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OPINION

GUEST ESSAY

This Is Not the Way to Help Depressed Teenagers

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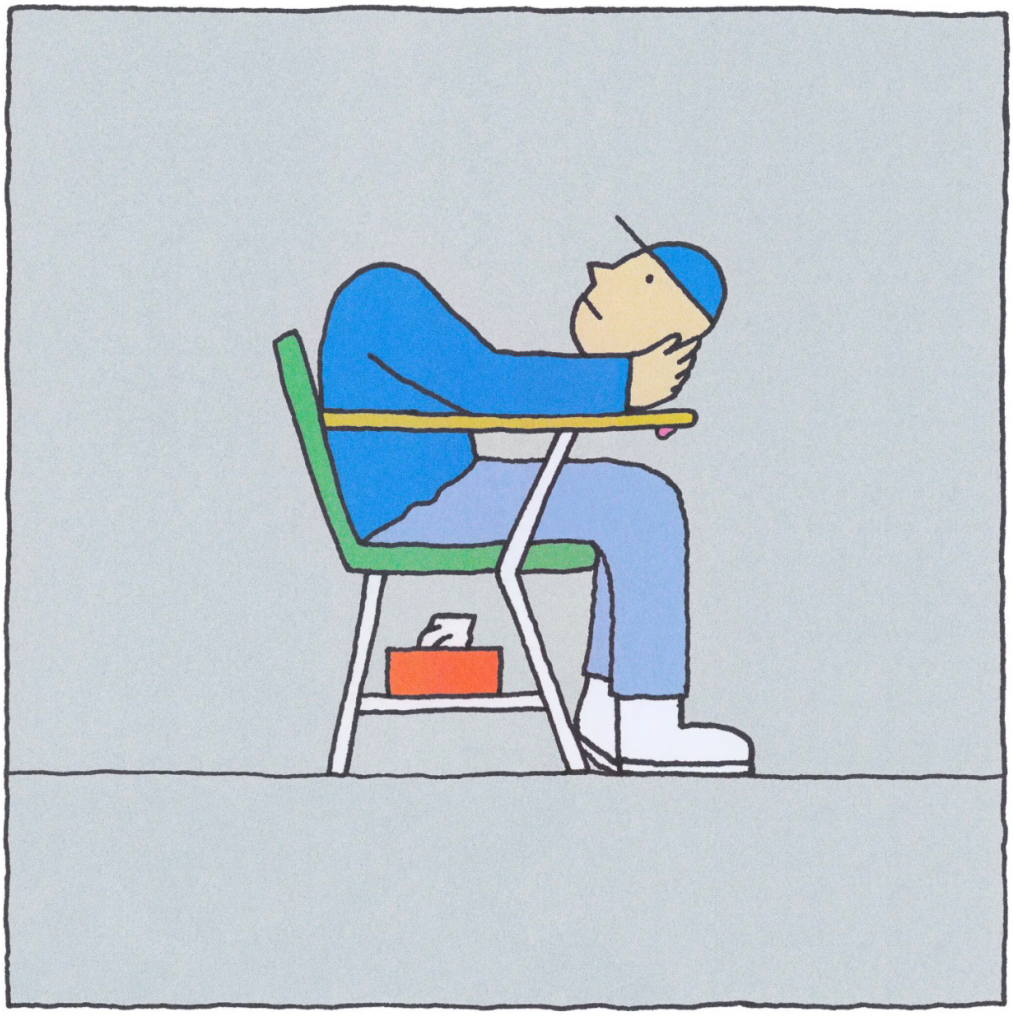

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Ever since the pandemic, when rates of teenage suicide, anxiety and depression spiked, policymakers around the world have pushed to make mental-health resources more broadly available to young people through programming in schools and on social media platforms.

This strategy is well intentioned. Traditional therapy can be expensive and time-consuming; access can be limited. By contrast, large-scale, "light touch" interventions — TikTok offerings from Harvard's School of Public Health, grief-coping workshops in junior high — aim to reach young people where they are and at relatively low cost.

But there is now reason to think that this approach is risky. Recent studies have found that several of these programs not only failed to help young people; they also made their mental-health problems *worse*. Understanding why these efforts backfired can shed light on how society can — and can't — help teenagers who are suffering from depression and anxiety.

Consider a "social-emotional skills training" school program called WISE Teens. Led by clinical psychologists in training, it consists of eight weekly hourlong classroom sessions in which students learn to manage their emotions with the help of tools and principles drawn from cognitive behavior therapy and Zen Buddhism.

