

## INTERVENTIONS FOR YOUTH DEPRESSION: FROM SYMPTOM REDUCTION TO WELL-BEING AND OPTIMAL FUNCTIONING

### *INTERVENCIONES PARA DEPRESIÓN EN JÓVENES: DE LA REDUCCIÓN DE SÍNTOMAS AL BIENESTAR Y FUNCIONAMIENTO ÓPTIMO*

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Received: February 19, 2014  
Revised: September 15, 2014  
Accepted: October 18, 2014

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#### Abstract

Depression is a major public health problem in children and adolescents, which makes the identification and implementation of effective interventions an increasing concern. Therefore, the main aim of this article is to discuss theoretically different psychological interventions for depression. In particular, those focused on psychopathology and depressive symptom reduction and the new interventions based on the positive psychology approach, which focus on optimal functioning and well-being. Empirically supported interventions for children and adolescents, such as cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT), have focus on symptom reduction, which represents an incomplete vision of youth functioning. In contrast, interventions based on positive psychology promote a more balanced approach that takes into consideration the negative and positive aspects of experience and aims to enhance well-being. We present and discuss new interventions, such as the Optimal Functioning Therapy for Adolescents, which suggest that the focus of interventions for depressed adolescents should integrate symptom reduction and well-being enhancement to achieve optimal functioning. Helping young people be happier and more engaged in their lives is part of a new perspective for clinical psychology practice.

*Keywords:* Depression, youth, interventions, well-being, optimal functioning.

## Resumen

La depresión es un problema de salud pública importante en niños y adolescentes, lo que hace que identificar e implementar intervenciones efectivas para su tratamiento sea de creciente interés. Por lo tanto, el objetivo principal de este artículo es discutir teóricamente diferentes intervenciones psicológicas para la depresión. En particular, las que se abordan la psicopatología, la reducción de los síntomas depresivos y las nuevas intervenciones basadas en el enfoque de la psicología positiva, que se centran en el funcionamiento óptimo y el bienestar de la persona. Intervenciones con respaldo empírico para los niños y adolescentes, como la terapia cognitivo-conductual (TCC) y la terapia interpersonal (IPT), tienen un enfoque de reducción de síntomas, lo que representa una visión incompleta de funcionamiento en la juventud. En contraste, las intervenciones basadas en la psicología positiva promueven una aproximación más equilibrada que contempla los aspectos negativos y positivos de la experiencia y tiene como objetivo mejorar el bienestar. En el artículo, se presentan y discuten intervenciones nuevas, como la Terapia del Funcionamiento Óptimo Terapia para Adolescentes, que sugieren que el enfoque de las intervenciones para los adolescentes con depresión debería integrar la reducción de síntomas y la mejora de su bienestar para lograr un funcionamiento óptimo. Ayudar a que los jóvenes sean más felices y más comprometidos en sus vidas es parte de una nueva perspectiva para la práctica de la psicología clínica.

*Palabras clave:* Depresión, la juventud, las intervenciones, el bienestar, el funcionamiento óptimo.

## Introduction

In the last three decades, there has been greater recognition and scientific interest about depression in children and adolescents (Baker, 2006; Burgić-Radmanović, 2011). Depression is an important public health problem and is among the most common and incapacitating psychological disorders (Horowitz & Garber, 2006; Weisz, McCarty, & Valeri, 2006). Prevalence rates of depression stand at 2% in children and range between 5% and 8% in adolescents (Choe, Emslie, & Mayes, 2012; Rhode, Lewinsohn, Klein, Seeley, & Gau, 2012). ). Currently, prevalence rates of depression have gradually increased, especially in adolescents (Williams, O'Connor, Eder, & Whitlock, 2009); in addition, the age at first onset of depressive episodes is gradually lower (Reinecke, Curry, & March, 2009). Early-onset depression increases the risk for subsequent depressive episodes during adolescence and adulthood, and studies show recurrence rates between 45% and 75% over a 3 to 7 year period in these developmental stages

(Horowitz & Garber, 2006; Weisz et al., 2006). Hence, children and adolescents depression seems to be characterized by an episodic and chronic course, with recurrence in adulthood (Choe et al., 2012).

