



UNIVERSITI PUTRA MALAYSIA

***EFFECTIVENESS OF COGNITIVE BEHAVIOR THERAPY AND REIKI
THERAPY ON ADOLESCENTS WITH DEPRESSIVE DISORDERS IN
TEHRAN, IRAN***

MANSOUREH CHARKHANDEH

FEM 2014 42



**EFFECTIVENESS OF COGNITIVE BEHAVIOR THERAPY AND REIKI
THERAPY ON ADOLESCENTS WITH DEPRESSIVE DISORDERS IN
TEHRAN, IRAN**

By

MANSOUREH CHARKHANDEH

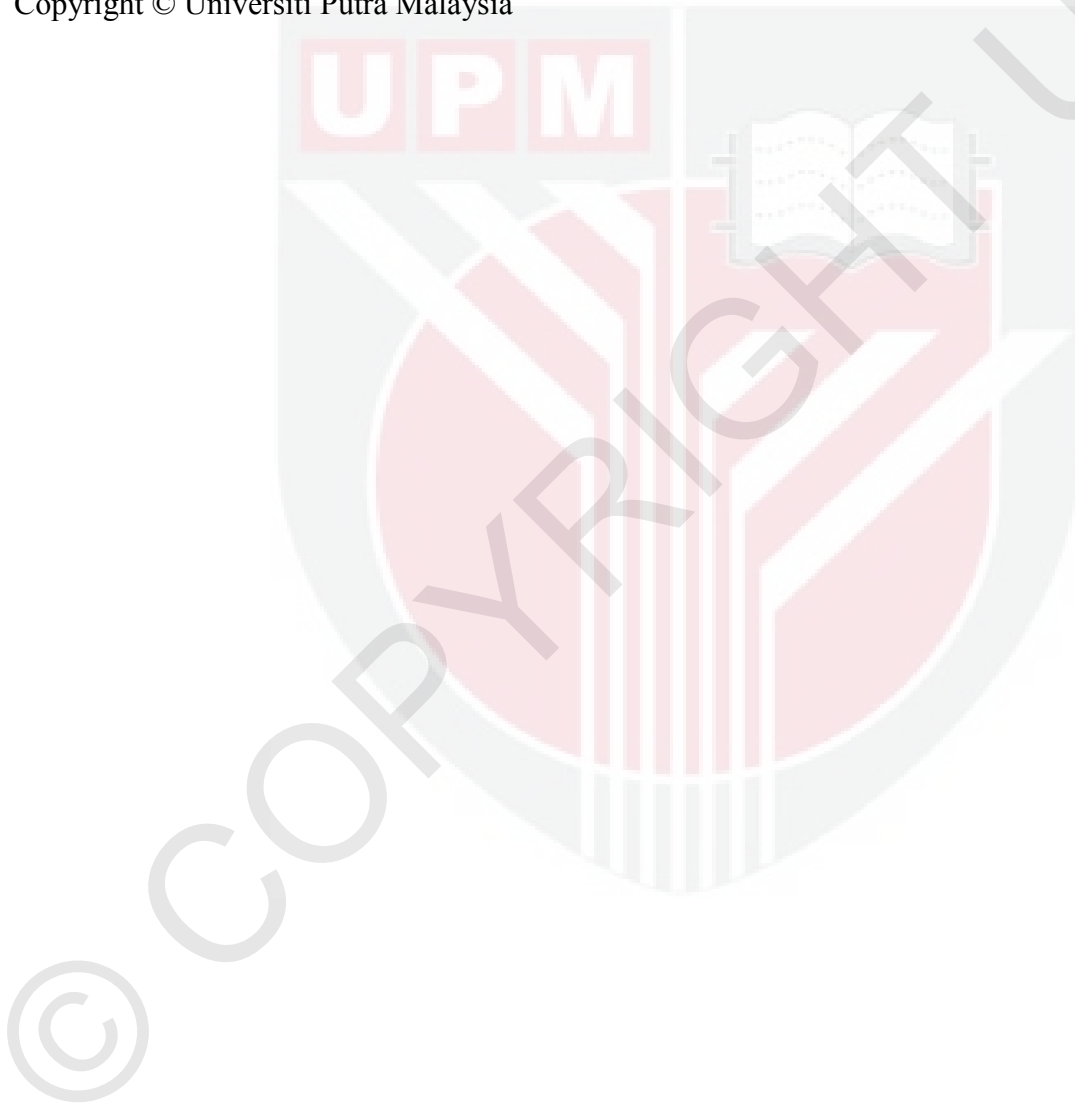
**Thesis submitted to the School of Graduate Studies,
Universiti Putra Malaysia, in fulfilment of the
requirements for the Degree of Doctor of Philosophy**

May 2014

COPYRIGHT

All material contained within the thesis, including without limitation text, logos, icons, photographs and all other artwork, is copyright material of Universiti Putra Malaysia unless otherwise stated. Use may be made of any material contained within the thesis for non-commercial purposes from the copyright holder. Commercial use of material may only be made with the express, prior, written permission of Universiti Putra Malaysia.

Copyright © Universiti Putra Malaysia



DEDICATION

*To my parents
To the masters who teaches to me with love and compassion*

*To my daughter
"Anita"*



© COPYRIGHT UPM

Abstract of thesis presented to the Senate of Universiti Putra Malaysia in fulfillment of the requirement for the degree of Doctor of Philosophy

EFFECTIVENESS OF COGNITIVE BEHAVIOR THERAPY AND REIKI THERAPY ON ADOLESCENTS WITH DEPRESSIVE DISORDERS IN TEHRAN, IRAN

By

MANSOUREH CHARKHANDEH

May 2014

Chairman: Mansor Abu Talib, Ph.D.

Faculty: Human Ecology

Depression in childhood and adolescence is among the most common and disabling disorders. It is defined as a mood of sadness plus other emotional symptoms, such as low self-esteem, anhedonia, anxiety, guilt, pessimism, and loneliness. Depression disorders are assessed through structured clinical interviews and observation. Estimates of the prevalence of Major Depression Disorder (MDD) in adolescence range from 0.4% to 8.3% lifetime prevalence. Epidemiological studies from the literature on mental health of youth indicate that depression, drug abuse and suicide are among the three most common causes of death among young people. Some studies have been conducted to assess the state of mental health in Iran. The rate of attempted suicide among depressed patients in a community area is 0.5% in Iran, which is significantly lower than in the most recent clinical research. The aim of current research is to investigate the effectiveness of CBT and Reiki among depressed adolescents in Tehran, Iran.

It is expected that using the CBT and Reiki approaches in the present study pioneers further work in this particular area of depression in children. Cognitive behavior therapy and Reiki are two non-pharmacological therapies. The purpose of the current study is to make a comparison between a psychotherapeutic approach (CBT) and an alternative medicine method (Reiki). Cognitive behavioral therapy is effective for mild childhood depression. Most anxiety and depression treatments include general skills-building strategies such as self-monitoring, psycho-education, problem-solving, social skills training, and reward plans thus; successful CBT would be expected to engender positive change in cognitive processing including decreasing negative automatic thoughts, maladaptive attitudes and assumptions, and decreased threat interpretations. Reiki is described by supporters as a holistic therapy which brings about healing on physical, emotional, mental and spiritual levels. It is classified as an alternative, complementary, or integrative method or therapy.

This study involved a quantitative data collection method, with pre-test and post-test is design with two experimental groups and one control group. There were two periods of data collection for this study. The period one employed pre-test (T1) to assess depression score of participant by CDI, and the period two (T2) to measure depression score when two treatments (CBT and Reiki) are performed. One of the most common mental disorders in children and adolescents in Tehran is depression. These adolescents had been referred to psychotherapy clinics in different districts in Tehran. A multistage random sampling method was used in this study. A random sample was constructed by taking a series of simple random samples in different stages. The eligible adolescents referred to these health centers recruited for the study from June to September 2010. The following criteria were used to recruits participants: (a) aged 12-17, (b) met a minimum CDI score of 20, (c) met DSM-IV-TR criteria for major depression based on structural interview by two clinical psychologists, and (d) completed a pretreatment assessment. Each of the three treatment groups (CDI, Reiki, and the control group) included 80 samples, which provided an accumulated mixed gender total of 240 boys and girls. The number in the CBT group was reduced to 63 (34 girls and 29 boys). Reiki group therapy was performed for 65 depressed adolescents (34 girls and 31 boys). The number of samples in the control group at the end of treatment was 60 (33 girls and 27 boys).

The data in this study were collected by a self-rating scale “Child Depression Inventory” (CDI) and backgrounds questionnaire. The CDI is a self-rating scale modeled on the Beck depression inventory (BDI) and adapted to young people 7-17 years of age. The depressive symptoms assessed include cognitive, affective, somatic and behavioral aspects. The 27 items were scored from 0 to 2. Clinical / categorical approach is proven that it covers symptoms of depression, most major and minor, according to the DSM-IVTR. The CDI takes about 10-20 minutes to complete and contains five subscales: negative mood, interpersonal problems, ineffectiveness, anhedonia and negative self-esteem. The CDI was taken before start of treatment at the first stage to determine the level of depression score in adolescence (pre-test). At the second stage, the CDI was used after period of 12 sessions in Reiki and CBT treatments to determine depression score of the participants and to assess the effectiveness of the two methods on reduction of depression in adolescents (post-test). The CBT program was arranged in two sessions of one and a half hours per week. The planning totaled eighteens hours in twelve sessions over six weeks of the treatment period. Some of the treatment activities such as relaxation, discussion, solving of problems skills, and positive cognitive changes in CBT method were performed in groups.

Reiki therapy was individually for 20 minutes in each session and two sessions in a week. The participants in a waitlist control group condition attended information sessions and were familiarized with the goals of the research. They were not receiving any treatment and education. Pearson Chi Square analysis to check any significant association although the demographic variables (gender, age, parental education, medical problems, living arrangements and family income) between there group (CBT, Reiki and control). Paired *t-test* was used to analyze the difference between pre-test and post-test in one group. One way ANOVA test and *post-hoc* test were used for analysis the difference between pre-test or post-test in three independent groups (CBT, Reiki and

control). An independent *t-test* was also done to determine differences between post-test of male and female scores.

The current study determined that CBT is an important independent variable in reducing of depression score of Iranian adolescents more than Reiki therapy. The CBT was same effect in decreasing depression scores of male and female while Reiki had different effect. The side results showed that CBT and Reiki programs led to reducing subscales scores (negative mood, interpersonal problems, ineffectiveness, anhedonia, negative self-esteem). Successful CBT treatment brings about positive changes in cognitive processing, including decreased negative automatic thoughts settings, and maladaptive assumptions and reduced threat interpretations. One of the most important findings from the quantitative data of this study is the number of participants who reported feeling relaxes during and after treatment. Some participants noted that the use of Reiki increases energy.

Moreover, the CBT effects should help to solve these social and individual problems and it is recommended that counseling centers and the Iranian Ministry support both schools and other educational institutions, in helping to minimize if not solve the problem of mental disorders among Iranian youth. The practice of Reiki should be promoted and there should be efforts made to train Reiki masters. Reiki research should be encouraged and this traditional art of healing should be introduced to the scientific community. To control depression, there must be practical programs, such as relaxation, mediation, individual and group counseling, so they can support programs and help students and their abilities to deliver better services in the school.

Abstrak tesis yang dikemukakan kepada Senat Universiti Putra Malaysia
Sebagai memenuhi keperluan untuk ijazah Doktor Falsafah

**KEBERKESANAN TERAPI TINGKAH LAKU KOGNITIF DAN TERAPI
REIKI KE PADA REMAJA DENGAN GANGGUAN KEMURUNGAN DI
TEHRAN, IRAN**

Oleh

MANSOUREH CHARKHDANEH

Mei 2014

Pengerusi: Mansor Abu Talib, Ph.D.

Fakulti: Ekologi Manusia dengan

Kemurungan dalam zaman kanak-kanak dan remaja adalah gangguan yang paling teruk dan paling kerap terjadi. Ianya didefinisikan sebagai perasaan sedih bercampur simptom emosional yang lain seperti rendah diri, anhedonia, kegelisahan, perasaan bersalah, pesimis dan kesunyian. Gangguan kemurungan telah dinilai menerusi temuramah berstruktur klinikal dan pemerhatian. Jangkaan bagi prevalen bagi Major Depression Disorder (MDD) dalam jangka alam remaja daripada 0.4% kepada 8.3% prevalen seumur hidup. Kajian Epidemiologikal daripada sorotan kajian ke atas kesihatan mental remaja menunjukkan kemurungan, penyalahgunaan dadah dan bunuh diri adalah antara tiga kes yang kerap penyebab kematian di kalangan golongan muda. Sesetengah kajian telah dijalankan bagi menilai tahap kesihatan mental di Iran. Kadar cubaan membunuh diri di kalangan pesakit kemurungan dalam satu kawasan komuniti adalah 0.5% di Iran yang mana adalah secara signifikannya rendah berbanding daripada kebanyakan kajian klinikal terkini.

Tujuan kajian ini adalah untuk menyiasat keberkesanan bagi CBT dan Reiki dikalangan remaja murung di Tehran, Iran. Ianya dijangkakan dengan menggunakan pendekatan CBT dan Reiki dalam kajian ini, pengkaji lebih memfokuskan kerja dalam bidang khusus bagi kemurungan bagi kanak-kanak. Terapi tingkah laku kognitif dan Reiki adalah dua terapi bukan farmasologikal. Tujuan kajian ini adalah untuk membandingkan pendekatan psikoterapeutik (CBT) dan pendekatan perubatan alternatif (Reiki). Terapi tingkah laku kognitif adalah efektif bagi zaman kemurungan kanak-kanak sederhana. Kebanyakan rawatan kegelisahan dan kemurungan termasuklah strategi umum pembinaan kemahiran seperti pemerhatian sendiri, pendidikan psiko, penyelesaian masalah, latihan kemahiran sosial dan rancangan ganjaran lalu, CBT yang berjaya dijangka dapat untuk mengakibatkan perubahan positif dalam pemprosesan kognitif termasuklah mengurangkan pemikiran automatik negatif, sikap maladaptif dan danaan dan mengurangkan interpretasi ancaman. Reiki telah diterangkan oleh penyokong sebagai terapi holistik yang membawa kepada penyembuhan ke atas fizikal, emosional,

mental dan tahap kerohanian. Ianya telah diklasifikasikan sebagai alternatif, komplementari atau pendekatan integratif atau terapi.

Kajian ini termasuklah pendekatan pengumpulan data kuantitatif dengan pra dan pasca ujian telah direka dengan dua kumpulan eksperimental dan satu kumpulan kawalan. Terdapat dua tempoh masa bagi pengumpulan data bagi kajian ini. Tempoh masa pertama menggunakan pra ujian (T1) untuk menilai skor kemurungan bagi peserta bagi CDI, dan tempoh masa kedua (T2) untuk mengukur skor kemurungan apabila dua rawatan (CBT dan Reiki) dijalankan. Salah satu gangguan mental yang paling biasa berlaku kepada kanak-kanak dan remaja di Tehran adalah kemurungan. Remaja ini telah dirujuk kepada klinik psikoterapi dalam daerah berbeza di Tehran. Satu kaedah pelbagai tahap persampelan rawak telah digunakan dalam kajian ini. Sampel rawak telah dibina dengan mengambil satu siri sampel rawak ringkas dalam pelbagai tahap. Remaja yang layak dirujuk kepada pusat kesihatan yang telah dilantik dalam kajian bermula Jun sehingga September 2010. Kriteria yang berikut telah digunakan untuk melantik peserta: (a) berumur 12-17, (b) memenuhi skor minimum CDI daripada 20, (c) memenuhi kriteria DSM-IV-TR bagi kemurungan utama berdasarkan keatas temubual berstruktur oleh dua psikologis klinikal, dan (d) menjawab ujian pra rawatan. Setiap daripada tiga kumpulan rawatan (CBT, Reiki, dan kumpulan kawalan) termasuklah 80 sampel, yang telah menyumbang kepada campuran jantina terkumpul berjumlah 240 lelaki dan perempuan. Bilangan dalam kumpulan CBT telah dikurangkan kepada 63 (34 perempuan dan 29 lelaki). Kumpulan terapi Reiki telah dijalankan bagi 65 remaja murung (34 perempuan dan 31 lelaki). Bilangan sampel dalam kumpulan kawalan di penghujung rawatan adalah 60 (33 perempuan dan 27 lelaki).

