v. 5, n. 7, 2025

International Journal of Health Science

Acceptance date: 28/01/2025

PSYCHOLOGICAL INTERVENTION STRATEGIES FOR ADDRESSING DEPRESSIVE INDICATORS IN YOUNG PEOPLE AND ADULTS IN ECUADOR

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Abstract: Student guidance departments (2020) reveal the importance of working on identifying and addressing psychological factors in students. Thus, depression is a challenge in the field of psychological well-being that requires immediate responses for youth and adults who are exposed to risks associated with the educational, social and family environment. In this context, the implementation of psychological intervention strategies is based on the attention to people with moderate and severe depressive indicators, through the Brief Systemic Therapy Focused on Solutions that aims to reduce depressive indicators. The methodology is exploratory-descriptive, with a qualitative-quantitative approach. The Beck Inventory was used in its version adapted to Ecuador by Astudillo and Quezada (2021), likewise, the analysis and processing of data were processed in an Excel statistical program. The participants who collaborated were 122 students from the Educational Institute of the city of Cuenca with 22.95% (28 students) obtained the most significant results, of which 13.11%, equivalent to 16 students participated actively and voluntarily in the intervention process. Of the latter group, 7 students (5.73%) showed signs of deep depression, while 9 students (7.37%) showed moderate depression. The final evaluation revealed a remarkable reduction in depression: 62.50% (10 students) reached minimal levels of depression, 12.50% (2 students) with mild depression and 25% (4 students) with moderate symptoms and finally 0% with profound depression. These findings support the efficacy of psychological intervention strategies in addressing depression. In addition, it raises new proposals to develop in the area of students' emotional well-being.
Keywords: depression, Beck inventory, strategies, psychological intervention.

INTRODUCTION

The article focuses on psychological strategies to assist young people and adults belonging to the Educational Institution of Cuenca-Ecuador with indicators of moderate and severe depression, generating a relevant contribution to the topic of interventions.

The Model of Integral Attention of the Student Counseling Departments (2020) highlights the responsibility of educational institutions in identifying and addressing psychological factors of the student body. In this context, it is stated that the educational institution where this study was conducted does not have psychology professionals, which evidences the need to conduct this research.

In Ecuador, it has been shown that there is little training in this area, in addition to the existence of numerous cases of violence and conflicts among students in educational institutions (Jordán Buenaño et al., 2021). In this sense, Acosta (2022) in his study conducted in the canton of Paute identified that there is a moderate and high risk of committing suicide in adolescents between 13 and 18 years, being 16 years and female sex the most marked, i.e. there is a high suicide risk with 50.5% and moderate 44.9%, the sub-scale in hopelessness with 87.4%, in loneliness and despondency with 50.5%, in low self-esteem with 52.8%, difficulty in coping with emotions with 75.7% and in suicidal ideation with 60.3%.

Aucapiña Cañar (2019) in his research conducted in Cuenca with 131 students, found that 29.01% were at risk for suicide. Likewise, it is evident that the actions taken so far are insufficient and interventions are required to meet the needs of the population (Jordán Buenaño et al., 2021)

Psychological intervention through strategies becomes a tool to address the individual and group emotional needs of students to achieve a comprehensive development, which demonstrates their ability to meet the challen-

ges of everyday life (López et al., 2022). For this reason, it is necessary to develop strategies that meet the needs of the people with whom the intervention is going to take place.

The WHO (2016) confirms that depression and anxiety are a priority for international health, due to the fact that an increase of 18% in cases of suicide among young people aged 15 to 18 years globally was manifested. This justifies the importance of this research. On the other hand, Arrarás et al. (2019) highlights that between 25 and 34 years of age (young adults), they present a more prevalent depressive disorder, that is to say that in young people aged 18 to 29 the occurrence of depression is triple that in adults aged 60 years.

According to León-Wong et al. (2022) depression is a complex, costly and heterogeneous disorder that is increasing. For this reason, psychological strategies are an effective alternative to meet the demand that exists in the world on this issue.

That is why according to the Organic Law of Intercultural Education (LOEI) mentions in art. 2 on principles highlights the national education system with the following elements: prevention, detection and treatment of situations of violence... (Reglamento General a la Ley Orgánica de Educación Intercultural, 2022). For this reason it is important to generate activities that allow the welfare of all students.

Within this line of ideas the psychoeducational area of the institutions should focus on identifying the psychological factors resulting from the daily difficulties in education from which to plan and implement strategies in prevention programs (MODEL OF INTEGRAL ATTENTION OF THE STUDENT COUNSELING DEPARTMENTS, 2020). In this way it is important to mention that the Educational Institute with which we worked has an absence of specialized personnel in the area of psychology which evidences the need to implement psychological intervention programs that manage strategies that meet the needs of the population (Unidad Educativa Semipresencial - irfe-irfeyal, s. f.).