Depression is also associated with several negative psychosocial consequences, including substance abuse, school dropout, health problems, and impaired interpersonal relationships (Cheung, Kozloff, & Sacks, 2013; Horowitz & Garber, 2006; Weersing & Brent, 2006). Most depressed children and adolescents present comorbidity with other psychiatric disorders, particularly anxiety disorders (30% - 80%; Baker, 2006; Rhode et al., 2012). Also, these populations are at greater risk of developing substance abuse disorders and maladaptive behaviors, such as suicide attempts, the third cause of death among adolescents (Rhode et al., 2012; Weisz et al., 2006).

There have been significant efforts to identify the most effective therapeutic approaches to treat depression in these developmental stages, because

of its association with a significant impairment of individual functioning (Weisz et al., 2006). The cognitive-behavioral therapy and the interpersonal therapy are psychological interventions with some of the strongest empirical evidence for the treatment of depression in children and adolescents (David-Ferdon & Kaslow, 2008; Watanabe, Hunot, Omoril, Churchill, & Furukawa, 2007). However, some authors noted limitations in their application, for example, the main focus of intervention and the efficacy assessment are based on the reduction in depressive symptoms (BurgiĆ-Radmanović, 2011; David-Ferdon & Kaslow, 2008). Moreover, their efficacy seems to be short-lived: they lose effectiveness over a six-month period after the end of the intervention (Watanabe et al., 2007).

Gradually, new approaches to clinical intervention in youth depression have emerged in the literature, in addition to these empirically validated programs. Among them, intervention programs based on the Positive Psychology theoretical approach stand out. Positive psychology interventions assume that depression can be treated effectively by not only alleviating depressive symptoms, but also enhancing well-being, happiness, positive emotions, strengths, and meaning in life (Seligman, Rashid, & Parks, 2006; Sin & Lyubomirsky, 2009; Wood & Tarrier, 2010). The latter factors can be achieved using an intervention intentionally aimed at promoting optimal functioning and well-being enhancement, within positive developmental processes that maintain and promote children and adolescents' physical and psychological health. Thus, the positive psychology movement has created a growing interest in the study of ways to promote well-being, which contrasts with and extends the broad knowledge and investigation about symptom reduction and the negative aspects of adolescence (Castro-Solano & Lupano-Perugini, 2013; Karwoski, Garratt, & Ilardi, 2006; Larson, 2000; Reyes-Jarquín & Hernández-Pozo, 2011).

The aim of this paper is to discuss different intervention approaches for depression in children and adolescents. We will summarize theoretical rationales and discuss the strength of empirical support and efficacy in the treatment of youth depression. We present the strengths and limitations of each of these interventions, shedding light on the

main implications for clinical interventions aimed at promoting positive mental health and optimal functioning. Finally, we will review well-established interventions that focus on depressive symptom reduction, and new interventions based on the positive psychology approach, which focus on flourishing and well-being enhancement. In line with this positive approach, we will present a new and recent intervention for optimal functioning as an example of an integrative perspective on adolescent intervention that balances strategies for symptom reduction and well-being enhancement.

#### Interventions focused on reducing symptoms

The study of psychological interventions for youth depression has garnered increased attention. However, the only well-established depression treatments are the cognitive-behavioral therapy (CBT) for children and adolescents and the interpersonal therapy (IPT) for adolescents (David-Ferdon & Kaslow, 2008; Watanabe et al., 2007). These approaches conceptualize depression as negative mood, and maladaptive emotions and cognitions; because of this conceptualization, interventions focus mainly on ameliorating and alleviating these negative symptoms and focus less on improving positive resources (Sin, Della Porta, & Lyubomirsky, 2011). Consequently, the effectiveness of the CBT and IPT interventions is mainly based on findings of symptom reduction and lack of criteria for diagnostic status (Beaver, 2008). These interventions will be briefly described in terms of their main components, their empirical support in the treatment of youth depression, and their limitations.