Data dalam kajian ini telah dikumpulkan dengan skala penilaian sendiri 'Child Depression Inventory (CDI)' dan borang kajiselidik latar belakang. CDI adalah skala rating sendiri yang dimodelkan berdasarkan kepada Inventori Kemurungan Beck (BDI) dan digunapakai kepada orang muda lingkungan 7-17 tahun. Simptom kemurungan dinilai termasuklah kognitif, afektif, somatik dan aspek tingkah laku. 27 item telah diskorkan bermula daripada 0 hingga 2. Pendekatan klinikal/ kategori telah terbukti dimana ianya meliputi simptom bagi kemurungan, kebanyakannya major dan minor menurut DSM-IVTR. CDI mengambil masa lebih kurang 10-20 minit untuk menyiapkan dan menyimpan lima sub skala: suasana negatif, masalah interpersonal, ketidakberkesanan, anhedonia dan nilai diri negatif. CDI telah diambil sebelum rawatan bermula pada tahap pertama untuk mengenalpasti tahap skor kemurungan dalam remaja (pra ujian). Pada tahap kedua, CDI telah digunakan selepas 12 sesi dalam rawatan Reiki dan CBT bagi mengenalpasti skor kemurungan bagi peserta dan menilai keberkesanan dua cara ke atas pengurangan kemurungan dalam remaja (pasca ujian). Program CBT telah diatur dalam dua sesi meliputi sejam setengah setiap minggu. Rancangannya berjumlah lapan belas jam dalam dua belas sesi merangkumi enam minggu tempoh rawatan. Beberapa aktiviti rawatan seperti rehat, perbincangan, kemahiran penyelesaian masalah dan perubahan kognitif positif dalam kaedah CBT telah dijalankan dalam kumpulan.

Terapi Reiki secara individu telah dijalankan selama 20 minit bagi setiap sesi dan dua sesi dalam seminggu. Peserta dalam senarai menunggu kumpulan kawalan telah hadir

bagi sesi maklumat dan dikenalkan dengan matlamat kajian. Mereka tidak menerima sebarang rawatan atau pendidikan. Analisis Pearson Chi Square untuk memeriksa sebarang pertautan signifikan meskipun pembolehubah demografik (jantina, umur, pendidikan ibubapa, masalah perubatan, kemudahan hidup dan pendapatan keluarga) antara tiga kumpulan (CBT, Reiki dan Kawalan). *t-test* berpasangan telah digunakan untuk menganalisa perbezaan antara pra ujian dan pasca ujian dalam satu kumpulan. Salah satu cara ujian ANOVA dan ujian *post-hoc* telah digunakan bagi analisis perbezaan antara pra ujian atau pasca ujian dalam tiga kumpulan bebas (CBT, Reiki dan kawalan). *t-test* yang bebas turut diadakan untuk mengenalpasti perbezaan antara skor pasca ujian bagi lelaki dan perempuan.

Kajian ini mengesahkan yang CBT adalah pembolehubah bebas yang penting dalam mengurangkan skor kemurungan bagi remaja Iran berbanding terapi Reiki. CBT menghasikan kesan sama bagi mengurangkan skor kemurungan bagi lelaki dan perempuan manakala Reiki menghasilkn kesan yang berbeza. Dapatan kajian menunjukkan yang CBT dan program Reiki telah menghubungkan skor sub skala (mood negatif, masalah interpersonal, ketidakberkesanan, anhedonia, nilai sendiri yang negatif) . Rawatan CBT yang berjaya dapat membawa kepada perubahan yang positif dalam pemprosesan kognitif termasuklah pengurangan penetapan fikiran negatif automatik dan andaian maladaptif dan mengurangkan interpretasi ancaman. Salah satu dapatan yang penting daripada data kuantitatif bagi kajian ini adalah bilangan peserta yang melaporkan berasa tenang semasa dan selepas rawatan. Beberapa peserta turut mencatatkan penggunaan Reiki meningkatkan tenaga.

Selain daripada itu, kesan CBT patut membantu dalam menyelesaikan masalah sosial dan individu dan ianya dicadangkan agar pusat kaunseling dan kementerian Iran menyokong kedua-dua sekolah dan institutsi pendidikan dalam membantu mengurangkan jika tidak dapat menyelesaikan masalah gangguan mental dikalangan remaja Iran. Penggunaan Reiki patut dipromosikan dan sepatutnya adalah usaha diambil untuk melatih pakar Reiki. Kajian Reiki patut digalakkan dan seni rawatan tradisional ini patut diperkenalkan kepada komuniti saintifik. Bagi mengawal kemurungan, sepatutnya diadakan program yang praktikal seperti relaksasi, meditasi, kaunseling perseorangan dan berkumpulan jadi mereka dapat menyokong program dan membantu pelajar dan keupayaan mereka untuk menyampaikan perkhidmatan yang lebih baik dalam sekolah .

ACKNOWLEDGEMENTS

I would like to appreciate the supervisory committee. First and foremost, I wish to thank my supervisor associate Prof. Dr. Mansor Abu Talib for his guidance, inspiration, support, encouragement and friendship throughout the course of my Ph.D. I specially appreciate that he has shown me the importance of having critical views in science in many ways. This has been and will be extremely influential in all of my scientific work. He took time out of his busy schedules to read the chapters of this thesis as they were completed. My thanks go to Dr. Siti Nor Yaacob and Dr. Mariani Bte Mansor for their insightful and helpful comments over the years and particularly for the valuable comments for improving the thesis.

I specially would like to thank Dr. Ma'rof Redzuan for discussions on the research methodology of the thesis and his valuable help for doing the statistical analyses. The help of Prof. Dr. Bahaman is acknowledged. Many thanks to all my friends and colleagues Dr Hasan Pasha Sharifi and Dr Anush Hashemian in past and present, for their support.

I would like to express my deep gratitude to my parents for their love and continuing encouragement.

MANSOUREH CHARKHANDEH

I certify that a Thesis Examination Committee has met on 16 May 2014 to conduct the final examination of Mansoureh Charkhandeh on her thesis entitled "Effectiveness of Cognitive Behavior Therapy and Reiki Therapy on Adolescents with Depressive Disorders in Tehran, Iran" in accordance with the Universities and University Colleges Act 1971 and the Constitution of the Universiti Putra Malaysia [P.U.(A) 106] 15 March 1998. The Committee recommends that the student be awarded the Doctor of Philosophy.

Members of the Thesis Examination Committee were as follows:

Zaid bin Ahmad, PhD

Professor
Faculty of Human Ecology
Universiti Putra Malaysia
(Chairman)

Hajjah Rusnani binti Abdul Kadir, PhD

Associate Professor
Faculty of Educational Studies
Universiti Putra Malaysia
(Internal Examiner)

Haslinda binti Abdullah, PhD

Associate Professor
Faculty of Human Ecology
Universiti Putra Malaysia
(Internal Examiner)

Caroline Jane Hunt, PhD

Associate Professor
University of Sydney
Australia
(External Examiner)



ZULKARNAIN ZAINAL, PhD

Professor and Deputy Dean
School of Graduate Studies
Universiti Putra Malaysia

Date: 9 December 2014

This thesis was submitted to the Senate of Universiti Putra Malaysia and has been accepted as fulfillment of the requirement for the degree of Doctor of Philosophy.

The members of the Supervisory Committee were as follows:

Mansor Abu Talib, Ph.D.

Associate Professor
Faculty of Human Ecology
Universiti Putra Malaysia
(Chairman)

Siti Nor Yaacob, Ph.D.

Senior Lecturer
Faculty of Human Ecology
Universiti Putra Malaysia
(Member)

Mariani Bte Mansor, Ph.D.

Senior Lecturer
Faculty of Human Ecology
Universiti Putra Malaysia
(Member)

BUJANG BIN KIM HUAT, Ph.D.

Professor and Dean
School of Graduate Studies
Universiti Putra Malaysia

Date:

Declaration by graduate student

I hereby confirm that:

- this thesis is my original work;
- quotations, illustration and citations have been duly referenced;
- this thesis has not been submitted previously or currently for any other degree at any other institution;
- intellectual property from the thesis and copyright of thesis are fully owned by Universiti Putra Malaysia, as according to the Universiti Putra Malaysia (Research) Rules 2012;
- written permission must be obtained from supervisor and the office of deputy vice chancellor (Research and Innovation) before thesis is published (in the form of written, printed or in electronic form) including books, journals, lecturer notes, learning modules or any other materials as stated in the Universiti Putra Malaysia (Research) Rules 2012;
- there is no plagiarism or data falsification/fabrication in the thesis, and scholarly integrity is upheld according to the Universiti Putra Malaysia (Graduate Studies) Rules 2003 (Revision 2012-2013) and the Universiti Putra Malaysia (Research) Rules 2012. The thesis has undergone plagiarism detection software.

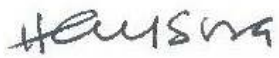
Signature: *Michelle Adams* Date: 2015-03-10


Name and Matric No: Mansoureh Charkhandeh (GS20730)


Declaration by Members of Supervisory Committee

This is to confirm that:

- the research conducted and the writing of this thesis was under our supervision;
- supervision responsibilities as stated in the Universiti Putra Malaysia (Graduated Studies) Rules 2003 (Revision 2012-2013) are adhered to.

Signature: 
Name of
Chairman of **MANSOR ABU**
Supervisory **TALIB**
Committee: **PROF. MADYA DR MANSOR ABU TALIB**
Jabatan Pembangunan Manusia & Pengajian Keluarga
Fakulti Ekologi Manusia
Universiti Putra Malaysia
43400 Serdang, Selangor Darul Ehsan

Signature: 
Name of
Member of
Supervisory
Committee: **DR. SITI NOR YAACOB**
PENSYARAH KANAN
JABATAN PEMBANGUNAN MANUSIA DAN PENGAJIAN KELUARGA
FAKULTI EKOLOGI MANUSIA
UNIVERSITI PUTRA MALAYSIA
43400 UPM SERDANG, SELANGOR

Signature: 
Name of
Member of **on behalf**
Supervisory **Pm by Mariani Mansor**
Committee:

Signature:
Name of
Member of
Supervisory
Committee:

PROF. MADYA DR MANSOR ABU TALIB
Jabatan Pembangunan Manusia & Pengajian Keluarga
Fakulti Ekologi Manusia
Universiti Putra Malaysia
43400 Serdang, Selangor Darul Ehsan

TABLE OF CONTENTS

	Page
ABSTRACT	i
ABSTRAK	iv
ACKNOWLEDGEMENTS	vii
APPROVAL	viii
DECLARATION	x
LIST OF TABLES	xv
LIST OF FIGURES	xvi
LIST OF ABBREVIATIONS	xvii
CHAPTER	
1 INTRODUCTION	1
1.1 Introduction	1
1.2 Statement of the Problem	3
1.3 Objectives	5
1.3.1 Main Objective	5
1.3.2 Specific Objectives	5
1.4 Research Hypotheses	5
1.5 Significance of the Study	6
1.6 Definition of Variables	7
1.7 Theoretical Framework	8
1.7.1 Piaget's Psychosocial Development Theory	9
1.7.2 Beck's cognitive theory	9
1.7.3 Holistic nursing theories	10
1.8 The Conceptual Framework of the Study	13
1.9 Limitation of the study	14
1.10 Summary	15
2 LITERATURE REVIEW	16
2.1 Introduction	16
2.2 Depression in Adolescents	16
2.3 Prognosis and Etiology	17
2.4 Cognitive Behavioral Therapy (CBT)	18
2.5 CBT and Adolescent Depression	19
2.6 Reiki therapy	25
2.7 Reiki and Depression	27
2.8 Children's Depression Inventory (CDI) in Iran	28
2.9 Summary	29

3	METHODOLOGY	30
3.1	Introduction	30
3.2	Research Design	30
3.3	Location of Study	31
3.4	Determination of the Sample Size	31
3.5	Sampling Participants, Eligibility and screening	31
3.6	Data Collection	33
3.7	Preparing the Participants	34
3.8	CBT Treatment Process	34
3.9	Reiki group process	35
3.10	Control Group Process	36
3.11	Instruments	36
3.12	Data Analysis	37
3.13	Summary	38
4	RESULTS AND DISCUSSION	39
4.1	Introduction	39
4.2	Respondents' Background Children's & Parental Demographic characteristics	39
4.3	Depression Scores of Respondents	42
4.4	Description of CBT, Reiki & Control groups According to Gender	42
4.5	Differences of Depression score (CBT, Reiki) and Control Group at Pre-Test and Post-Test.	43
4.6	Discussion on General Objective	46
4.7	Differences of Depression Scores in two Experimental Groups (CBT and Reiki) at Pre-Test and Post-Test	46
4.8	Discussion of Objective 1	47
4.9	Discussion of Objective 2	49
4.10	Analysis of depression score of Male, Female at Pre-Test and Post-Test in CBT and Reiki	49
4.11	Discussion of Objective 3	51
4.12	Discussion of Objective 4	54
4.13	Analysis of Subscales in CBT Group at pre and posttest	55
4.14	Analysis of Subscales in Reiki Group at pre and posttest	57
4.15	Summary	59
5	SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS	62
5.1	Introduction	62
5.2	Summary	62
5.3	Conclusion of the Study	64
5.4	Implications	66

5.5	Recommendations for Future Research	67
5.6	Summary	68

REFERENCES	69
APPENDICES	92
BIODATA OF STUDENT	135
LIST OF PUBLICATIONS	136



LIST OF TABLES

Table	Page	
3.1	Experimental Design	30
3.2	Sampling size	33
3.3	The Intervention and Times in Data Collection of Groups	33
3.4	CBT Programs (Treatment Activities, Treatment Goal and Session)	35
3.5	Factor Scale, Factor Measured and Items in CDI	37
3.6	Hypotheses and methods of analysis	38
4.1	Personal Characteristics and Family Profiles of the Respondent in three Groups	41
4.2	Frequency and Distribution Percentage of Depression Levels in Pretest and posttest of Respondent	42
4.3	The Normality Description of CBT, Reiki and Control group	43
4.4	One-Way ANOVA Test of the Mean Scores in Pre-Test (CBT, Reiki and Control)	44
4.5	One-Way ANOVA Test, the Mean Scores of Post-Test in CBT, Reiki and Control	45
4.6	Turkey's HSD, Post-Test difference results in CBT, Reiki and Control	45
4.7	Paired Sample T-Tests (Pre and Post) test of CBT Scores	47
4.8	Paired Sample T-Test (Pre and Post) test of Reiki Scores	48
4.9	Paired sample t-test of male in CBT	50
4.10	Paired Sample T-Test of Female in CBT	50
4.11	T-Test, Post-Test Score of Male and Female in CBT	51
4.12	Paired sample t-test of male in Reiki	53
4.13	Paired Sample T-Test of Female in Reiki	53
4.14	T-Test, Post-Test Score of Male and Female in Reiki	54
4.15	Paired sample t-test of subscales in CBT	56
4.16	Paired Sample T-Test of subscales in Reiki	58
4.17	Summary of the findings	59

LIST OF FIGURES

Figure	Page
1.1 The Theoretical Framework	12
1.2 The conceptual Framework of the Study	14
3.1 The location of Tehran (Capital of Iran)	31
3.2 Sampling Process	32
4.1 differences of (pre and post) test scores of five subscales in CBT	57
4.2 Differences of (pre and post) test scores of five subscales in Reiki	58
A.1 Chakras, indicated by circles along the center of the body	124
A.2 The different of symbols the body for Reiki therapy	125
A.3 The different positions of head for Reiki therapy	126
A.4 The different positions of front for Reiki therapy	127
A.5 The different positions of back for Reiki therapy	128

LIST OF ABBREVIATIONS

APA	American Psychiatric Association
BDI	Beck Depression Inventory
CDI	Children Depression Inventory
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders
M	Mean
MDD	Major Depressive Disorder
NCCAM	National Center for Complementary and Alternative Medicine
NIH	National Institute of Health
OAM	Office of Alternative Medicine
RIA	Relaxation Induced Anxiety
SD	Standard deviation
SUD	Subjective Units of Disturbance
US	United States
WHO	World Health Organization

CHAPTER 1

INTRODUCTION

1.1 Introduction

Depression in childhood and adolescence is among the most common and disabling disorders. It is reported that childhood depression ranges from 2% -6% among the school-age population and may end up seriously affecting such children in their adult life (World Health Report, 2001). Depression is among the most common mental disorders and is often referred to as the common "cold" of mental illness. It is estimated that 5% through 25% of the population experience depression at some point in their lives and 15% of severely depressed people will commit suicide worldwide (Gotlib & Hammen, 2002). During puberty, about 2% of 13-year-olds suffer from depression and on average, 17% at age of 18 years are similarly affected worldwide (Angold et al., 2002). The current prevalence of depressive disorders in Iran is 2% (1.8% major depressive disorders and 0.2% minor depressive disorders), among those living in cities and who are not housewives (Mohammadi et al., 2006). Using the Diagnostic and Statistical Manual of Mental Disorders -IV (DSM-IV) criteria and clinical interviews, findings indicate that the prevalence of depression disorders is 9.2 % ((4.4% major depressive disorder, 3.9% minor depressive, and 0.8% dysthymia in Iran (Noorbala, 2008). Depression is defined as a mood of sadness plus other emotional symptoms, such as low self-esteem, anhedonia, anxiety, guilt, pessimism, and loneliness. Depression disorders are assessed through structured clinical interviews and observation. Estimates of the prevalence of Major Depression Disorder (MDD) in adolescence range from 0.4% to 8.3% lifetime prevalence; across youth it ranges from 15% to 20% and point prevalence rate for Depression Disorder (DD) ranges from 1.6% to 8.0%, with a small number in the world having both disorders (Roberts & Bishop, 2003).