Rodriguez & Gonzalez (2020) demonstrated that Solution Focused Therapy in a case of Major Depression is useful to combat this imbalance. That is why young and adult students identified with moderate and severe depression were part of the therapeutic process in which an intervention plan based on psychological strategies was elaborated.

The American Psychiatric Association (2020) defines depression as a medical condition that negatively affects the way individuals think, act, and feel. Furthermore, PAHO (2020) mentions that depression is a common but serious illness that interferes with daily life, the ability to work, sleep, eat, study and enjoy life. In conclusion, it greatly impairs the normal development of daily activities.

The National Institute of Mental Health (2021) affirms that all people at some point can be affected by this medical condition, which is influenced by genetic, biological, environmental and psychological factors. According to Major (2021) depression is among the main causes of psychological deterioration in the world. It is also associated with various social, family and interpersonal factors, many of which change during life, depending on the individual's stage of development (Kostev et al., 2019).

A study conducted on 1373 university students in the province of Azuay determines that depression is multicausal and in which the following factors interfere, such as: unsatisfaction of basic psychological needs, frustrating environment, inadequate education patterns, age, sex, inadequate family environment, low family economic level, emigration of one and/or both parents, family structure (ASOCIADOS, P. D. D. D. Y. F, 2015).

Within the symptomatology we talk about emotions contrary to pleasure, authors such as Hippocrates contributed with the basis of

medicine by conceptualizing melancholy and mania, followed by Celsus who studied melancholy, and later Falret in 1882 considered suicide as a consequence of mental disorder, Likewise, it was Kraepelin who described manic depression and defined involutional melancholia, and later Freud pointed out that the loss of the loved object causes a depressive state characterized by the melancholy of mourning, and Beck identified a cognitive triad of depression (Bayona, 2007).

In Latin America, research on the elements influencing depression in university students reveals that 58.8% have only factors linked to situational depressive disorder. In contrast, 32.3% exhibit exclusively factors related to psychogenic depressive disorders. A sketch of 16.1% revealed presenting depressive disorders, situational depression and psychogenic factors (Vargas Granda, 2021). It is essential to reflect on the kind of depression scale that young and adult students currently have in order to design an approach according to their needs.

Authors such as Arias & Pérez (2022) conducted a research in Ibagué - Colombia where they reveal the complexity of depression in young people, whose origin could be found in a mixture of academic overload, fragile family relationships, lack of emotional support and mental openness. Therefore, the importance of prioritizing the emotional well-being of students over academic achievement is key.

It is essential to support the use of diverse educational psychological strategies to ensure the comprehensive development of students. In a study conducted by Ruiz (2017) points out that the connection between self-confidence and mood trances in young people from an educational campus in the Peruvian capital showed that 24.1% presented light signs, 70.7% showed clinical signs and only 5.2% exhibited moderate signs. With data from the collective mind of the National Institute, the suspicion vibrates that between 1 and 3 fatal acts dance every day in the shadows of the South American nation. Now, in a disturbing revelation, 8.9% of the inhabitants have deeply felt the impulse to take their own lives. In about 95% of situations, they are related to a previously unattended underlying psychological condition.

On the other hand, the strategies used in the Psychological Intervention are based on Solution Focused Brief Therapy, aimed at young people and adults with depressive indicators of the San Francisco de Asis Fiscomisional Educational Unit in Loja. It has been divided 120 young people considered normal, 45 with mild disturbance of their mood, 19 with intermittent depression, 17 with moderate depression, 11 with severe depression, 1 adolescent with extreme depression (Mendoza, 2019).

Within this same order of ideas Jadán (2017) mentions that depression in adolescents between 14 and 16 years of age from the Colegio 27 de febrero of the City of Loja is evidenced that there is a prevalence of depression of 65.75%. They highlight data on depression by age and sex, placing females with 92.20% and males 88.30% with a ratio of 1.5:1 respectively and finally mentions that the age group with the highest depression is 15 years old with 34.59%.

A study by Tepán (2022) conducted in Cuenca highlights a pioneering mental well-being prevention plan for adolescents. The results show a curious division: eleven and fifteen year olds present low scales of wellbeing, in contrast, twelve, thirteen and fourteen year olds are located in moderate wellbeing (14.2 %; 23.3 % and 13.2 %) respectively.