#### *Cognitive-behavioral therapy*

The cognitive-behavioral therapy originated from the cognitive (e.g., Beck, 1967) and behavioral conceptualizations of depression (e.g., Lewinsohn, Weinstein, & Shaw, 1969). It is a manual-based, time-limited intervention for youth depression that aims to understand and modify maladaptive cognitions and behaviors to improve current mood and prevent future depressive episodes (Cheung et al., 2013; David-Ferdon & Kaslow, 2008; Weersing & Brent, 2006).

The cognitive component of CBT aims to co-

rect maladaptive beliefs and thinking patterns associated with greater depressive symptomatology. The behavioral component emphasizes engaging youth by promoting greater participation in pleasant activities, and developing social skills and problem-solving strategies. These skills help to create and maintain supportive relationships and to regulate emotions (Cheung et al., 2013; David-Ferdon & Kaslow, 2008; Weisz & Gray, 2008). Through a collaborative therapeutic relationship, these interventions teach specific skills to children and adolescents, and encourage their practice in-session and between sessions (Baker, 2006; Cheung et al., 2013). The skill-acquisition component is similar to an experiment in which individuals are coached by their therapists to make changes in their lives (Weersing & Brent, 2006).

In addition to the main procedures of cognitive-behavioral therapy, the therapist might invite parents to be part of the treatment to improve communication patterns with their children; parents are encouraged to help their children learn and generalize acquired skills (David-Ferdon & Kaslow, 2008). CBT protocols vary in the number of sessions (between 8 to 10 sessions), modality (group versus individual) and level of structure (Cheung et al., 2013; David-Ferdon & Kaslow, 2008; Weersing & Brent, 2006).

Previous reviews and empirical research indicate that cognitive-behavioral therapy is the most widely researched intervention of youth depression, and more than 80% of published psychotherapy trials test the effects of CBT protocols (Weisz et al., 2006). This intervention received the most empirical support for the treatment of youth depression, although it showed greater effectiveness in adolescent samples (David-Ferdon & Kaslow, 2008; Weersing & Brent, 2006). There is also evidence that cognitive behavioral therapy may be more appropriate for mild to moderate depression, than for cases of severe depression (Weersing & Brent, 2006).

#### *Interpersonal therapy*

The interpersonal therapy is another well-established intervention for youth depression that was adapted by Mufson et al. (2004) for the treatment of adolescents with non-bipolar, non-psychotic depression. According to this approach, interper-

sonal conflicts and transitions maintain depression; hence, this therapy aims to improve adolescents' interpersonal patterns to improve their mood. During adolescence, experiencing interpersonal difficulties after intervention increases the likelihood of relapse or recurrence of depression. Therefore, the focus on interpersonal difficulties seems to be an effective treatment during this developmental period (Mufson, 2010).

Similar to the adult version, the Interpersonal Therapy for Adolescents (IPT-A) addresses one to two of the four specific areas of interpersonal difficulty associated with the start of depression (*i.e.*, grief, interpersonal role disputes, interpersonal role transitions, and interpersonal deficits). The most common area of intervention is interpersonal disputes. Interpersonal role transitions might include starting a new academic level, puberty, and the end of an important relationship (e.g., intimate partner relationship, separation from parents). The therapeutic focus on interpersonal deficits occurs when adolescents have a limited number of significant interpersonal relationships, in which case the intervention aims to increase the number of these relationships.

The IPT-A helps adolescents identify specific areas of interpersonal difficulty (e.g., improved communication, expression of affect, development of an effective social support system) and develop effective strategies to cope with them. Adolescents have the opportunity to practice these skills in session and are encouraged to apply them in other interpersonal relationships (Mufson, 2010). Like cognitive-behavioral therapy, IPT-A is a manual-based, time-limited psychotherapy that includes 12 to 15 individual sessions (30 to 60 minutes each).