In the past 20 years, awareness and attentiveness to depression in children have led to significant advances in treatment and the availability of much literature concerning the phenomenology, etiology correlates and psychosocial factors of depression, particularly childhood depression (Asarnow et al., 2001). Clinicians now recognize how to approach depression in children and prescribe treatment for it while parents have been made familiar with their children's depression in order that they can better understand their children's condition. In light of this, there are the usual requirements to explore other treatments, assess their effectiveness, and evaluate it in relation to previous treatment strategies for promoting recovery among those insensitive to any treatment. Now, clinicians have an understanding of what to do when depression is diagnosed but there is still a need to investigate alternative treatment strategies to ensure that successful treatments are available (Asarnow et al., 2001).

Adolescents may suffer from depression which may cause despair and forlornness in them, and make them disheartened about doing their daily jobs (Pike and Fitzpatrick, 2003). Depressed adolescents may not show any sign of despair or hopelessness, rather they may get easily irritated. Furthermore, they may have a cynical and antisocial

attitude toward others and have the misconception that others do not understand them. There are some social and cognitive factors which are used to define adolescent depression. Increased extent of critical self-referent attributions among adolescents (Prinstein et al., 2005), lack of proper capability to perceive oneself (Tram & Cole, 2000), idealist attitude and seeking social endorsement (Ginsburg et al., 2009), and finally, uncontrollable pessimistic perceptions about themselves and others are among these factors (Greening & Martin, 2005).

The American Psychiatric Association (2000) guidelines indicate that among psychotherapeutic approaches, Cognitive Behavioral Therapy (CBT) has the best documented effectiveness for the treatment of depression disorders. Clinical depression undoubtedly has a significant impact on the developmental pathways of youth and adolescents. The CBT psychotherapist commonly aims at ensuring a development by reducing depressingly distorted perception, achieve problem solutions, learn coping skills and promote active participation of adolescents in healthy and pleasant activities. The CBT treatments frequently consist of necessary skill- building sessions and optional modular sessions for particular problems (Tads, 2004). The findings by Oei & Dingle (2008), Henderson (2004), Fujisawa et al. (2010), Kerfoot et al. (2004), Hyun & Seo (2005), Pamela et al. (2010), Snead et al. (2004), Spielmans et al. (2007), Prins & Ollendic (2003), Weisz et al. (2006), Barlow et al. (2004), Clarke et al. (2003), Brent (1997) and Asarnow (2001) exposed that CBT intervention in group format resulted in reduction of depression of children.

In 1992, the national institute of health (NIH) established the office of alternative medicine (OAM) to evaluate alternative therapies. In 1998, there was the OAM freestanding center, National Center for Complementary and Alternative Medicine (NCCAM) (Dossey et al., 2000). The foundation has completed a study on mental health and the use of complementary therapies in the field of mental health and it is obvious that a series of different therapies can be used, for example, massage, reflexology, Reiki, therapeutic healing, herbal medicine and aromatherapy (Wiles & Brooker, 2003). Reiki is a technique that uses a spiritual approach to healing. There is evidence that Reiki can help people with various complaints, serious and minor. It is often used as a complementary therapy in some conventional hospitals today (Ell yard, 2004). It complements and enhances the health care given to the patient in the hospital or some other health care provider. The findings of past studies about comparison of Reiki therapy and control group by Miles (2003), Ell Yard (2004), Harrison et al. (2001), Fleming (2003) and Olson et al. (2003) which concluded that Reiki therapy decreases depression of participants. Reiki has not only helped patients with physical complaints, but also been effective for minor psychological problems (Nield et al., 2001). One of the most significant health benefits of Reiki is stress relief and relaxation, which triggers the body's natural healing abilities for improving and maintaining health. Reiki helps to bring about inner peace and harmony; it can be a valuable instrument in the search for spiritual growth (Peggy, 2001).

1.2 Statement of the Problem

More than 450 million people universally are affected by neurological, psychological or behavioral problems at one time or another (WHO, 2001). Epidemiological studies from the literature on mental health of youth indicate that depression, drug abuse and suicide are among the three most common causes of death among young people (Brookman, 2006). Some studies have been conducted to assess the state of mental health in Iran. Recent studies showed that 9.7% of 24-year-olds from the northwestern Iran people interviewed were diagnosed with a mental disturbance (Mohammadi et al., 2006). The number of cases has been established to increase with increasing age, and women are twice more likely than men to be diagnosed with a mental disorder (Fakhari et al., 2007). Noorbala (2008) examined the mental health of 35,014 people, including 11,448 adolescents and young adults between 15 and 24 years in Tehran with the General Health Questionnaire-28 (GHQ-28). The results showed that (women, 25.9% and men, 14.9%), about one-fifth of the population experienced mental disorders, with women being at higher risk than men. In the general population of Iran, the rate of lifetime prevalence of suicide attempts is 1.4% and the depression related to attempted suicide attempt is 0.5% (Malakouti et al., 2009). The strong religious and cultural prohibitions against suicide in Iran could have played a significant role in the survey conducted, and led to under-reporting it, so the actual suicide attempt rates could be much higher. The rate of attempted suicide among depressed patients in a community area is 0.5% in Iran, which is significantly lower than in the most recent clinical research (Nojomi et al., 2008). Otherwise, it can be expected that the rate of suicide attempts in the clinical sample to be higher than in the epidemiological studies in Iran (Mohammadi et al., 2006). Many children diagnosed with depression, when evaluated analytically, exhibit symptoms of other problems such as anxiety and disruptive disorders. A series of studies have reported that drug abuse has become a social evil due to the prevailing social, psychological (depression and anxiety), domestic and economic conditions. Moreover, the rapid rise of drug abuse has resulted in an alarming increase in the incidence of infectious diseases and other health problems in Iran (Mokri, 2002).

Depression can lead boys and girls to miss training or to lag behind in school (Busari & Uwakwe, 2001). Education is a very important determinant of adult earnings, so if school attendance and performance are significantly affected by depression, adolescents can put their future in jeopardy. Depression can negatively impact concentration among adolescents in school as well as at work. Such negative effects could be related to depression and subsequent harmful behaviors like substance abuse (smoking, alcohol and drug), and eating problems (Cooper, 2008). Additionally, Adolescent behavioral disturbances are generally much more likely to lead to higher risk of association with youth gangs and similar undesirable company. There is also the belief that depression brings on debilitating infectious diseases in adolescents (Cohen et al., 2000).

Many adolescent depressions are linked to interpersonal deficits due to social problems. These deficits lead to depression and feelings of worthlessness, hopelessness and isolation. It is important for therapists, teachers and parents to be aware of these problems and understand the full extent of these negative feelings and to examine the patient using character-playing problem-solving techniques, communication and self-assertion training and conflict resolution, which were among the most important

advances in clinical child and adult psychiatry in the last century. Conflict resolution recognizes that internalizing disorders, depression and anxiety states can be reliably diagnosed in this age group. The diagnostic criteria for depression are essentially the same for the young and the growing, with the exception of the inclusion of irritable moods (Brent et al., 1997). Teenagers and younger children can certainly become seriously depressed. Adolescents need careful treatment because i) they are going through all the stresses of adolescence, ii) they are growing rapidly and facing with all sorts of new challenges in their lives, and iii) it's not easy to know what they're thinking. Also, children might go to the doctor with physical symptoms, so that depression is visually very hard to recognize (Cembrowicz, 2002).

The use of CBT for children and the young has been extended with good outcomes. It is often used to treat depression, anxiety disorders and symptoms in connection with trauma and posttraumatic stress. Important work in this area has been done by Beck and his colleagues (Beck et al., 1979) in a psychology program in Chicago. Earlier studies show that cognitive behavior therapy is effective in treating depression among the adolescents (Clarke et al., 2001; Abolghasemi, 2008). Forozande (2002) investigated group CBT on college students in Shah Record (Iran). These findings highlighted that CBT is an effective intervention to decrease depression among college students in Shah Record. Alavi et al., (2013) and Khaneh Keshi et al. (2013) evaluated the effectiveness of a Cognitive Behavioral therapy for suicide prevention in decreasing suicidal ideation and hopelessness in adolescents who had at least one previous suicidal attempt in Iran. The findings shows that CBT is an effective method in reducing suicidal ideation and hopelessness in the depressed adolescents with previous suicidal attempts. The other obtained finding is consistent with the result of this study (Rohde et al., 2006; Henderson, 2005; Rossello et al., 2006; Hyun & Seo, 2005; Pamela et al., 2010) concerning depression and aimed at evaluating cognitive behaviour therapy influence and its comparison with a control group. It was concluded that CBT reduces depression levels. In general, cognitive behaviour therapy can lead to changes in depression scores of participants.

Although the use of Complementary and Alternative Medicine (CAM) has been evaluated globally, there are few studies about it and specific Reiki in Iran. The findings (Fahimiet et al., 2011; Tonekaboni et al.2011; Abolhassani et al., 2012) shows that (CAM) includes techniques such as homeopathy, acupuncture, chiropractors, herbal medicine and spiritual healing, energy therapies are used in Iran. Reiki is described by supporters as a holistic therapy which brings about healing on physical, emotional, mental and spiritual levels, in the belief is that the energy will flow through the practitioner's hands whenever the hands are placed on or held near a potential recipient (Ell yard, 2004).The effectiveness of Reiki intervention for decreasing depression is supported by other studies such as: Nancy (2010), Etephene (2006), Crawford et al. (2006), Vital & O'Connor (2006), Brathovde (2006), Ameling & Anderson (2001), Wardell & Engebretson (2001), Shiflett et al. (2002), Shore (2004), Deborah (2006) and Miles (2003).

However, the clinical impact of these two therapies are not investigated in Iranian population. Therefore, I aimed at studying CBT and Reiki, which are two non-pharmacological therapies, among adolescents in the metropolitan city of Tehran. It is expected that using the CBT and Reiki approaches in the present study pioneers further work in this particular area of depression in children. The result of this study could address the significance of juvenile conduct problems especially in the Tehran-Iran context, and leads to development of psychotherapies for reducing the prevalence of depression among children.

The current research was done among Iranian depressed adolescences to answer the following questions:

Is there any difference between the effectiveness of CBT and Reiki on depression of adolescences?

Is CBT effective in reducing depression of adolescences?

Is Reiki therapy effective in reducing depression of adolescence?

Is there any difference between the effectiveness of CBT in reducing depress boys and girls?

Is there any difference between the effectiveness of Reiki therapy in reducing depression of boys and girls?

1.3 Objectives

1.3.1 Main Objective

The main objective of this research is “to compare the effectiveness of CBT and Reiki among depressed adolescents in Tehran, Iran”.

1.3.2 Specific Objectives

The specific objectives of the study are as follows among Iranian adolescences:

To determine the effectiveness of cognitive behavior therapy in reducing depression among Iranian adolescents.

To determine the effectiveness of Reiki in reducing depression among Iranian adolescents.

To compare cognitive behavioral therapy among depressed boys and girls.

To compare Reiki therapy among depressed boys and girls.

1.4 Research Hypotheses

According to the objectives of the study, the following hypotheses were proposed:

General objective: To compare cognitive behavioral therapy and Reiki among depressed adolescents in Tehran, Iran”.

H01: There is no significant difference in the depression scores of three groups (cognitive behavior therapy, Reiki and control group) at pre-test.

H02: There is no significant difference in the depression scores of three group (cognitive behavior therapy, Reiki and control) at post-test.

Objective 1. To determine the effectiveness of cognitive behavior therapy in reducing depression among Iranian adolescents.

H03: There is no significant difference in pre-test and post-test of adolescent depression score based on CBT therapy.

Objective 2. To determine the effectiveness of Reiki in reducing depression among Iranian adolescents.

H04: There is no significant difference in pre-test and post-test of adolescent depression score based on Reiki therapy.

Objective 3. Comparison of cognitive behavioral therapy in depressed boys and girls in Iran.

H05: There is no significant difference in pre-test and post-test of male's depression scores based on CBT treatment.

H06: There is no significant difference in pre-test and post-test of female's depression scores based on CBT treatment.

H07: There is no significant difference in post-tests of depression scores of male and female based on CBT treatment.

Objective 4. Comparison of Reiki therapy in depressed boys and girls in Iran.

H08: There is no significant difference in pre-test and post-test of male's depression scores based on Reiki treatment.

H09: There is no significant difference in pre-test and post-test of male's depression scores based on Reiki treatment.

H010: There is no significant difference in post-tests of depression scores of male and female based on Reiki treatment.

1.5 Significance of the Study

Cognitive behavior therapy and Reiki are two non-pharmacological therapies. The purpose of the current study is to make a comparison between a psychotherapeutic approach (CBT) and an alternative medicine method (Reiki) (Sameer & Milind, 2011). This study compares the effectiveness of CBT and Reiki as two intervention approaches for decreasing depression among Iranian adolescent. Reiki therapy is cheaper than CBT, requires a shorter treatment time and can be easily used (Shore, 2004). This will significantly reduce the burden for the affected youth, their families and society in general. Medical treatment and prevention programs are important to focus on an individual risk and resilience factors, family and community risk and resilience variables that have been developed, including the development and maintenance of depression in adolescent treatment (Clarke et al., 2003).

The use of electro-shocks for decrease of depression in medical young treatment lead to side effects and other disadvantages while CBT and psychotherapy has important benefit for them although it is time-consuming and expensive (Mushtag, 2010). Therefore, there is a need for an effective treatment that is less time-consuming to treat adolescent depression. Reiki can be a solution to save money and time, which would be ideal at a time of economic, educational and social deficits besetting Iran and thus contribute to a healthier people, and generally a healthier public (shore, 2004). Overall, CBT aims at modifying maladaptive thinking and attitudes, increase skill sets, and change unrewarding or avoidant behavioral patterns (Weisz et al, 2006). Even though Reiki therapy has been reported to have plenty of merits and benefits, people are still cynical about its probable side effects. Dupler and Rey (2005) have demonstrated that Reiki therapy does not bring out any side effects, rather it is proved to be an easy-to-perform and light therapy. The individuals who have received Reiki therapy sometimes state that they have had feelings of hotness or coldness, or even feelings of despair and apprehension, but Reiki therapy has never been reported to cause serious side effects among its recipients. Most anxiety and depression treatments include general skills-building strategies such as self-monitoring, psycho-education, problem-solving, social skills training, and reward plans thus; successful CBT would be expected to engender positive change in cognitive processing including decreasing negative automatic thoughts, maladaptive attitudes and assumptions, and decreased threat interpretations (Chen, 2006).

