated with other conditions not accounted for in the study. For example anxiety disorders, stress, recent gains or losses in important support resources could result in similar symptoms.

Implications for Practice

The findings confirm that the brief cognitive-support treatment was effective in reducing depressive symptoms among Thai secondary school students. As presented in this study, brief cognitive-support treatment was designed to focus on reducing negative thoughts, promote realistic thinking, increase positive interpersonal interactions with others, and improve symptom self-management skills. Both process and counselor of brief cognitive-support treatment differs from strict cognitive therapy for depression (Beck et al., 1979). The teachers who are trained can provide students help in three weeks. This is practical in the Thai context where there are limited numbers of psychiatric specialists. If an adolescent student is feeling depressed, lonely, or socially isolated, the teachers could access and manage their students' problem with brief cognitive sessions, assess the potential social support in the family and school context and seek to use someone from it as a resource. The treatment does not demand additional resources but can be effective in reducing

depressive symptoms in adolescent students who, if left untreated, may be at increased risk for severe depression.

Based on above reasons, the involved personnel worker, especially those who work in the secondary school, can apply these results for helping adolescent students both in general and for students who are at risk of severe depression. As stated, the processes and goals of the treatment can be used as a guideline for helping system to prevent mental health problems such as substance abuse, study problem, violence, sexual behaviors, etc as well as to promote mental health such as to increase their power, self-confidence, self-esteem, etc among adolescent students. The effectiveness of brief cognitive-support treatment would also apply to multilevel of mental health problems including depression.

Another finding indicated that adolescent students, their parents/guardians, and their teachers agreed with the effectiveness of the brief cognitive-support treatment to reduce depression among adolescent students in the school. This result can claim that this treatment is feasible with Thai secondary school students. In addition, the results also showed that higher scores in perceptions of treatment effectiveness in all three groups lowered depression scores in depressed adolescents who received the experimental treatment over periods. This result encourages the practitioner to ask if the perceptions of treatment effectiveness can influence the treatment outcomes. If it was impact, it needs to promote high level of perceptions of treatment effectiveness among these group participants.

Implications for Research

In spite of its limitations in present study, this study adds pertinent information to the field of depression and other mental health problems among adolescent students in the Thai secondary schools. This study provides evidence that brief cognitive-support treatment may be important to the mental health well-being of depressed students. To date, no other study has ever examined how levels of brief treatment and other sources of supportive environment may affect each level of depression and other mental health problems in the schools.

Future research in this area should examine how brief cognitive treatment and sources of support differ across different level of depression, as well as for other psychological problems. It may show that adolescent students with various levels of depression, along with other types of mental health problems, need different models of brief cognitive-support treatment. Further, the study should also illustrate how the other types of support (e.g., structural vs. functional) may also be important for treating, as well as preventing depression and other mental health problems. In addition, future studies should address more specifically whether the obtained improvement in psychological well-being is differentiated related to specific aspects of the combined model of brief treatment and school environment support intervention.

Aside from the previously mentioned implications, this study also highlights the need for more studies examining brief cognitive-support in ethnically diverse populations such as Muslim adolescents. With larger sample sizes and careful consideration of these issues, diverse adolescent groups may need equally diverse

treatment from their context. Furthermore, following the results in longitudinal design is another way that will be useful to confirm the effectiveness of the program.

Finally, depressive symptoms are thought to be a precursor to more severe mental illnesses such as disorder and suicide (World Health Organization, 2005). Conducting research with depressed Thai adolescent students provided challenges. Providers should implement programs aimed at increasing the awareness of depression with an emphasis on the importance of the source and the type of brief cognitive-support that can be provided.