There is growing evidence of the efficacy of the interpersonal approach and psychotherapy in the treatment of adolescent depression (David-Ferdon & Kaslow, 2008; Gunlicks-Stoessel, Mufson, Jekal, & Turner, 2010; Weisz & Gray, 2008). According to David-Ferdon and Kaslow (2008), the theoretical approach of interpersonal therapy is a well-established intervention for the individual treatment of adolescents' depression, and IPT-A is considered a probably efficacious intervention for this age group. Empirical research demonstrates consistently that adolescents treated with IPT-A

show greater improvements in their depressive symptoms and better social and overall functioning, compared to adolescents in control conditions (Mufson, 2010; Mufson et al., 2004). Also, research has identified some moderators of treatment results, for example, this intervention is more effective for older adolescents (15–18 years old), with a more severe ill, poorer interpersonal functioning, and comorbid anxiety (Gunlicks-Stoessel et al., 2010; Mufson, 2010; Mufson et al., 2004).

#### *Remarks on symptom reduction focus*

As discussed previously, although the cognitive-behavioral and interpersonal therapies exemplify empirically-supported interventions for youth depression, they also present important limitations. The effectiveness of these interventions is typically based on depressive symptom reduction, though they seem to be ineffective in achieving this goal over a long period after treatment (Watanabe et al., 2007) and often disregard well-being enhancement (Ruini & Fava, 2012). These interventions mainly focus on reducing and removing symptoms and problems, highlighting the perspective that without symptoms life can be lived more positively. However, youth positive functioning is defined not just by the absence of illness, but also by the presence of positive psychological resources (e.g., positive affect, life satisfaction, personal growth), which are not included as formal intervention aims in CBT and IPT interventions.

These factors emphasize the need to develop new interventions for youth depression that take into consideration the overall functioning of children and adolescents, and that promote the development of resources associated with positive mental health (Sin et al., 2011).

#### Interventions for flourishing and well-being enhancement

Positive psychology interventions are a new branch in clinical intervention that evolved from the emergence of Positive Psychology. In the last years, the concept of psychotherapy has changed within this new conceptual approach and it is now understood not just as “a place where only troubles are discussed,” but also as “a place where strengths are discovered, where positive emotions

are cultivated, where gratitude and optimism are fostered” (Rashid, 2009, p. 462).

Nowadays, there is an increasingly greater number of positive psychology interventions aimed at enhancing well-being and promoting positive development and optimal functioning in youth (Ruini, Belaise, Brombin, Caffo, & Fava, 2006; Suldo, Savage, & Mercer, 2013). Positive psychology interventions are defined as “treatment methods or intentional activities that aim to cultivate positive feelings, behaviors, or cognitions” (Sin & Lyubomirsky, 2009, p. 468).

According to Seligman and colleagues (2006), positive psychological interventions can be used in the treatment of several mental disorders and can be especially relevant for the treatment of depressive symptoms. According to these authors, depression is characterized by the lack of positive affect, engagement, and life meaning. Therefore, the authors consider that addressing directly and primarily these positive resources may counteract depressive symptoms and prevent future relapses. Thus, positive psychology interventions propose a new way of treating depression instead of focusing directly on depressive symptoms.

A meta-analysis of 51 studies on positive psychology interventions concluded that these interventions increase well-being and decrease depressive symptoms (Sin & Lyubomirsky, 2009). Of these studies, only five were conducted with children and adolescents, and from those, only two measured and analyzed depressive symptomatology. These will be analyzed within the two main positive psychology interventions we chose to discuss in this paper: the Well-Being Therapy (WBT, Ruini et al., 2006; Ruini et al., 2009) and the Positive Psychotherapy Intervention (PPI, Rashid, Anjum, & Lennox, 2006).