This study will also focus on Reiki therapy in other areas of health care. Alternative therapies are gaining currency in the treatment of people with depression. These therapies often lack empirical insights about their effectiveness (Marshall & Hutchinson, 2001). Reiki is the least expensive and less time-consuming and can be administered very simply by non-academic technical personnel. The effectiveness of Reiki will then be compared with CBT. The research purpose is for emphasizing psychotherapy and alternative medicine method to treatment mental health problem in among youth. Quantitative findings suggest Reiki have the potential to improve health outcomes and increase individuals' coping findings that warrant further study. One of the key findings from the quantitative data of this study is a number of participant's reports feeling relaxed during and after Reiki treatments (Nancy, 2010). Participants' reports of relaxation are consistent with the author's experiences using progressive muscle relaxation and Reiki in clinical populations (Bowden et al., 2010). Another interesting finding was that, for some participants, the duration of benefit persisted for periods beyond the treatment itself. In addition, some participants' remarks suggest that the benefits of Reiki are cumulative (Nancy, 2010). Specialists have long been concerned that it is time consuming and expensive to prevent and treat depression in health centers (Stewart et al., 2003). In Iran, depression has been attracting more and more attention in the past decade as a very significant public health problem. Depression among adolescents in Iran is a serious problem, based on reviews of the young in school and this study hopes to address this problem and contributes to solving the educational problems of adolescents (Modabber-Nia et al., 2007).

1.6 Definition of Variables

Depression

Conceptual definition:

According to DSM-IV-TR, to be considered clinically depressed, a child or adolescent must have at least two weeks of persistent change in mood manifested by either depressed or irritable mood and/or loss of interest and pleasure plus a group of other symptoms including wishing to be dead, suicidal ideation or attempts; increased or decreased appetite, weight or sleep; and decreased activity, concentration, energy or self-worth or exaggerated guilt (American Psychiatric Association, 2000).

Operational definition

In the present study, depression was assessed based on responses to the Children's Depression Inventory (CDI). The CDI quantifies a wide range of depressive symptoms including disturbances in mood and capacity to enjoy activities, vegetative functions, self-evaluations, and interpersonal behavior (Kovacs, 1992).

CBT

Conceptual definition:

Cognitive Behavioral Therapy is a form of psychotherapy that emphasizes the role of rational thinking in how individuals feel and behave. A central tenet of this approach is that an individual's thoughts, not outside people or events, cause feelings and behaviors (National Association of Cognitive Behavioral Therapists, 2002).

Operational definition:

The CBT program was arranged in two sessions of one and a half hours per week. The planning totaled eighteens hours in twelve sessions over six weeks of the treatment period (National Association of Cognitive Behavioral Therapists, 2002).

Reiki

Conceptual definition:

Reiki is an ancient hands-on healing art that is used today as a modern healing intervention. In modern nomenclature, Reiki is classified as an alternative, complementary, or integrative method or therapy (Debbie, 2005). Reiki is described by supporters as a holistic therapy which brings about healing on physical, emotional, mental and spiritual levels.

Operational definition:

Reiki therapy programs was arranged in 12 session of 20 minutes per week (Nield-Anderson & Ameling, 2001). The Reiki treatment proceeded with the practitioner placing his hands in various positions for three to five minutes at each position. They used the non-touching technique, where the hands were held a few centimeters away from the recipient's body, for some or all of the positions. (Ell yard, 2004).

1.7 Theoretical Framework

CBT

The cognitive component in cognitive-behavioral psychotherapy refers to the way people think and create meaning about situations, symptoms and events in their lives and develop beliefs about self, others and the world (Dobson & Dobson, 2009). CBT uses techniques to help people become more aware of how they reason, and types of thought patterns come to mind and make sense of things. Cognitive interventions use a style of questions to gauge people, meanings and use it to stimulate alternative viewpoints or ideas. This is called the discovery guided, and involves exploration and reflection on the style of reasoning and thinking, and opportunities to think differently and more effectively. On the basis of these alternatives, people conduct behavioral experiments to test the accuracy of these alternatives, and to adopt new ways of thinking and acting. Overall, intention is to move away from the most extreme ways unnecessary and see things for more useful and balanced conclusions (Dozois, 2001). The behavioral component in cognitive-behavioral psychotherapy refers to how people react in times of distress. Responses, such as avoidance, reduced activity and behavior may be unnecessary or the problems will get worse. CBT practitioners can help the person feel safe enough to gradually test their assumptions and fears and change their behavior. For example, it may help people to cope with feared situations gradually or avoid them as a means of reducing anxiety and learning new skills to solve behavior problems (Hembree & Foa, 2004).

1.7.1 Piaget's Psychosocial Development Theory

Early momentum to study cognition in the United States came from Jean Piaget (1896-1980), a Swiss developmental psychologist. Piaget focused on the changes that occur in children, the thinking of the participant. To Piaget, the heart of the work of the cognitive stages is involved in the development of successive periods of growth or maturation of an individual, the participant's ability to think about acquiring knowledge, self-awareness and awareness of the environment (Mooney, 2006). Piaget studied the growth of children and how they adapt to the world they live in. Playing and interacting with their world, children develop schemas or mental frameworks. Cognitive psychologists are particularly interested in the cognitive structures and processes that allow a person to mentally represent events that transpire in the environment. Piaget said that children in general schema stretch as much as possible to adapt to new comments. But life regularly confronts them with the undeniable fact that some of their comments are simply not in their current patterns. Depressed adolescents have a negative schema of the world in which childhood and youth are affected by stressful events in life. If the person meets with such schema for a situation that is similar in a sense, the conditions in which the original schema was learned, the negative schemas will be active in that person (Neale et al, 2001).

1.7.2 Beck's Cognitive Theory

Cognitive behavior therapy was developed by Aaron Beck in the 1960s as asset directive psychotherapy, short-term and structured to treat depression. This theory is based on theoretical assumptions underlying the individual, emotions and behaviors are largely determined by the way he structures the world. Recent developments in behavioral

psychology emphasized individual cognition. According to Beck's theory, cognitive symptoms of depression actually precede the affective and mood symptoms of depression, rather than vice versa. To Beck, what are central to depression are the negative thoughts, instead of hormonal changes or low rates of reinforcement as postulated by other theorists. It can be seen how his contributions have been used in recent studies concerning depression, whether related to his work on negative automatic thoughts, biases and distortions or his cognitive Model of Depression (Beck et al., 1979). The many cognitive processes are emphasized in Beck's cognitive therapy which has created a methodical series of therapy procedures. The majority of controlled trials demonstrate that Beck's cognitive therapy has been proved to be much more effective than pharmacotherapy, which often includes tricyclic antidepressants (Henderson, 2004). It is suggested that cognitive therapy along with medication can provide the most effectual treatment for clinical depression. It is verified by several controlled trials. Schwartz and Schwartz (1993) have conducted a study and have shown that a more effective result can be achieved when a joint cognitive-behavioral therapy is being used and it shows better results than when either of these therapies is being used in isolation. Accordingly, the efficiency of these approaches is approved by plentiful evidence. Such evidence shows that this therapy can be used to cure a disorder which, in its severe status, may cause a person to commit suicide.

Reiki

According to Rand (2005), Reiki energy promotes general well-being as it flows into the energy system of a person. These systems can be described as universal energy field and chakras. The field of universal energy is a multi-energy field that surrounds and permeates the physical body. Chakras are wheel-shaped vortices, often referred to as focal points for the reception and transmission of energies. Chakras bring energy to the person in the field of universal energy. There are seven main chakras that can block, thus distorting the natural flow of energy. According to Herron-Marx et al. (2008), when a person receives a Reiki treatment, the practitioner channels energy to the recipient, bring balance in mind, body and spirit. The Reiki practitioner is done by placing their hands lightly on or just above the body, using a series of training hand.

1.7.3 Holistic Nursing Theories

Martha Rogers, Margaret Newman, Rosemarie Rizzo Parse, and Jean Watson have presented holistic nursing theories (Barnum, 1998; Chinn & Kramer, 1995). The practice of Reiki easily fits into the paradigm of holistic nursing theory. Roger's theory defines human beings as unitary wholes and as energetic beings within universal energy fields. Roger's theory espouses the interconnection of humans to the larger universe through energy fields. According to Rogers (1994), nursing practice aims towards promoting a harmonic interaction between the person and his environment, and reinforcing the cohesion and wholeness of a person's energy field. Its goal is to appropriately guide the organization and synchronization of a person's fields and environment in order to achieve the highest possible health potential. Margaret Newman's theory of expanding consciousness speaks to the unity of life, human energy fields, and the pattern and organization that is evolutionary in human beings and Nature. Health refers to a person's

ability to interact with his environment and to integrate thinking, feeling and processing of the information contained in all natural systems. Parse (1981) also developed her own language with the concepts of coexistence, co-creation, and pattern and organization. Coexistence is the assumption that human beings exist with others and the environment and co-creation is the creative process with self, others, and the universe. Human beings interact with the environment through energy exchange in a recognizable pattern and organization. According to Parse, human is considered as a Being, of his own will, who actively participates inside the world. A person can only be whole when he participates in the cosmic process. He is whole, open and free to choose the ways of the process. Watson's theory (Watson, 1988) is a theory of human caring that assumes nursing is a human science and that caring is the moral idea of nursing. Nurses engage clients as caring occasions in the human energy field in a lived moment, when both are touched and changed (Barnum et al., 1998). The holistic approach summarizes the psychosomatic approach of a disease and expands it by putting the patient in a specific time and cultural context. It deals with his own special needs and quality of life, by respecting his convictions (McEvoy and Duffy, 2008).

Reiki therapy is often applied as a holistic nursing medication. Holistic nursing denotes that this medical framework takes over the responsibility of improving an individual's health from birth to death through a holism approach. According to the holism approach, a person is known as a homogeneous whole that is more substantial than its building constituents and is separate from them. Rogers, Newman, Parse, and Watson (1998) have put forward several nursing theories, which offer the idea of inter-relationship of the universe's natural phenomena. Meanwhile, what is used as a basic framework and guide for holistic nursing practice is the bio-psycho-social-spiritual model. The American Holistic Nursing Association Standards of Holistic Nursing Practice proposes a scheme to achieve such an objective and elucidates the spectrum of holistic nursing practice and the kind of protection and care a holistic nurse should give to their patients (Dossey et al., 2000). There are two different holism standpoints in holistic nursing, one identifies a person as a single whole and the other represents a person as a set of inter-relationships between the bio-psycho-social-spiritual facets of him/her in a way that the whole is more significant and substantial than the building constituents. A holistic nurse believes that the treatment process will be more effective and faster when it is offered as a therapeutic cooperation with families, communities, persons and finally patients. Implementation of self-care practice is known as a pre-requisite for holistic nursing procedure. It can result in self-knowledge, self-responsibility and recognition of connections which can enhance the treatment process. Reiki therapy draws on some fundamental notions regarding energy therapies. These notions have common conceptual foundations and are embodied through diverse frameworks in physics. However, they have never had any experimental connections with medicine or clinical results.

Figure 1.1 shows the relationship between the theories and depression. This model describes the negative thinking characteristic of depression and how this relates to the symptoms and to other emotional behavioral and functional problems in illness. In CBT, the depression results from lack of environmental interpretations and negative interactions with it. Treatment includes behaviors that challenge negative cognitions and

increasing adaptive cognitive behavioral therapy skills, as well as having an accurate identification of feelings, the supervision and care of self-reward, problem solving, social skills, and relaxing procedures (Asarnow et al., 2001). Reiki heals by flowing through the affected parts of the energy field and charging it with positive energy, raising the vibratory levels of the energy field and negative thoughts and feelings are dissipated. Reiki is guided by a universal intelligence (God). In a typical whole body Reiki treatment the practitioner asks recipient to lie down, usually on a massage table and relax. The practitioner might take a few moments to enter a calm or meditative state of mind and mentally prepare for the treatment that is usually carried out without any unnecessary talking (Ell yard, 2004).

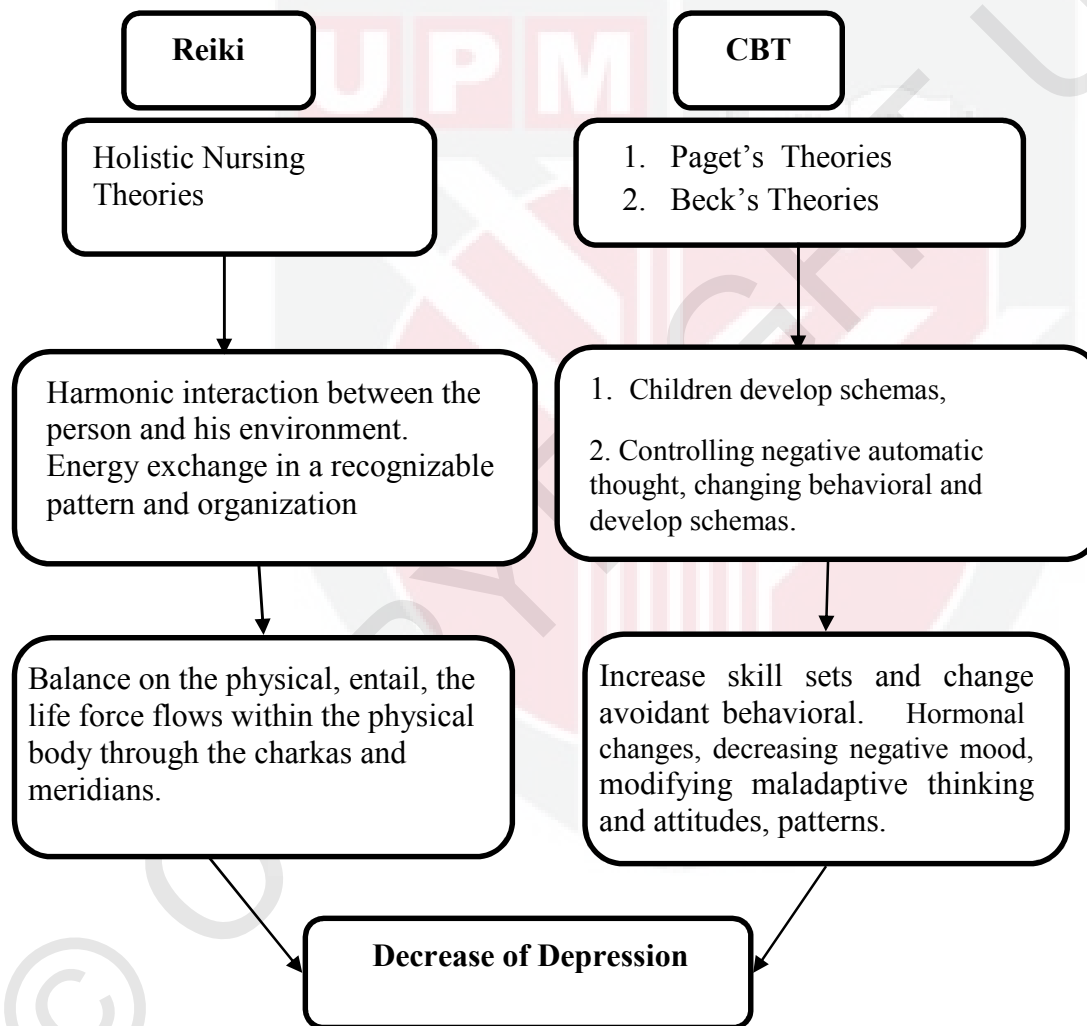


Figure 1.1. The Theoretical Framework

1.8 The Conceptual Framework of the Study

According to the theoretical background, the conceptual framework of the present study was developed (Figure 1.2). The conceptual framework of this study outlines between two treatments which are considered as independent variables CBT and Reiki, and also depression is a dependent variable. This research involved a quantitative data collection method, with pre-test and post-test designed with two experimental groups and one control group. There were two data collection stages. Stage one employed pre-test (T1) for assessing depression score of participant and stage two employed post-test (T2) to measure depression score after two treatments (CBT and Reiki) using Child's Depression Inventory (CDI). Conceptual framework shows relationship between background factors (family income, living arrangement, medical problems, father's education, mother's education, age and gender) and independent variables (CBT, Reiki) with dependent variable (depression). It is important to classify the risk factors associated with depression among adolescents, as this can help control and prevent depression. Many risk elements have been reported in the literature such as being female (Danesh, 2007; Genaabadi, 2010; Rahmani, 2007), poor interparental relationship (Ghorbani, 2003; Zahirodin, 2005; Kooroshnia, 2007), low socioeconomic status (Rostamzadeh, 2001; Shojaezadeh, 1999; Modabernia, 2005), low level of parents' education (Mirza & Jenkins, 2004; Shahnazi, 2007), and poverty (Mirza & Jenkins, 2004). Given its vast personal, social, and economic impacts, depressive disorders create significant stresses on individuals, health service providers, and the society as a whole (Thomas & Morris 2003).