Last month, the journal Behavior Research and Therapy published a study of 1,071 Australian teenagers who were observed from 2017 to 2018: One group participated in WISE Teens; another group participated in a standard health-class curriculum. Compared with the teenagers who got the standard education, the students in WISE Teens reported more depression, more anxiety, more difficulty managing their emotions and worse relationships with their parents. One out of every eight WISE Teens participants appeared clinically depressed after completing the program, compared with one out of every 13 participants who did the regular health classes.

These results are striking but not unique. Last year, an even larger study of a school-based mindfulness program, which looked at more than 8,000 British teenagers in more than 80 schools, foundthat the program did not improve mental health — and in fact led to worse anxiety and emotional problems, plus lower levels of mindfulness skills. Yet another study published last year, which included some 2,500 Australian teenagers, also found that a mental health program made students more distressed.

Why were these programs counterproductive? The WISE Teens researchers suggest, convincingly, that the teenagers weren't engaged enough in the program and might have felt overwhelmed by having too many tools and skills presented to them without enough time to master them. (The study found that WISE Teens participants who spent more time practicing the skills at home showed some slight mental health benefits — though most of the participants did not engage in home practice.)

But I would venture three additional explanations for the backfiring, all of which dovetail with what other research tells us about youth mental health.

First, by focusing teenagers' attention on mental health issues, these interventions may have unwittingly exacerbated their problems. Lucy Foulkes, an Oxford psychologist, calls this phenomenon "prevalence inflation" — when greater awareness of mental illness leads people to talk of normal life struggles in terms of "symptoms" and "diagnoses." These sorts of labels begin to dictate how people view themselves, in ways that can become self-fulfilling.

Teenagers, who are still developing their identities, are especially prone to take psychological labels to heart. Instead of "I am nervous about X," a teenager might say, "I can't do X because I have anxiety" — a reframing that research shows undermines resilience by encouraging people to view everyday challenges as insurmountable.

It's generally a sign of progress when diagnoses that were once whispered in shameful secrecy enter our everyday vocabulary and shed their stigma. But especially online, where therapy "influencers" flood social media feeds with content about trauma, panic attacks and personality disorders, greater awareness of mental health problems risks encouraging self-diagnosis and the pathologizing of commonplace emotions — what Dr. Foulkes calls "problems of living." When teenagers gravitate toward such content on their social media feeds, algorithms serve them more of it, intensifying the feedback loop.

A second possible explanation for why these programs backfired is that they were provided in the wrong place and to the wrong people. The structure of school, which emphasizes evaluation and achievement, may clash with practicing "slow" contemplative skills like mindfulness. Plus, many of the skills taught in these programs were developed for people coping with severe mental illness, not everyday stresses. These tools might not feel applicable to teenagers who aren't deeply struggling — and on the flip side, their wide-scale adoption

might make them seem too generic and watered-down to teenagers who are truly ill.

A third possible explanation is that these interventions offered enough information to highlight a problem, but not enough to fix it. As research has repeatedly shown, the most effective therapies involve not just learning skills but also developing meaningful relationships. Even the most structured cognitive behavioral approaches recognize the value of a strong working therapeutic alliance between therapist and client. Effective therapies often require clients to do hard things: Exposure therapies for anxiety, for example, ask clients to confront fears they'd prefer to avoid. Such interventions work best with steady, consistent, hands-on support from a dedicated therapist.

To be sure, psychologists have done some important and innovative work making mental health interventions more broadly accessible. To cite just one example, Jessica Schleider, a psychology researcher at Northwestern University, has tested several single-session treatments that can be offered online and show promising results in teenagers. But although such offerings fill gaps in our mental health infrastructure, they cannot take the place of more time- and resource-intensive forms of care.

The hard truth is that soaring rates of teenage depression and anxiety present a structural problem requiring structural solutions, including the training of a much larger work force of therapists. In school settings, creating more opportunities for young people to build relationships with adults through smaller class sizes and greater access to traditional guidance counselors might move the needle more than specialized mental-health curriculums can. Other, more prosaic-seeming changes like starting school later to encourage sleep, decreasing the homework burden and creating more opportunities for play, exercise, music, arts and community engagement are all empirically supported strategies for improving mental health.

In the meantime, those serving up mental health guidance, both online and at school, should be cautious. It's critical to keep pace with the evidence and attend to the first principle of all health care providers: First, do no harm.

More on teenage mental health

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https://www.nytimes.com/2023/11/18/opinion/teenagers-mental-health-treatment.html