#### *Well-Being Therapy (WBT)*

The WBT was developed by Fava and colleagues (Fava, 1999; Fava & Ruini, 2003; Fava & Tomba, 2009) as a psychotherapeutic strategy for increasing psychological well-being and resilience. This therapy is based on the Ryff multidimensional model of psychological well-being that comprises six dimensions: environmental mastery, personal growth, purpose in life, autonomy, self-acceptance, and positive relations with others. Therefore, the

aim of the WBT is to enhance psychological well-being levels on each of these dimensions (Ruini et al., 2006). This therapy can be implemented as a relapse-preventive strategy for mood and anxiety disorders and as a complement to CBT (Fava, 1999). It uses techniques of self-observation, a structured diary (to report the daily experiences of well-being), and interaction between patient and therapist to increase well-being (Fava & Ruini, 2003; Ruini & Fava, 2012).

Although the WBT was first implemented and empirically tested in clinical adult samples (Ruini & Fava, 2012), recently it has been applied to non-clinical youth samples in school settings. From a preventive perspective, the school setting has been considered the ideal context for WBT youth interventions. Hence, several school intervention studies have tested the efficacy of the WBT in at-risk age groups for mood and anxiety disorders (Ruini et al., 2006; Ruini et al., 2009; Ruini & Fava, 2012).

Ruini et al. (2006) tested the effectiveness of a school-based intervention protocol adapted from WBT and compared it with the CBT using a sample of one hundred and eleven participants (mean age = 13.04; standard deviation = 0.76). Both interventions were composed of four biweekly sessions. Findings revealed that both groups experienced similar decreases in symptomatology and similar increases in psychological well-being. However, the CBT intervention group showed a significant decrease in depression, whereas the WBT group did not.

Another study tested the efficacy of a new school program, adapted from the WBT that aimed to promote psychological well-being (Ruini et al., 2009). The study compared the new intervention with an attention placebo intervention in a sample of two hundred and twenty seven high school students (mean age = 14.4; standard deviation = 0.67). Both interventions included six sessions of two hours. Results revealed that the WBT school intervention had a significant effect in promoting psychological well-being (namely personal growth) and in decreasing distress (somatization and physical well-being), in comparison with the attention-placebo group. There were no significant effects of either intervention on depressive symptoms.

### *Positive Psychotherapy Intervention (PPI)*

Rashid and Seligman developed the PPI based on Seligman's (2002) work on well-being. Seligman defined well-being as the existence of three factors: the *pleasant life*, which can be promoted through savoring strategies that increase pleasure and positive emotions about past, present, and future; the *engaged life*, characterized by an intense involvement in everyday life and can be attained through the use of signature strengths such as gratitude and forgiveness; and the *meaningful life*, in which strengths are put in service of something greater than the self and can be fostered through relationships with family and institutions (Carr, 2011; Seligman, 2002).

The PPI addresses clients' positive resources by developing positive emotions and strengths and helping individuals find meaning in their lives. In turn, these developments promote happiness and alleviate psychological disorders, such as depression. Furthermore, PPI has been implemented and empirically tested in the form of individual psychotherapy with adults from clinical and non-clinical samples (Seligman et al., 2006). According to findings from these preliminary studies, PPI reduces depression and increases well-being (Carr, 2011).

For children population, we highlight the study of Rashid et al. (2006), in which the authors developed a group version of PPI and implemented it in twenty-two middle school students (mean age = 11.77; standard deviation = 0.69). The aim of this eight-week program is to decrease depressive symptoms through the promotion of positive emotions, character strengths, and meaning. The following exercises were implemented during the program: positive introduction, use of signature strengths, three blessings, savoring, and family tree of strengths. The intervention group showed a significant increase in scores of pleasant, engaged life, meaningful life, and overall happiness from the start to the end of the intervention program, compared with the control group. However, there were no significant group differences on the scores for life satisfaction and depression.

### *Remarks on flourishing and well-being enhancement focus*

Positive interventions that emerged from the

positive psychology movement have succeeded in demonstrating their efficacy in the promotion of well-being, life satisfaction, and happiness in children and adolescents (Rashid et al., 2006; Ruini et al., 2006; Ruini et al., 2009). However, the evidence that these interventions contribute to the reduction of depressive symptoms in youth population is still lacking. Studies on positive psychology interventions have been conducted mainly in normative populations, which might account for the lack of significant differences in depressive symptoms reported at the start and end of the intervention. Therefore, further research should include clinical youth populations to investigate whether these positive interventions are also effective in reducing depressive symptoms.