In this study, effectiveness of two non-pharmacology treatment are compared on depression levels changes, and background factors were controlled in two intervention groups (CBT and Reiki). The Cognitive Behavior Therapy was supported by Oei and Dingle (2008), Henderson (2004), Fujisawa et al. (2010), and Kerfoot et al. (2004). They stated that CBT intervention resulted in reduction of depression scores. Depressed adolescents have a negative schema of the world in which childhood and youth are affected by stressful events in life. If the person meets with such schema for a situation that is similar in a sense, the conditions in which the original schema was learned, the negative schemas will be active in that person (Neale et al, 2001). Cognitive behavior therapy can help one to break this vicious cycle of change, feelings and behavior. Cognitive behavior therapy encourages the affected child or adolescent that he or she can "do it yourself" and work out their own paths to the solution of these problems. The American Psychiatric Association (APA, 2000) guidelines indicate that among psychotherapeutic approaches, CBT and interpersonal psychotherapy have the best documented effectiveness for the treatment of depression disorders.

The effectiveness of Reiki intervention for decreasing depression is supported by Nancy (2010), Etephene (2006), Crawford et al.(2006), Vital and O'Connor (2006) and Brathovde (2006). When a person receives a Reiki treatment, the practitioner channels energy to the recipient, bring balance in mind, body and spirit (Herron-Marx et al. 2008). Furthermore, to assist policy development for tackling adolescent depression, empirical investigation and evidence are the prerequisites. Thus, considering the importance of depression among Iranian adolescents, a systematic review of the

prevalence and risk factors of depression among adolescent in Iranian studies was conducted as no such work has been carried out to the best of my knowledge.

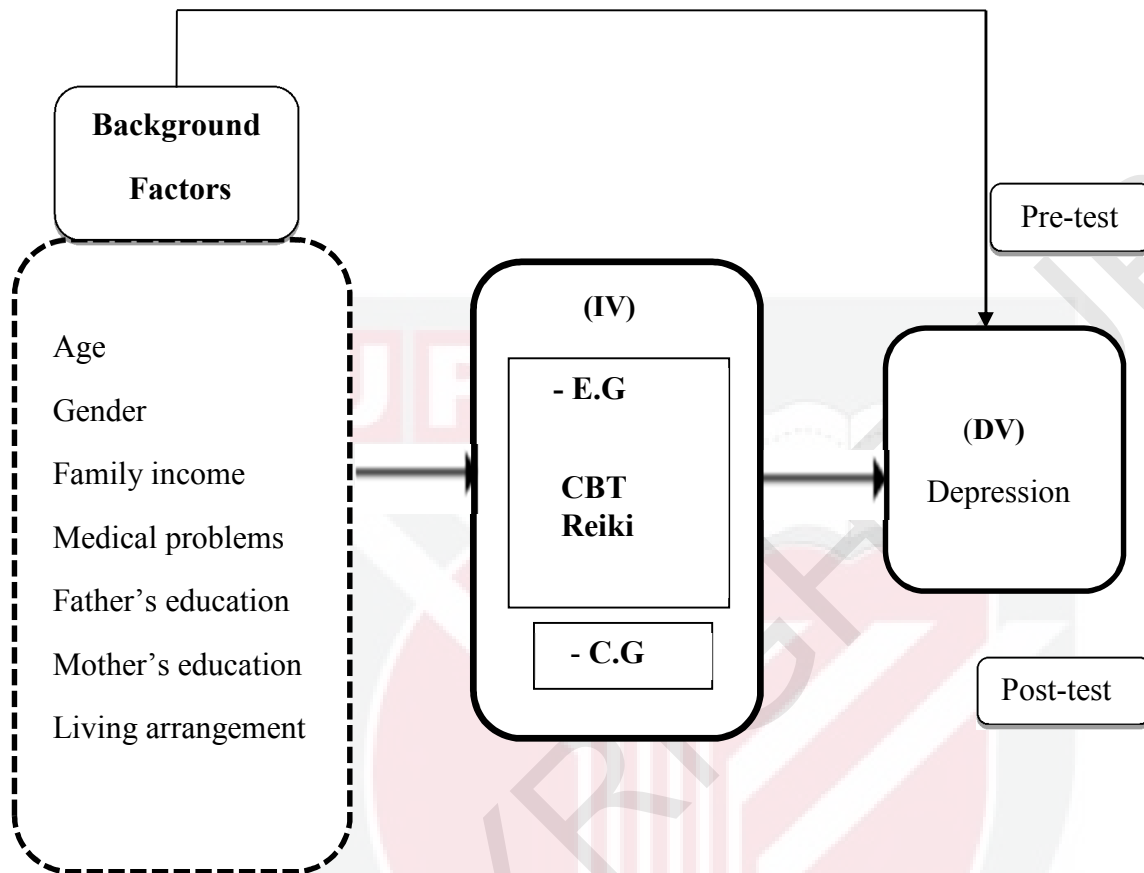


Figure 1.2 The Conceptual Framework of the Study

1.9 Limitation of the study

The first limitation was on the age of the participants. The CBT training and answering the CDI questions was difficult for the majority of participants who were in the age of 12-13 years. They needed longer to do assignments. The second limitation was related to times interventions. The period of treatments was only six week that this time wasn't enough for psychotherapy. Other limitation was group training in CBT that they must become arrangement by special knowledge and persons. Control group was one another limitations of the current study. They had to be in the waiting list for six week and they didn't receive any therapy for decrease of depression. Due to the depression of these samples and unstable mood, they may show disinterest or even cause problems by their lack of cooperation. The possibility of an error in CDI is relatively high due to the lack of necessary information/knowledge in understanding the method questions. The mood at the time of completion of the questionnaire affects the rating and total score of the CDI. In CDI, boredom and carelessness, which are caused by the high number of questions, may lead to poor reliability of the answers given. There is also some

limitation associated with the self-report measures of the CDI questionnaire. There is normally some concern about the reliability of the information which participants given by self-inventory measurements. For evaluating the level of depression based on CDI, it is possible that participants may under-report or over-report-symptoms.

The strength and weakness of Reiki cannot be estimated and the case may show lack of cooperation, which results in low effectiveness and poor treatment. This mainly takes place because Reiki therapy is neither familiar nor tangible in revealing the desired effect/result. Reiki therapy has to be conducted individually, which necessitates spending a lot of time and energy, and hiring professionals. This naturally means high expenses of the treatment. Due to the shortage of the time (six weeks) and the high number of samples, some of CBT techniques such as relaxation are to be conducted in groups. Under ideal circumstances, they can then be performed individually. Another restriction is the literature review in Iran. The researcher could not lay hands on any study similar to the present research in Iran, which could help to support of the present study.

1.10 Summary

This chapter covered the introduction, background, problem statement, research question and objectives of the study, as well as the hypothesis, and definition of terms. The theoretical framework and conceptual framework was described Piaget's psychosocial development theory, Beck's cognitive theory, holistic nursing theories. Limitations of the present study in relation to effectiveness of cognitive behavioral therapy and Reiki on depression of adolescents have also been discussed.

REFERENCES

- Albert, D. (1992). *Quantum Mechanics and Experience*. Cambridge, MA: Harvard University Press, pp. 88–92, 161–164.
- Abela, J. R. Z. (2001). The hopelessness theory of depression: A test of the diathesis stress and causal mediation components in third and seventh grade children *Journal of Abnormal Child Psychology*, 9, 241-254.
- Abela, J. R. Z., & D'allesandro, D. U. (2000). Beck's cognitive theory of depression. *Journal of Abnormal child psychology*, 28, 523-526.
- Abela, J. R. Hankin B. L, Haigh E, A. Adams, Vinokurof, T. Trayhern, N. (2005). Interpersonal vulnerability to depression in high-risk children. The role of insecure attachment and reassurance seeking. *Journal of clinical child Adolescence psychology*, 34, 182-192.
- Abolhassani, H., Naseri, M., Mahmoudzadeh S. (2012). A survey of complementary and alternative medicine in Iran. *Chinese Journal of Integrative Medicine*. pp 409-416
- Abolghasemi, A. (2008) Using metacognitions to identify emotionally vulnerable college students. *American journal health behavior*, 42, 56.642.
- Abramson, L. Y., Alloy, L. B., Hogan, M. E., Whitehouse, W. G., Donovan, p. Rose, D. T., panzarella, C., and Ranieri, D. (1999). Cognitive vulnerability to depression: Theory and evidence, *Journal of cognitive psychotherapy* 13, 5-20.
- Afshar, H., Roohfza, H., Sadeghi Saadaty, M., Salehi. M., Motamedi, M., Matinpour, M.Naji, H., Isfahan&Asadollahi, Gh. (2011). Positive and negative perfectionism and their relationship with anxiety and depression in Iranian school students. *Journal of Research in Medical Sciences*, 16(1), 79-86.
- Alavi, A., Sharifi, B., Ghanizadeh,A., Dehbozorgi,G.(2013). Effectiveness of Cognitive-Behavioral Therapy in Decreasing Suicidal Ideation and Hopelessness of the Adolescents with Previous Suicidal Attempts. *Iran J Pediatr*. Vol 23 (No 4).
- Allen, J. P., Insabella, G., Portger, M. R., Smith, F. D., Land, D., & Phillips, N. (2006). A social-interactional model of the development of depressive symptoms in adolescence. *Journal of Consulting and Clinical Psychology*, 74 (1), 55-65.
- Allen, J. P., Porter, M., McFarland, C., McElhaney, K. B., & Marsh, P. (2007). The relation of attachment security to adolescents' paternal and peer relationships, depression, and externalizing behavior. *Child Development*, 75 (4), 1222-1239.

- Alloy, L. B., Abramson, L. Y., Smith, J. M., Gibb, B. E., & Neeren, A. M. (2006). Role of parenting and maltreatment histories in unipolar and bipolar mood disorders: Mediation by cognitive vulnerability to depression. *Journal of Clinical Child and Family Psychology Review*, 9 (1), 23-64.
- Alonso, A., Rodriguez, M., Alonso, J., Carretero, G., and Martin, M. (2005). Eating Disorders: Prevalence and risk profile among secondary students. *Social Psychiatry Psychiatric Epidemiology*, 40, 980 – 987.
- Amaya-Jackson, L. (2002). Adverse behavioral and emotional outcomes from child abuse and witnessed violence. *J Am Acad Child Adolesc Psychiatry*, 162(7), 1305-10.
- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (DSM IV). Washington, DC: American Psychiatric Association.
- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4 th ed., text rev.). Washington, DC: Author.
- Ameling, A. & Nield-Anderson, L. (2001). Reiki: A complimentary therapy for nursing practice. *Journal of Psychosocial Nursing and Mental Health Services*, 39, 42-49.
- Angold, A., Erkanli, A., Silberg, J., Eares, L., and Costello, E. J. (2002). Depression scale scores in 8 to 17 years-old: Effects of age and gender. *Journal of child psychology and psychiatry*, 43, 1052-1063.
- Asadollahi, G. (2010). “The relationship between perfectionism and academic achievement, depression and anxiety”. *Iranian Journal of psychiatry and behavioral sciences*, 4(2), 31.
- Asarnow, J. R., Jaycox, L. H., & Tompson, M. C. (2001). Depression in youth. Psychosocial interventions. *Journal of Clinical Child Psychology*, 30, 33-47.
- Asarnow, J. R., Scott, C. V., & Mintz, J. (2002). A combined cognitive behavioral family education intervention for depression in children: A treatment development study. *Cognitive Therapy and Research*, 26, 221 – 229.
- Attari A., Moghaddam, F., Hasanzadeh, M. Soltani, M. Mahmoodi (2005). Comparison of Efficacy of Fluoxetine with Nortriptyline in Treatment of Major Depression in Children and Adolescents: a double-blind study. *Journal of Research in edictal Sciences*; Vol. 11, No. 1.

- Auger, R. W. (2005) School based interventions for students with depressive disorders. *Professional School Counseling*, 8, 344-352.
- Bowden, D., Goddard, L., Gruzelier, J. (2010). A randomized controlled single-blind trial of the effects of Reiki and positive imagery on well-being and salivary cortisol. *Brain Research Bulletin*, 81(1), 66–72.
- Baldwin, A.I, Baldwin, C., Cold, R.E, Rolf, J., Masten, A, S., Cicchetti, D., Nuechterlein, K, H., Weintraub, S. (2000) Stress -resistant families and stress – resistant children. In: Risk and protective factors in the development of psychopathology. *Cambridge University Press*, pp. 257 – 280.
- Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: W. H. Freeman and Company.
- Bandura, A. (1986). *Social Foundations of Thought and Action*. Englewood Cliffs, NJ: Prentice-Hall.
- Barbe, R. P., Bredgc, J., Birmaher, B., Kolko, D., & Brent, D. A. (2004). Sociality and its relationship to treatment outcome in depressed adolescents. *Suicide and Life-Threatening Behavior*, 34, 44 – 55
- Barlow, D. H., Allen, L. B., & Choate, M. L. (2004). Toward a unified treatment for emotional disorders. *Behavior Therapy*, 35, 205 – 230.
- Barnett, L., & Chambers, M. (1996). *Reiki energy medicine: Bringing healing touch into home, hospital and hospice*. Rochester, VT: Healing Arts Press.
- Barnum, B. (1998). *Nursing theory: Analysis, application, evaluation Philadelphia PA: Lippincott-Raven Publishers*.
- Beardslee, W. R. Gladstone, T. R. Wright, E. J. Cooper A. B. (2003). A Family –based approach to the prevention of depressive symptoms in children at risk. *Pediatrics*, 112,119-131.
- Bech AT., Ward, C, H., Mendelson, M., Mock, J., Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, 4: 561-571.
- Beck, A.T., Rush, B.F. Shaw & Emery G. (1979). *Cognitive Therapy of Depression*. New York: Guilford.
- Bennett, B.E., Bricklin, P.M., Harris, E., Knapp, S. VandeCreek, L., & Younggren

- , J.N. (2006). *Assessing and Managing Risk in Psychological Practice: An Individualized Approach*. Rockville, MD, American Psychological Association Insurance Trust.
- Betterton, M.D (2001). *Theory of structure formation in snowfields motivated by penitents, sun cups, and dirt cones*. *Physical review. E, Statistical, nonlinear, and soft matter physics* 056129.
- Birmaher, B., Williamson, D., Dahl, R., Axelson, D., Kaufman, J., Dorn, L., Ryan, N. (2004). Clinical presentation and causes of depression in youth. Does onset in childhood differ from onset in adolescence? *Journal of Child Adolescent Psychiatry*, 43, 63 – 70.
- Brathovde, A. (2006). A pilot study: Reiki for self-care of nurses and health care providers. *Holistic Nursing Practice*, 20 (2), 95 – 101.
- Brent, D.A., Holder. D., Kolko, D. (1997). A clinical psychotherapy trial for adolescent depression comparing cognitive, family, and supportive therapy. *Archives of General Psychiatry*, 54, 877-885.
- Brookman-Frazer, L., Haine, R. A. and Garland, A. F. (2006). Measuring outcomes of real-world psychotherapy: Whom to ask and what to ask. *Psychiatric Services*, 57(10), 1373-1375.
- Briefly, A.S., Thomas, D.N., (2002). Ecology of Southern Ocean pack ice. *Journal of Advances in Marine Biology*, 43, 171–276.
- Busari, A.O. & Uwakwe C.B.U. (2001). The Effect of Stress Inoculation Training Technique in the Management of worry as a Self-handicapping Strategy in Intellectual Performance. *Nigeria Journal of Emotional Psychology and Sport Ethics*. 3, 6 -12.
- Cacioppo, J. T. Amaral, D. G, Blanchard, J. J., Cameron, J. L. Carter, C. S. (2007). Social neuroscience progress and implications for mental health. *Journal of Perspectives on psychological science*, 2, 99-123.
- Carey, M.P., Faulstich M.E., Gresham F.M., Ruggiero, L., Enyart .P. (1987). Children's Depression Inventory: Construct and discriminate validity across clinical and no referred (control) populations. *Journal of Consult Clint Psycho*, 55, 755-61.
- Carlson, N. R. (2007). *Physiology of Behavior*. (9th Ed.) Amherst, MA: Pearson Education.
- Center for Mental Health services (2003). *CMHS program Spotlight child*, adolescent and family branch of the Center for Mental Health Services (CMHS).