Finally, other perspectives suggest that integrating strategies of cognitive-behavioral therapy and positive psychology intervention could lead to promising results in clinical populations by decreasing depressive symptoms and promoting optimal functioning (Ingram & Snyder, 2006; Karwoski et al., 2006).

#### A positive intervention for adolescent optimal functioning: An integrative perspective

Over the years, several authors have highlighted the importance of applying the principles of positive psychology to the cognitive-behavioral therapy in clinical practice (Bannink, 2013; Ingram & Snyder, 2006; Karwoski et al., 2006). These authors believe that the limitations of CBT can be overcome by incorporating a more positive focus and techniques from positive psychology interventions. Karwoski et al. (2006) discussed the conceptual and technical overlap between CBT and positive psychology, and provided several directions to integrate the two interventions by promoting factors that contribute to well-being enhancement: capitalizing on strengths, hope, flow, mindfulness, addressing unsolvable problems, optimism training, meaning, humor, and physical exercise.

Based on this integrative perspective, Teixeira and Freire (n.d.) developed a manualized fourteen-week individual intervention, designed to treat depressive disorders entitled *Optimal Functioning Therapy for Adolescents* (OFTA). This therapy aims

to promote adolescents' optimal functioning by reducing depressive symptoms and increasing well-being. It uses cognitive-behavioral strategies built for this purpose and incorporates related positive psychology issues to promote happiness and well-being. The novelty of this therapy consists on the integration of CBT and positive psychology strategies, following recommendations by Karwoski et al. (2006).

The OFTA is structured in three main modules according to different themes. Module I addresses the identification and recognition of experiences of well-being and happiness (past and present), the identification of life domains not affected by problems, and the identification of factors that may be contributing to success in these identified domains. In addition, during Module I the therapist helps to promote positive experiences in the daily life of adolescents (participation in structured leisure activities is strongly encouraged), positive ways of thinking, a more positive interpretation of reality (through cognitive restructuring that was adapted for the purposes of the OFTA therapy), and the enhancement of secondary control over uncontrollable adverse events and problems. This first module addresses the reduction of depressive symptoms through the combination of adapted CBT and positive psychology strategies. Subsequent modules focus on the enhancement of well-being and promotion of optimal functioning, using mostly positive strategies.

Module II focuses on the identification and reflection about experiences of success that occurred in the past and present. In this module, the therapist and the client focus on identifying and recognizing adolescents' strengths of character; reflect and discuss the advantages of those strengths; attend to opportunities for the application of strengths on several life contexts; and discuss different ways of using those strengths to solve problems. Finally, module III focuses on identifying activities that induce a state of flow and encourages adolescents to incorporate these activities into their daily life routines, fostering hope and optimism through the development of future life goals and discussing the steps needed to achieve them, with the aim of developing a life project for the future.

At the moment, this therapy is under empirical

evaluation. The assessment of OFTA has been conducted using retrospective instruments that assess psychopathology symptoms (including depression) and variables associated with optimal functioning, such as self-esteem, self-concept, life satisfaction, psychological well-being, and positive affect. The authors of OFTA also included real time measures to the assessment of this therapy, namely the Experience Sampling Method (ESM, Csikszentmihalyi & Larson, 1987). Real time measures assess the impact of this therapy on the daily lives of adolescents as they provide information about their mood and affect over time. Furthermore, it makes it possible to verify whether adolescents are more engaged in their life contexts at the end of the therapeutic process. These assessments are performed in four different moments of the therapeutic process: pre-intervention; middle-intervention; post-intervention; and follow-up.

Until now, the results obtained with clinical samples have been promising, showing significant decreases in depressive symptoms and increases in well-being, maintained until follow-up assessment. Integrating CBT and positive psychology techniques in module I seems to contribute to a significant reduction in depressive symptoms early on the therapeutic process; this seems to create the necessary conditions to address well-being enhancement in the subsequent modules. Well-being enhancement is addressed mainly at two different, but related, levels: the therapeutic relationship and youth' promptness to change and flourish.