- Centers for Disease Control (CDC) (2005). *Youth Risk Behavior Survey (YRBS)*. MS K-33, 4770 Buford Hwy, NE, Atlanta, GA 30341.
- Chen, S., Jordan, C., & Thompson, S. (2006). The effect of cognitive behavioral therapy (CBT) on depression: The role of problem-solving appraisal. *Journal of Research on Social Work Practice*, 16, 500–510.
- Chinn, P. & Kramer, M. (1995). *Theory and nursing: A systematic approach* (4th Ed.). St. Louis, MO: Mosby-Year Book, Inc.
- Clarke, G., Lewinsohn, P. & Hops, H. (2001). *Instructor's manual for adolescents coping with depression course*. Retrieved from Kaiser Permanente Center for Health Research website.
- Clarke, G.N., Horn brook, M. C., Lhynch, F.I., Pollen, M. (2003). Group cognitive behavioral Treatment for depressed adolescent off springs of depressed parents in a HMO. *Journal of American Academy of Child and Adolescent psychiatry*, 41, 305-313.
- Cohen, P., Pine, D. S., Gurley, D., Brook, J., & Ma, Y. (2000). The risk for early adulthood anxiety and depressive disorders in adolescents with anxiety and depressive disorders. *Journal of Archives of General Psychiatry*, 55, 56–64.
- Cohen, J. (1988). *Statistical Power Analysis for the Behavioral Sciences*, (2nd Ed.). New York: Academic Press.
- Conger, R. D., Wallace, L. E., Sun, Y., Simons, R. L., Mcloyd, V. C., & Brody, G. H. (2002). Economic pressure in Africa-American families: A replication and extension of the family stress model. *Journal of Developmental Psychology*, 38, 179 – 193.
- Cooper, M. (2008). *Essential Research Findings in Counseling and Psychotherapy: The Facts are Friendly*. SAGE Publications.
- Compas, B. E., Connor-Smith, J. K., Saltzman, H., Thomsen, A. H., & Wadsworth, M. E. (2001). Coping with stress during childhood and adolescence: Problems, progress, and potential in theory and research. *Journal of Psychological Bulletin*, 127, 87–127.
- Corson, P. (2000). Laying the foundation for literacy: An anti-bias approach. *Journal of Childhood Education*, 76, 385-389.
- Crawford, S. E., Leaver, V. W., & Mahoney, S. D. (2006). Using Reiki to decrease memory and behavior problems in mild cognitive impairment and mild Alzheimer's disease. *The Journal of Alternative and Complementary Medicine*, 12, 911-913.

- Creswell, J. W. (2008). *Educational research: Planning, conducting, and evaluating. Quantitative and qualitative research* (3rd Ed.). Upper Saddle River, NJ: Prentice Hall.
- Costello, E.J., S.N., Compton, G., Keeler & Angold (2003). Relationships between Poverty and Psychotherapy: A Natural Experiment. *Journal of the American Medical Association*, 290(15), 2023-2029.
- Cummings, E. M., Keller, P. S., & Davies, P. T. (2005). Towards a family process Model of maternal and paternal depressive symptoms: Exploring multiple relations with child and family functioning. *Journal of Child Psychology and Psychiatry*, 46 (5), 479-489.
- Dahlquist, L. M. (2003). Commentary: Are children with JRA and their families at risk or resilient? *Journal of Pediatric Psychology*, 28, 45 – 46.
- Danesh, E. (2007). The role of parenting style and parental depression in children. *Journal of Applied Psychology*, 1(2), 125-141.
- Deborah Salach, M. (2006) .*The Effects of Reiki, a Complementary Alternative Medicine, on Depression and Anxiety in the Alzheimer's and Dementia Population*. 55, 56–64.
- Deborah, B., Lorna, G., John, G. (2011). A Randomized Controlled Single-Blind Trial of the Efficacy of Reiki at Benefitting Mood and well-being. *Evidence-Based Complementary and Alternative Medicine*, 38, 18-62.
- Debbie, R. Caldwell, R.N. (2005). Altruism and Informed Consent in Chemotherapy Trials in Childhood Cancer. *Journal of Consulting and Clinical Psychology*, 65:120–129.
- Dyczkowski, M.S.G. (1987). *The Doctrine of Vibration*. Albany, NY: SUNY Press.
- Dobson, Keith S., Dozois, David J.A. (2001). *Historical and Philosophical Bases of The Cognitive Behavioral Therapies*. In Dobson, Keith, Handbook of cognitive - behavioral therapies (2nd Ed.). New York: Guilford Press. Pp. 3 – 39.
- Doerfler, L., Felner .R.D., Rowlinson, R.T., Raley, P.A., Evans, E. (1988). Depression in children and adolescents: A comparative analysis of the utility and construct validity of two assessment measures. *Journal of Consulting Clinical of Psyching*, 56, 769-72.
- Dressin, L.J. & Singg, S. (1998). Effects of Reiki on pain and selected affective and personality variables of chronically ill patients. *Subtle Energies and Energy Medicine*, 9(1), 53-82.

- Double, B. A., Moretti, M. M., Brendgen, M., & Budowski, W. (2004). Parent-child relationships and adjustment in adolescence. *Journal for the Scientific Study of Religion*, 36(2), 194-206.
- Dobson, D., & Dobson, K. S. (2009). *Evidenced-based practice of cognitive behavioral therapy*. New York: Guilford.
- Dossey, B., Keegan, L., & Guzzetta, C. (2000). *Holistic nursing: A handbook for practice*. Gaithersburg, M.D: Aspen Publishers, Inc.
- Dozois, D. (2001). *Historical and philosophical basis of cognitive-behavioral therapy*. In K. Dobson (Ed.), *Handbook of cognitive-behavioral therapies* (pp. 3–39). New York: Guilford.
- Dupler, D. & Frey, R. J. (2005). *Reiki Retrieved*. <http://galenet.galegroup.com>.
- Ellis, A. (1977). Discomfort anxiety: A new cognitive behavioral construct. *Rational Living*, 14(2), 3-8.
- Ellis, A. and Greiger, R. (1977). *Handbook of Rational-Emotive therap*. New York: Speriger.
- Ellis, A. (2005). *The Myth of Self-Esteem*. New York: Prometheus books.
- Ell yard, L. (2004). *Reiki Healer*. A complete Guide to the path and practice of Reiki, (pp. 15-78).
- Emavardhana, T & Tori, C.D. (1997). Changes in self-concept, ego defense mechanisms, and religiosity following seven-day Vipassana meditation retreats. *Journal for the Scientific Study of Religion*, 36(2), 194-206.
- Emily, B., Eric Stice, M., Sarah Kate Bearman, L., and Paul, R. (2007). *An Experimental Test of the Affect-Regulation Theory of Bulimic Symptoms and Substance Use: A Randomized Trial Disorder*. 40 (1), 27–36.
- Ernst, E. (2003). *Distant healing-an “update” of a systematic review*, 115, 241 – 5
- Fahimi, F., Hrgovic, I., Safadi, S., Münstedt, K. (2011). Complementary and alternative medicine in obstetrics: a survey from Iran. *Arch Gynecol Obstet*.284 (2):361-4.
- Fakhari, A., Fatemeh, R., Dadashzadeh, H., Moghaddas, F. (2007). Razi University Hospital, Mental Center, *Tabriz Medical Science Iran*, 23(1), 54-8.
- Fergusson, D. M., Horwood, L. J., Ridder, E. M., & Beautrais, A. L. (2005). Childhood sexual abuse and psychiatric disorder in young adulthood. *Psychiatric outcomes*

of childhood sexual abuse. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 65–74.

Flech, M. p., Horvath, E. (2005). Pharmacological management of difficult to treat depression in clinical practice. *Psychiatry Serve*, 56, 1005 – 1011

Fleming, D. (2003). *Reiki: A gift and a skill anyone can learn*. 23(1), 12-13.

Foroozandeh, F. (2002). Effectiveness of CBT on college students in Shah Record (Iran). *Iranian Journal of Reproductive Medicine*, 7, 12-56.

Fowler, F. J, Jr. (2002). *Survey research methods*. New Burg Park. CA: Sage.

Freda, M. (2009). Cognitive-Behavior Therapy for Low Self-Esteem: A Case Example. *Cognitive and Behavioral Practice*, 16, 266–275.

Fujisawa, D., Atsuo, N., Miyuki, T., Mitsuhiro, S., Toshiaki, K., Motomi, H., & Yutaka, O. (2010). *Cognitive behavioral therapy for depression among adults in Japanese* .Clinical settings: a single-group study, Licensee BioMed Central Ltd.

Gall, M.D., Gall, J.P., Borg, W.R. (2003). *Educational research: An introduction*. New York: Allyn & Bocon.

Garber, J., Horowitz, J.L. (2002). *Depression in children*. In Gotlif, I.H., Hammen, C.L. (eds) Handbook of depression. New York: Guilford, pp. 510 – 540

Ge, X., Comger, R., and Elder, G. (2001). Pubertal transition, stressful life events and the emergence of gender differences in adolescent depressive symptoms. *Journal of Developmental Psychology*, 37 (3), 404 – 417.

Genaabadi, H. (2010). Aggression, anxiety, and depression among high school adolescents. *Journal of nursing and midwifery*, 3(32), 148-156.

George, D. and Mallery, P. (2003). *SPSS for Windows Step by Step*. Boston: Pearson Education Inc.

Ghorbani, B. (2003). Depression in children and adolescents compared with normal families and families Divorce. *Applied Psychology*, 1(27), 95-112.

Ginsburg, G. S., Silva, S. G., Jacobs, R. H., Tonev, S., Hoyle, R. H., Kingery, J. N., & March, J. S. (2009). Cognitive measures of adolescent depression: Unique or unitary constructs? *Journal of Clinical Child & Adolescent Psychology*, 38, 790-802.

- Goodyer, I.M., Herbert, J., Templin, A. et al. (2007). First-episode major depression in adolescents. Affective cognitive and endocrine characteristics of risk status and predictors of onset. *British Journal of Psychiatry*, 176, 142 – 149.
- Gotlib, I.H., Neubauer, D.L. (2000). *Information-processing approaches to the study of cognitive biases in depression and Stress, coping*. Mahwah, NJ, US: Lawrence Erlbaum Associates Publishers. P, 117–143.
- Gotlib, I. H., & Hammen, C. L. (Eds.). (2002). *Introduction. Handbook of depression*. New York: Guilford Press.
- Gotlib, I. H., and Neubeuer, D. L. (2007). *Information-processing approaches to the study of cognitive biases in depression*, In Johnson, S. L., Hayes, A. M., Field, T. M., Schneider man N., and McCabe, P. M. (Eds.), *Stress, coping, and depression* (pp. 117 – 143).
- Gottlieb, M.C., Younggren, J. N., and Murch, K.B (2009). *Boundary management for cognitive behavioral therapies*, pp. 164 – 171.
- Gould, M.S., Greenberg, T., Velting, D.M. (2003). Youth suicide risk and preventive Interventions: A review of the past 10 years. *Child Adolescent Psychiatry*, 42 (4) 1-20
- Greene, B. (1999). *The Elegant Universe*. New York, NY: Norton & Co.
- Grillo, E., Silva, R.J. (2004). Early manifestations of behavioral disorders in children and adolescents. *Journal of Pediatrics*, 80, 21 – 27.
- Greening, L., Stoppelbein, L., Dhossche, D., & Martin, W. (2005). Psychometric evaluation of a measure of Beck's negative cognitive triad for youth: Applications for African-American and Caucasian adolescents. *Depression and Anxiety*, 21, 161-169.
- Grunbaum. J. A., Kann, L., Kinches, R., J. Hawkins, J., Lowry, R. (2004). *Youth Risk behavior surveillance United States*. MMWR Surveillance Summary, 53 (2), 21-96.
- Habib Dand Seif El din (2007). Effectiveness of cognitive behavior therapy in Schoolchildren with depressive symptom in Alexandria Egypt. *Journal of East Mediterr Health*, 13(3), 615-24.
- Haimerl, C.J., & Valentine, E. (2001). The effect of contemplative practice on interpersonal, and transpersonal dimensions of the self-concept. *Journal of Transpersonal Psychology*, 33(1), 37-52.
- Hale, W. W., van der Valk, I., Akse, J., & Meeus, W. (2008). The interplay of early

adolescents' depressive symptoms, aggression and perceived parental rejection: A four-year community study. *Journal of Youth and Adolescence*, 37, 928-940.

- Harrington, J. A. & Blankenship, A. (2002). Ruminative thoughts and their relation to depression and anxiety, *Journal of Applied social psychology*, 32, 465 – 485.
- Harrison, L.L., Williams, A.K., Berbaum, M.L., Stem, J.T., Leeper, J. (2001). The University Of Alabama School Of Nursing, *Physiologic and behavioral effects of gentle human*, 11, 130-603.
- Harvey, A. G., Watkins, E. R., Mansell, W., & Shoran, R. (2004). Cognitive behavioral processes across psychological disorders: A Trans-diagnostic approach to research and treatment. Oxford: University Press.
- Hazel, P. (2002). Depression in children. *Journal of British Medical*, 325, 229-231,
- Hazel, P (2004). Depression in children and adolescents. *Journal of American family psycatry*.12, 427 – 42.
- Heinz, A., Jones, D.W, Gorey, G, Bennet, A., Suomi, S.J, Higley, A. (2002). Relationship between cortical and serotonin metabolites and transporters in alcoholism (correction of alcoholism). *Journal of Pharmacy and psychiatry*, 35, 4 127 – 34.
- Hembree, E. A., & Foa, E. B. (2004). *Promoting cognitive change in posttraumatic stress disorder*. Cognitive therapy across the lifespan: Evidence and practice (pp. 231–257). New York: Cambridge University Press.
- Henderson, S.C. (2004). Cognitive Behavioral Therapy versus Short Psychodynamic Supportive Psychotherapy in the outpatient treatment of depression: a randomized Controlled trial. *Journal of BMC Psychiatry* , 7, 1- 58.
- Herron-Marx, S., Price-Knol, F., Burden, B., & Hicks, C. (2008). A systematic review of the use of Reiki in health care. *Alternative and Complementary Therapies*, 14, 37-42.
- Hilt-Peahen, A., Kern, L., Divatia, A. & Gresham, F. (2007). School-based interventions for student with or at risk for depression: a review of the literature. *Journal of Advances in School Mental Health Promotion*, 1, 32-41.
- Horman, P. (2002). *The ultimate Reiki touch*. Twin Lakes, WI: Lotus Press.
- Hudson, J. L. (2005). Interparental conflict, violence and psychopathology. *Journal of Psychopathology and the Family*, 3, 53-69.
- Hughes, D.C (2003). Reducing health disparities among children. *Journal of Future of children*, 13 (1), 153 – 167.

- Hunna J. Watson & Paula R. Nathan, A. (2008). Role of Gender in Depressive Disorder Outcome for Individual and Group Cognitive-Behavioral Treatment. *Journal of Clinical Psychology*, 64, 23-37.
- Hyun MS, Hyang-In cho chang, T. Young-Ja Lee. (2005). Effect of cognitive-behavioral group therapy on self-esteem, depression, and self-efficacy of runaway adolescents in a shelter in South Korea. *Journal of Applied Nursing Research*, 3, 16-166.
- Hyun, M.S., Seo, M.A. (2005) Rehabilitation for homeless adolescent substance abusers at a halfway house in South Korea. *Journal of Korean Academy of Nursing*, 33(8), 1161–1170
- Jaycox, L. H. stein, B. D., Kataoka, S, H., Wong, M., Fink, A., Escudero, 1. & Zaragwza, C. (2002). Violence exposure, post-traumatic stress disorder, and depressive symptoms among recent immigrant schoolchildren. *Journal of the American Academy of Child and Adolescent Psychiatry*. 4, 1104 – 1110.
- Jeannette, R., Guillermo, B., and Rivera-Medina, C. (2008). Cultural Diversity and Ethnic Minority Psychology. *Journal of American Psychological Association*, 14, 3, 234–24.
- Jennifer, M. & Primack, A. (2010).The Men's Stress Workshop: A Gender-Sensitive Treatment for Depressed Men. *Journal of Cognitive and Behavioral Practice*, 17, 77-87.
- John Best, W. (2006). Research in Education” Prentice Hall of India (P) Ltd, New Delhi.S.M Sujatha, *A critical evaluation of class X Social studies textbook*.
- Jordan, C., Thompson, S. Chen, S. (2006). The effect of cognitive behavioral therapy (CBT) on depression: The role of problem-solving appraisal. *Journal of Research on Social Work Practice*, 16(5), 500-510.
- Jorm, A.F., Korten, A.E., Jacomb, P.A., Christensenm, H., Henderson, S. (2008). Attitudes towards people with a mental disorder: a survey of the Australian public and health professionals. *Australian and New Zealand Journal of Psychiatry*, 33(1), 77-83.
- Johnson, P. B & Richter, L. (2002). The relationship between smoking, drinking and adolescents' self-perceived health and frequency of hospitalization: Analyses from the 1997 National Household Survey on Drug Abuse. *Journal of Adolescent Health*, 30(3), 175-183.
- Joiner, T., Longan, C. (2000). Tripartite model of depression and anxiety in youth psychiatric inpatients Relations with diagnostic status and future symptoms. *Journal of clinical child psychology*, 29, 372–382.

- Karle, M. (2005). Combined pharmacotherapy and psychological treatment for Expressional systematic review. *Journal of Archives General Psychiatry*, 61:714–9.
- Kann, L., Kinchen, S.A. Williams, B.I. (2000). *Youth risk behavior surveillance – United States*, 49 (SS – 5), 1 – 32.
- Kataoka, S.H., Zhang, L., Wells, K, B. (2002). Unmet need for mental health care among US children, variation by ethnicity and insurance status. *American Journal of Psychiatry*, 159(9),341.
- Kazdin, A.E. (1987). Children's depression scale: Validation with child psychiatric In patients. *Journal of Child Psychology and Psychiatry*, 28, 29-41.
- Kendall, P. C., Hudson, J. L., Gosch, E., Flannery-Schroeder, E., & Suveg, C. (2008). Cognitive-behavioral therapy for anxiety disordered youth: A randomized clinical trial evaluating child and family modalities. *Journal of Consulting and Clinical Psychology*, 76(2), 282–297.
- Kerfoot, M., Harrington, R., Harrington, V., Rogers, J., & Verduyn, C. (2004). A step too far? Randomized trial of cognitive-behavioral therapy delivered by Social workers to depressed adolescents. *Journal of European Child and Adolescent Psychiatry*, 13, 92-99.
- Kelly, A., Neil, Jennifer, L., Podell, Courtney, L., Benjamin Philip C. Kendall. (2010). Comorbid Depressive Disorders in Anxiety-disordered Youth: Demographic, Clinical, and Family Characteristics. *Journal of Child Psychiatry and Human Development*, 41, 330–341.
- Khaneh Kesh, A., Moosavi Nik,M., Basavarajappa,H .(2013). Effectiveness of Cognitive Behavior Therapy on Depression among High School Students. *Journal of Basic and Applied Scientific Research*, 3(2), 147-158.
- Khodayarifard, M. (2000). Application of positive thinking in psychotherapy from Islamic perspective. *Journal of psychology and Education*, 5, 141-164.
- Kolko, D. J., Brent, D. A., Baugher, M., Bridge, J., & Birmaher, B. (2000). Cognitive and family therapies for adolescent depression: Treatment specificity, mediation, and moderation. *Journal of Counseling and Clinical Psychology*, 68(4), 603-614.
- Kooroshnia, M. (2007). The relationship between family communication patterns of anxiety and depression in children. . *Journal of Family Research*, 3(10), 587-600.

- Kovac, M. (1983). *The Children's Depression Inventory: A Self Rated Depression Scale for School Aged Youngsters*. University of Pittsburgh School of Medicine.
- Kovacs, M. (2003). *The Children's Depression Inventory: A self – rating depression scale for school – age youngsters*; unpublished work.
- Lambert, M. J.; Bergin, A. E.; Garfield, S. L. (2004). *Introduction and Historical Overview*. In Lambert, M. J. Bergin and Garfield's Handbook of psychotherapy and Behavior Change (5th Ed.). New York: John Wiley & Sons. Pp. 3 – 15.
- Larsson, B. (1990). (CDI Swedish translation) Iverson T, editor. 1 January .Personal Communication. *Nordic Journal of Psychiatry*, 9- 60, 3.
- Larson-Hal, J. (2008). *A guide to doing statistics in second language research using SPSS*. New York: Routledge.
- Lewin, B. (2005). Group Treatment of depression individuals: the "coping with depression Course. *Journal of Advances in Behavior Research and Therapy*, 6-90, 114.
- Lewinsohn, P. M., Joiner, T. E., Jr., & Rohde, P. (2001). Evaluation of cognitive diathesis – stress models in predicting major depressive disorder in disorder in adolescents. *Journal of Abnormal Psychology*, 110, 203 – 215.
- Lewis, D., Diamond, S., Scott, D. (2004). Prophylactic treatment of pediatric Migraine. *The Journal of Head and Face Pain Headache*; 44, 230–237.
- Liboff, A.R. (1985). *Cyclotron resonance in membrane transport*, In Chiabrerra A., Nicolini C., Schwan H.P., (Eds): "Interactions between Electromagnetic Fields and Cells." New York: Plenum Press, pp 281-296.
- Lipinski. K (2006). "Reiki and the Helping Professions," Part II, Reiki News Magazine, winter, p. 37. 12.
- Lovibond, S.H., & Lovibond, P.F. (1995). *Manual for the Depression Anxiety Stress Scales (2nd Ed)*. Sydney, Australia: Psychological Foundation of Australia.
- Luby, J.L., Mrakotsky, C., Heffelfinger, A., Brown, K., Hessler M, Spitznagel, E. (2003). Modification of DSM-IV criteria depressed preschool children. *Journal of Psychiatry*, 160, 1169 – 1172.
- MacDonald, G.B., & Valdivieso, R. (2000). *Measuring deficits and assets: How we track youth development now, and how we should track it*. In Youth Development: Issues, Challenges and Directions (pp. 149-184). Philadelphia: Public/Private Ventures.
- McEvoy, L., Duffy, A. (2008). *Holistic practice--a concept analysis*. Nurse

Education in Practice. 8:412-9.

- Malakouti SK, Nojomi, M., Bolhari, J., Hakimshooshtari, M., Poshtmashhadi, M., DeLeo, D. (2009). Prevalence of Suicide Thoughts, Plans and Attempts in a Community Sample from Karaj, Iran. *Journal of Community Mental Health*, 45: 37-41.
- Mansell, W., Harvey, A., Watkins, E., & Shafran, R. (2008). Conceptual foundations of the Trans-diagnostic approach to CBT. *Journal of Cognitive Psychotherapy: An International Quarterly*, 22, 561–576.
- Marshall, M. & Hutchinson, S. (2001). *Journal of Advanced Nursing*, 35, 488–496.
- March, J., Silva, S., Petrycki, S., Curry, J., Wells, K., Faribank, J., Burns, B., Domino, M., McNulty, S., Vitiello, B., Severe, J. (2004). Treatment for Adolescents with Depression Study (TADS): Safety Results. *Journal of the American Medical Association*, 292, 807-820.
- Margolese, S., Markiewicz, D., & Camping, C. (2001). Adolescent attachment to Parents, best friend and romantic partner: How differential processing of interpersonal stress leads to depression. Minneapolis, MN. *Journal of Society for Research in Child Development*, 24, 55-98.
- Martin, G., & Pear, J. (1992). *Behavior modification: What it is and how to do it (4th Ed.)*. Englewood Cliffs, NJ: Prentice Hall.
- Mcadoo, H. P., & Coll, C. G. (2001). The home environments of children in the United States Part I: Variations by age, ethnicity, and poverty status. *Journal of Child Development*, 72, 1844 – 1867.
- McCullough, J.P. (2000). *Treatment for Chronic Depression: Cognitive Behavioral Analysis System of Psychotherapy*. New York: Guilford Press.
- McMahon SD, Grant KE, Compas BE, Thurm AE, (2003). Sisters and Psychopathology in children and adolescents: Is there evidence of specificity? *Journal Child Psycho Psychiatry Allied Discipline*, 44: 107–33.
- McMullin, R.E. & Giles, J. (1981). *Cognitive-behavior therapy. A restructuring approach*. New York: Grune and Stratton.
- Merrill, K.A., Tolbert, V.E., & Wade, W.A. (2003). Effectiveness of cognitive therapy for depression in a community mental health center: A benchmarking study. *Journal of Consulting and Clinical Psychology*, 71, 404–409.
- Mirza, I., & Jenkins, R. (2004). Risk factors, prevalence, and treatment of anxiety and depressive disorders in Pakistan: systematic review. *British Medical Journal*, 328(7443), 794.

- Michael, K. D., & Crowley, S. L. (2002). How effective are treatments for child and adolescent depression? A Meta-analytic review. *Journal of Clinical Psychology Review*, 22, 247-269.
- Michelle, M. H., Bruce, T., Lyn, L., Carter, R., Theo, V. (2004). *Australian and New Zealand Journal of Psychiatry*; 38, 579–591.
- Miles, P. True, G. (2003). Reiki vibration healing – interview. *Journal of Alternative Therapies*, 9 (4), 74 – 83.
- Modabernia, M. (2005). Prevalence of depression in Rasht adolescents. *Journal of Gilan University of Medical Sciences*, 18(71), 15-24.
- Modabber-Nia, M., Shodjai Tehrani, H., Moosavi, S., Jahanbakhsh Asli, N., Fallahi, M. (2007). The Prevalence of Depression among High School and Preuniversity Adolescents: Rasht, Northern Iran. *Journal of Archives of Iranian Medicine*, 10, 141 – 146.
- Moenizadeh, M. & Salagame, K. (2010). Well-being therapy for depression. *Journal of Psychological Studies*, 2(1), 107-115.
- Mohammadi, M.R., Ghanizadeh, A., Rahgozart, M., Noorbala, A.A., Malekafzali, H., Davidian, H., Naghavi, H., Soori, H., Yazdi, S.A. (2006). Suicidal attempts and Psychiatric disorders in Iran. *Journal of Suicide life threat Behavior* 35, 39-316.
- Mokri, A. (2002). A brief overview of the status of drug abuse in Iran. *Journal of Archives of Iranian Medicine*, 5(3), 184-190.
- Mooney, C.G. (2000). *Theories of Childhood*. An Introduction to Dewey, Montessori, Erikson, Piaget and Vygotsky. St Paul, MN: Redleaf Press.
- Munoz-Solomando, A., Kendall, T. & Whittington, C. (2008). Cognitive behavioral therapy for children and adolescents. *Journal of Current Opinion in Psychiatry*, 21, 332-337.
- Muris, P, Schmidt, H, Lambrichs, R., & Meesters, C. (2001). Protective and Vulnerability factors of depression in normal adolescents. *Journal of Behavior Residual Therapy*, 39 (5), 555-65.
- Myung-Sun, H. Hyang-In, C .C. Young-Ja, L. (2005). The effect of cognitive-behavioral group therapy on the self-esteem, depression, and self-efficacy of runaway adolescents in a shelter in South Korea, *Journal of Applied Nursing Research*, 152, 502-506.

- Nathan, P.R., Rees, C.S., & Smith, L.M. (2001). *Mood management course: A group cognitive behavioral program for anxiety disorders and depression*. Perth: Rioby Publishing.
- National Center for Complementary and Alternative Medicine (2006). *Energy Medicine Overview*. National Institutes of Health.
- National Association of Cognitive Behavioral Therapists. (2002). *Why Cognitive-Behavioral Therapy?* Cognitive Behavioral Therapists. 1, 232-242.
- National Center for Complementary and Alternative Medicine (2007). (Accesses December). An Introduction to Reiki.
- National Institute of Mental Health (2001). *Depression*. Publication No. 00-3561.
- National Research Council. (2002). *Community programs to promote youth development*. Washington, DC: National academy press.
- Nancy, E. (2010). Effects of Reiki on Anxiety, Depression, Pain, and Physiological Factors in Community-Dwelling Older Adults. *Research in Erotological Nursing*, 3, 12- 3.
- Ndetei, D.M. & Vadher, A. (1982). A study of some psychological factors in depressed and non-depressed subjects in a Kenyan setting. *British Journal of Medical Psychology*, 55, 235–239.
- Neale, K., John, M., Davison, Gerald, C. (2001). *Abnormal psychology* (8th Ed.). New York: John Wiley & Sons. pp. 247.
- Nield- Anderson, L, & Ameling, A. (2001). Reiki, a complementary therapy for nursing practice. *Journal of Psychosocial Nursing and Mental Health Services*, 39 (4), 42 – 49.
- Nilforooshan, P., Ahmadi, A, Abedi, M, R, Ahmadi, M. (2006). A study of the level of anxiety and depression in infertile couples. Psychological studies. (A quarterly. *Journal of Psychiatry and clinical psychology*, 1(4), 5-16.
- Nojomi, M., Malakouti, S.K, Bolhari, J., Hakimshoostari, M., Fleischmann, A., Bertolote, J.M. (2008). Epidemiology of suicide attempters resorting to emergency departments in Karaj. *Eur J Emerg Med*, 15(4), 221-223.
- Noorbala, N. (2008). Epidemiology and Biostatistics Department, School of Public Health, Tehran University of Medical Sciences, Tehran, Iran. *The British Journal of Psychiatry*, 184, 70-73.