Together, symptom reduction and well-being enhancement may contribute to adolescents' overall optimal functioning by facilitating the positive participation in life contexts and the positive engagement with significant others in everyday contexts.

### Conclusion and Future Directions

This paper presents a new approach on psychological interventions for depression in children and adolescents. We differentiated between interventions focused in symptom reduction, which were empirically tested according to literature review, and interventions based on positive psychology approaches, aimed at promoting human flourish-

ing and well-being. These different interventions should not be considered as independent, opposite, or complementary; instead, they should be seen as two sides of the same coin when considering the purposes and guidelines for clinical interventions in children and adolescents that aim to facilitate the development of healthy individual trajectories. This underlines the importance of addressing conceptual and methodological issues by testing the effectiveness of positive interventions in depressed children and adolescents, and establishing an evidence-based condition for the inclusion of positive psychology constructs in depression intervention with youth, akin to other validated clinical interventions (Beaver, 2008; Wood & Tarrier, 2010).

Positive interventions should include groups to allow comparisons with previously validated interventions, and should develop and use follow-up measures that assess the impact of these interventions over time and in daily life. In addition, developing comparison studies between normative and clinical samples might offer new insights about the strengths and limitations of these interventions.

Positive clinical psychology is particularly interested in understanding ways to enhance developmental assets and improve well-being, regardless of individual - healthy or psychopathological - functioning patterns. As suggested by Ruini and Fava (2012), taking into consideration well-being and distress levels for the promotion of flourishing will contribute to a deeper knowledge about the impact of clinical and preventive interventions on youth flourishing. These authors emphasized the concept of "optimal-balanced well-being" and the need to resolve impairments of psychological well-being in clinical and normative children and adolescents. In their perspective, well-being enhancement is not automatically achieved through reinforcement and growth of positive psychological dimensions. Interventions must help individuals balance psychological dimensions to either increase levels from low to optimal levels, or to decrease levels from inappropriately high to optimal-balanced levels, thus assuring optimal functioning and well-being in daily life.



To achieve these goals – and according to OFTA –, positive interventions aimed at improving optimal functioning in depressed children and adolescents underline the need to focus on youth subjective experience in daily life. Focusing in their day-to-day experiences may promote connectedness and engagement in different contexts and interpersonal relations, with school context being highlighted as a main life context for children and adolescents. Schools contribute not only to the development of learning and educational processes, but are also privileged contexts for illness prevention and for promoting mechanisms of resilience and psychological well-being (Romo-González et al., 2013; Ruini & Fava, 2012).

This perspective supports a developmental and ecological perspective based on individual-context interactions. Intervention processes need to facilitate these interactions to promote the development of healthy trajectories that are sustained in their strengths and potentialities, thus facilitating well-being enhancement. The discussion of the validation and efficacy assessment of clinical strategies and techniques is a main concern if we want to ensure interventions for depression are achieving their proposed aims. As OFTA, interventions should be based simultaneously on CBT techniques and positive strategies and should create new intervention tools, conceptually based on the positive psychology framework and evidence-based intervention approaches.

This perspective contributes greatly to the advancement of the knowledge, planning and implementation of positive interventions for youth depression. However, researchers should be aware of the strengths and pitfalls associated with these interventions in specific clinical disorders and populations, especially their efficacy in achieving optimal functioning through developmental promotion and disorder resolution. As suggested by Sin et al. (2011), positive psychology interventions “are not one-size-fits-all” (pp.92) and it is necessary to understand depression and its functioning patterns when considering children and adolescents that are *in* development.

Future research should aim to study healthy and flourished youth and to balance knowledge on psychopathology, its onset, and optimal development. In line with the aims of the OFTA

intervention, studies on positive interventions should focus on extending the knowledge about how positive daily subjective experience and life conditions impact flourishing, momentary experience, and lifelong trajectories in youth.

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Self-references for authors: 1

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