- Oei, T.P. & Dingle, G. (2008). The effectiveness of group cognitive behavior therapy for unipolar depressive disorder. *Journal of effective disorders*, 107(1-3): 5-21.
- Ollendick, T.H., Yule, W. (1988). Depression in British and American children and its relation to anxiety and fear. *Journal of Consulting Clinical Psychology*; 58, 126-9.
- Ollendick, T. H., & King, N. J. (2000). Empirically supported treatments for children and adolescents. . *Journal of Clinical Psychology: Science and Practice*, 3, 289–294.
- Olson, K., Hanson, J., Michaud, M. (2003). A phase II trial of Reiki for the management of pain in advanced cancer patients. *Journal of Pain Symptom Management*, 26, 990 – 7.
- Panahon H, A., Kern, L., Divatia, A., & Gresham, F. (2007). Advances in School Mental Health Promotion. *Journal of Inaugural Issue*, 9, 32-41.
- Parse, R.R. (1981) *Man- living – health: A theory of nursing*. New York, Wiley.
- Parse, R. R. (1998). *The human becoming school of thought: A per spectate for nurses and other health professionals*. Thousand Oaks, CA: Sage.
- Patton, M. Q. (2002). *Qualitative research and evaluation practice*. Thousand Oaks CA: Sage.
- Page A. C & Hooke, G. R. (2012). Effectiveness of Cognitive-Behavioral Therapy Modified for Inpatients with Depression. *International Scholarly Research Network*, 4, 61-265.
- Peggy, L. (2001). Reiki Unleashed Usui Reiki. *Contemporary and Traditional Reiki Journal*, 73, 44-54.
- Peterson, A.L., & Halstead, T.S. (1998). Group cognitive behavior therapy for depression in a community setting: A clinical replication series. *Journal of Behavior Therapy*, 29, 3–18.
- Petterson, S. M. & Allbers. A. B. (2001). Effects of poverty and maternal depression on early child development. *Journal of Child Development*, 12, 1794 – 1813.
- Pike, B.F. Fitzpatrick, K. M. (2003). Depression Symptom metrology among Hungarian youth. A risk and protective Factors approach. *American Journal of psychiatry*, 73, 44-54.

- Pittman, K., Irby, M., & Ferber, T. (2000). *Unfinished business: Further reflections on a decade of promoting youth development*. In Public/ Private Ventures (Ed.), Youth development: issues, challenges, and directions (pp. 17 – 64).
- Plant, E.A., Sachs-Ericsson, N. (2004). Racial and ethnic differences in depression: the roles of social support and meeting basic needs. *Journal of Consulting Clinical Psychology, 72*, 41 – 52
- Pometants, E. (2001). Parent X child socialization: Implications for development of depressive syndromes. *Journal of family psychology, 15*, 510-525.
- Potter, P.J. (2007). Breast biopsy and distress: Feasibility of testing a Reiki Intervention. *Journal Holist Nurse, 25*, 238-48.
- Puskar, K.S., Sereika, S., Tusaia –Mumford, K. (2003). Effect of Teaching Kids to cope (TKC) program. *Journal of child Adolescent psychiatric, 16* (2), 71-81.
- Prins, P.J.M., Ollendick, T.H. (2003). Cognitive change and enhanced coping: Missing Meditational links in Cognitive Behavior Therapy with anxiety-disordered children. *Journal of Clinical Child and Family Psychology Review, 6*(2), 87–105.
- Prinstein, M. J., Chea, C. S., & Guyer, A. E. (2005). Peer victimization, cue interpretation, and internalizing symptoms: Preliminary concurrent and longitudinal findings for children and adolescents. *Journal of Clinical Child & Adolescent Psychology, 34*, 11-24.
- Rahmani, F. (2007). Frequency of Depression during Menstrual Period and its Relation with Religious Attitudes in Karaj High School Girls. *Journal of Dena, 1*(2), 1-11.
- Ranchman, S. (1997). *The evolution of cognitive behavior therapy*. In Clark, D, Fairburn, C.G. & Gelder, M.G. Science and practice of cognitive behavior therapy. Oxford: Oxford University Press. pp. 1 – 26.
- Rand, W.L. (2005). *The Reiki touch workbook*. Louisville, CO: Sounds True.
- Report of the Surgeon General. (2001). *Mental health: A report of the Surgeon General* (chap. 3).
- Reinharz, S. (1994). *Feminist methods in social research*. New York: Oxford University Press.
- Rice, F., Harold, G., Thapar, A. (2002). The genetic etiology of childhood depression: a review. *Journal of Child Psychology & Psychiatry, 43*, 65 – 79.

- Richaud de Minzi, M. C. (2005). Parental styles and coping in children. *Journal of Revisit Latino Americana de Psychologies*, 37, 47 – 58.
- Roberts, C., Bishop, B. (2003). *Depression, adolescents*. In T. Gullotta and M. Bloom (Eds). *Encyclopedia of primary prevention and Health promotion* PP. 403-410.
- Robertson, M, M., Banerjee, S., Eapen, V., & Fox-Hiley, P. (2002). Obsessive compulsive behavior and depressive symptoms in young people Tourette syndrome. A controlled study. *Journal of European Child and Adolescent Psychiatry*, 11(6), 261 - 265.
- Rohde, P., Seeley, J. R., Kaufman, N. K., Clarde, G. N., & Stice, E. (2006). Predicting time to recovery among depressed adolescents treated in two psychosocial group interventions. *Journal of Consulting and Clinical Psychology*, 74, 80 – 88.
- Rogers, M.E. (1994). Nursing science evolves. In: Madrid, M., Barrett,E.A.M., (eds). *Roger's scientific art of nursing practice*. New York, National League for Nursing Press.
- Roohafza, H., Afshar, H., Sadeghi, M., Soleimani, M. (2010). The Relationship between Perfectionism and Academic Achievement, Depression and Anxiety. *Iranian Journal of Psychiatry and Behavioral Sciences*, 2, 31-36.
- Rossello' J, Bernal G (2005). New developments in cognitive – behavioral and interpersonal treatments for depressed Puerto Rican adolescents. In: Hibbs, E.D., Jensen, P.S., eds. *psychosocial treatments for child and adolescent disorders: empirically based strategies for clinical practice*. Washington, DC, US: American Psychological Association; 187 – 217.
- Rossello, J., Guillermo, B., and Carmen Rivera-Medina (2008). Individual and Group CBT and IPT for Puerto Rican Adolescents with Depressive Symptoms. *Cultural Diversity and Ethnic Minority Psychology*, 14(3), 234–245
- Rhode, P., Seeley, J.R., Kaufman, N.K., Clarke, G.N., Stick, E. (2006). Predicting time to recovery among depressed adolescents treated in two psychosocial group interventions. *Journal of Consulting Clinical Psychology*, 74, 80 – 88.
- Rostamzadeh, Z. (2001). Prevalence of depression in high school students in Uromia. *Journal of Uremia University of Medical Sciences*, 5(2), 7-12.
- Roth, J. L., & Brooks-Gunn, J. (2000). What do adolescents need for healthy development? Implications for youth policy. *Society for Research in Child Development Social Policy Report*, 14 (1), 3 – 19.
- Rutter, M., & Silberg, J. (2002). Gene-environment interplay in relation to emotional and behavioral disturbance. *Annual Review of Psychology*, 53, 463

- Sameer, D. & Milind, P. (2011) Non-drug strategies in the management of depression: A comprehensive study of systematic review and met analysis of randomised controlled trials. *Journal of Neuroscience and Behavioural Health*, 3, 6-73.
- Saylor, C. F., Finch, A. J., Spirito, A., & Bennett, B. (1984). The Children's Depression Inventory: A systematic evaluation of psychometric properties. *Journal of Consulting and Clinical Psychology*, 52, 955-967.
- Schwartz, A. and Schwartz, R. M. (1993). *Depression: Theories and Treatments*. New York, NY: Columbia University Press.
- Scourfield, J., Riec, F., Thapar, A., Harold, G., Martin, N., & McGuffin, P. (2003). Depressive symptoms in children and adolescents: Changing and etiological influences with development. *Behavior Genetics*, 44, 968 – 976.
- Sepehrmanesh, Z., Alavi A., Arabgol, F. (2008) The Psychopathology of Heroin Abuse Injectors in Kashan Prison. *Iranian Journal of Psychiatry and Behavioral Sciences*, 2, 55-58.
- Shahnazi, B. (2007). Depression among female students in public schools in Tabriz. *Journal of Nursing and Midwifery*, 3(9), 22-30.
- Sheeber, L., Davis, B., Hopsh, T., Tildesley, E. (2007). Adolescents' relationships with their mothers and fathers. Associations with depressive disorder and sub-diagnostic symptom metrology. *Journal of Abnormal psychology*, 116(d1), 144-154.
- Shiflett, M. W., Gould-Beierle, K. L., Smulders, T. V., & DeVoogd, T. J. (2002). Septum volume and food-storing behavior are related in parids. *Journal of Neurobiology*, 51, 215- 222.
- Schroeder, C., Elizabeth G. D., Philip, C. (2003). Cognitive-behavioral therapy for Anxiety-disordered youth: Secondary outcomes from a randomized clinical trial Evaluating child and family modalities, *Journal of Anxiety Disorders*. 65, 123-98.
- Shore, A. G. (2004). Long-term Effects of Energetic Healing on Symptoms of Psychological Depression and Self Perceived Stress. *Alternative Therapies in Health and Medicine*, 10(3): 42-48.
- Shojaeezadeh, D. (1999). Prevalence of depression and its influencing factors in male students. *Journal of Medicine and Rehabilitation*, 2(7), 23-29.
- Sinha, M., Deepak, K. (2010). Mindfulness-based Cognitive Behavior Therapy with emotionally disturbed Adolescents affected by HIV/AIDS. *Journal Indian Assoc. Child Adolescent. Ment. Health*. 6(1), 19-30.

- Slavin, R. E. (2002). Evidence -Based education policies transforming educational practice and research. *Educational Researchers*, 31 (7), 15-22.
- Smokowski, P.R., Mann, E.A., Reynolds, A.J., & Fraser, M.W. (2004). Childhood risk and protective factors and late adolescent adjustment in inner city minority youth. *Children and Youth Services Review*, 26, 63 – 91.
- Snead K, Ackerson J, Baileny K, et al (2004): Taking charge of epilepsy: the development of a structured psychoeducational group intervention for adolescents with epilepsy and their parents. *Epilepsy & Behavior*; 5, 547 – 56.
- Sped. V, Cuijpers. P., Nykli, Riper H, Keyzer. J., and Pop V (2006) Internet –based Cognitive behavior. Therapy for mood and anxiety disorders: a Meta -analysis. *Journal of Psycho Medication*, 37, 319 – 328.
- Spielmanns, G.I., Pasek, L.F., & McFall, J. P. (2007). What are the active ingredients in cognitive and behavioral psychotherapy for anxious and depressed children? A meta-analytic review. *Clinical Psychology Review*, 27, 642 – 654.
- Statistical Center of Iran (2006). *Educational Yearbook of the country in Tehran*: Iran Statistical Center.
- Steinberg, L. (2007). *Adolescence (8th Ed)*. New York: McGraw-Hill.
- Stephen E. Crawford, V. Wayne Leaver, and Sandra D. Mahoney (2006). Using Reiki to Decrease Memory and Behavior Problems in Mild Cognitive Impairment and mild Alzheimer's Disease .*The Journal of Alternative and Complementary Medicine*. 12(9), 911-913.
- Strauch, B. (2003). The diathesis – stress and causal mediation components. *British Journal of clinical Psychology*, 41, 111 – 128.
- Takakura, M., Sakihara, S. (2000). Gender differences in the association between psychosocial factors and depressive symptoms in Japanese junior high school Students. *Journal of Epidemiology*; 10, 383-91.
- Tonekaboni, Sh., Jafari Naeni, S., Khajeh, A., Yaghini, O., Ghazavi, A., Abdollah Gorji, F. (2011). Use of Complementary and Alternative Medicine for Epileptic Children in Tehran: A Cross-Sectional Study. *Iran J Child Neurol*. 8(1):26-31.
- Tram, J. M., & Cole, D. A. (2000). Self-perceived competence and the relation between life events and depressive symptoms in adolescence: mediator or moderator? *Journal of Abnormal Psychology*, 109, 753-760.
- Thomas, C. M., & Morris, S. (2003). Cost of depression among adults in England. *British Journal of Psychiatry*, 183, 514–519.

- Thompson, J. (2003). *Compassion and social healing*. Boston: Boston Research Center.
- Tloczynski, J. & Tantriella, M. (1998). A comparison of the effects of Zen Breathes Meditation or relaxation on college adjustment. *Journal of Psychologia in the Orient*, 41(1), 32-43.
- Treatment for Adolescent Depression study (TADS) Team (2004). Fluoxetine, Cognitive-behavioral therapy and their combination for adolescents with depression. *Journal of the American Medical Association*, 229, 307-820.
- Twenge J. M, Nolen-Hoeksema, S. (2002). Age, gender, race socioeconomic status and birth cohort differences on children's depression inventory: a Meta-analysis. *Journal of Abnormal psychology*, 111, 578-588.
- Uday, K., Sinha (2010). Mindfulness-Based Cognitive Behavior Therapy with Emotionally Disturbed Adolescents Affected by HIV/AIDS. *Journal of Indian Association for Child and Adolescent Mental Health*, 6(1), 19-30.
- U.S. Public Health services. (2000). *Report of the surgeon General's conference on Children's Mental Health*.
- Usui, M., and Petter, F. A. (2003). *Original Reiki Handbook of Dr. Mika Usual twin lakes, WI: lotus press*.
- Vitale A., O'Connor, P.C. (2006). The effect of Reiki on pain and anxiety in women with abdominal hysterectomies: A quasi-experimental pilot study. *Holistic Nursing Practice*, 20(6), 263-272.
- Wallerestain,R. (2000). *Forty-Two Lives in Treatment: A Study of Psychoanalysis and Psychotherapy*. New York: Guilford press.
- Wang, L., & Crane, R. (2001). The relationship between marital satisfactions, marital stability, nuclear family triangulation, and childhood depression. *The American Journal of Family Therapy*, 29, 337-347.
- Wany, P.S., Berglund, P., Kessler, R.C. (2001). Recent Care of common mental disorders in the United States, prevalence and conformance with evidence-based recommend dating. *Journal of General Internal Medicine*, 34, 282-292.
- Wany, L. & Rrane, D. R. (2001). The relationship between marital satisfaction, marital stability, nuclear family triangulation and childhood depression. *The American Journal of Family therapy*, 29,337-347
- Wardell, D.W., & Engebretson, J. (2001). Biological correlates of Reiki touch(sm) therapy. *Journal of Advanced Nursing*. 33 (4), 439 – 445.

- Watson, J. (1988). *Nursing: Human science and human care: A theory of nursing*. New York, NY: Churchill-Livingstone.
- Weiss, B., and Garber, J. (2003). Developmental differences in the phenomenology of depression. *Development and Psychopathology*, 15 (2), 403 – 430.
- Weisz, J. R., McCarty, C. A., & Valeri, S. M. (2006). Effects of psychotherapy for depression in children and adolescents: A meta-analysis. *Psychological Bulletin*, 132, 132-149.
- Whelan, K., & Wishnia, G. S. (2003). Reiki therapy: The benefits to nurse / Reiki practitioner. *Holistic Nursing Practice*, 17 (4), 209-218.
- Wilansky-Traynor, P., Manassis, K., Suneeta Monga, S., Shaw, M., Merka, P., Anne-Marie, L., Kleiman, V. (2010). Cognitive Behavioral Therapy for Depressed Youth: Predictors of Attendance in a Pilot Study. *Journal of Child Adolescent Psychiatry*, 19, 2-54.
- Willeke, C. (1998). *Reiki level I manual*. Tibetan Usui Method of natural healing. ISBN NO. 0-646-31218-9.
- Wiles, A. & Brooker, D. (2003) Complementary therapies in-dementia care. *Journal of Dementia Care*, 11, 31–36.
- Woolley, S. (2000). Gender biases and therapists' conceptualizations of couple difficulties. *American Journal of Family Therapy*, 28, 181-192.
- World Health Organization. (2001). *Investigating mental health*. Retrieved from http://www.who.int/mental_health/en/investing_in_mnh_final.
- Wolp, J. (1997). *The practice of behavior therapy*. New York: Pergamum press.
- Wu, P., Hoven, C. W., Cohen, P., Liu, X., Moore, R. E., Tiet, Q., Okezie, N., Wicks, J., & Bird, H. R. (2001). Depressive and disruptive disorders and mental health service utilization in children and adolescents. *Journal of Psychiatric Services*, 52, 189-195.
- Zahirodin, A. (2005). Depression prevalence and associated factors among high school students. *Journal of Pajo handeh*, 9(37), 61-64.