In this context he suggests that the creation of a primary preventive program focused on students' mental well-being can foster positive emotions, optimism, gratitude and strength, thus building a solid ground for students to raise their mental well-being to new heights (Tepán, 2022). So too, according to Mendoza (2019) the unique determinants of depression

are the primary pillar for the creation of an Action program, guiding the bases, tools, tactics, strategies and methods that enable an approach in line with the demands of the student body. Thus, the Psychological Intervention Strategies for Addressing Depressive Indicators in Youth and Adults, which was developed in the city of Cuenca - Ecuador, was born

METHODOLOGY

This research is of an exploratory-descriptive type, the quantitative-qualitative approach was used, and through a literature review, the exploration, evaluation and selection of the theoretical foundations related to the study were organized. From the quantitative point of view, the Beck Inventory adapted and validated for the Ecuadorian context by Astudillo and Quezada (2021) was used, it uses a Likert scale and is a self-report that is identified as one of the most effective for detecting depression, thus giving four results: minimal, mild, moderate and severe. The person must choose the item that best describes his or her state during the last two weeks, each item is rated from 0 to 3 points depending on the alternative chosen and, after adding the score of each item, a total score ranging from 0 to 63 is obtained.

A total of 122 male and female students participated. The year of execution was 2024 and the study developed an intervention plan based on psychological strategies to work on a therapeutic process with students with moderate and severe depressive indicators using Solution Focused Brief Systemic Therapy.

Exclusion criteria: Students who do not belong to the Educational Institute of the city of Cuenca, students who do not wish to participate in the study.

Inclusion criteria: Students of the Educational Institute of the city of Cuenca, voluntary participation in the research, male and female students enrolled and regularly attending classes.

Next, in the qualitative part, a semi-structured health interview was constructed and validated, which allowed us to deepen and clarify the ideas about the causes and effects of depression on the health of students. Through this technique, we sought to gather the participants' perspectives on the information and relevant aspects of the research.

After collecting and analyzing all this information, an Intervention Plan with Psychological strategies based on Solution Focused Brief Systemic Therapy will be elaborated, it is estimated to structure 4 group sessions that respond to the needs of the students identified with moderate and deep depression. The execution of this plan will allow sharing meanings and perspectives regarding depression. It is intended to create a space for listening and opinions in the participants through group therapy as a way to obtain information and create a therapeutic space.

RESULTS AND DISCUSSION

The number of students who responded to the Beck Inventory is specified in Figure 1. The data show that 122 students participated, which is equivalent to 100%. It stands out that 61.47% have minimal depression, 15.57% mild, 13.11% with moderate, and 9.83% sink into severe depression. There are studies that support the effectiveness of the inventory (Ruiz, 2017; Mendoza, 2019).

Regarding the distribution by sex and the key scales, such as moderate and severe depression to be addressed, these are detailed in Table 2. The data indicate that on average 4.01% of men and 9.01% of women have moderate depression. While 0.81% of men and 9.01% of women have severe depression. Cross-checking the results with Jadan (2017) reveals that women are the age group with the highest depression.

The data on the age distribution and scales of moderate and severe depression of the 122 students are shown in Table 3. The findings suggest that moderate depression affects 8.19% of 15-30 year olds, 4.10% of 31-45 year old adults, and only 0.81% of 46-60 year olds. Meanwhile, severe depression appears in 8.19% of 15-30 year olds, in only 0.81% of 31-45 year old adults and in another 0.81% of 46-60 year olds.

Table 4 reveals the distribution of students immersed in meaningful scales and balanced with their work roles. The data highlight that those experiencing moderate depression who are employed represent 11.47%, in contrast to 1.64% of the unemployed. On the other hand, cases of severe depression show 8.20% of employed and 1.64% of unemployed.

It is essential to note that, among the 28 students diagnosed with moderate and severe depression, 16 voluntarily agreed to collaborate in the therapeutic treatment by signing the act of commitment and willingness to participate in the therapeutic process. With this select group, an innovative approach was implemented through semi-structured interviews to explore the roots of their discouragement, as shown in Table 5. Within this complex analysis, multiple causal facets emerge: family problems with 87.50%, health problems and work problems with the same percentage of 43.75% and finally academic and social problems with an equal percentage of 31.25% each.

Thus, the proportion of responses in Table 6 is related to students who received therapy for depression. The data show that 87.50% chose not to do so, while 12.50% did undergo treatment

Thus, Tables 7, 8, 9 and 10 present the intervention sessions with psychological strategies that respond to Solution-Focused Brief Systemic Therapy to treat students affected by a depressive state of varying intensity. This consolidates the premise of Tepán (2022), suggesting that devising a primary prevention plan focused on the emotional well-being of students contributes to building emotional stability.

It is also important to take into account that after the therapeutic treatment a final evaluation was carried out, detailed in Table 11. This table shows the results, which are equivalent to minimal depression with 62.50%, mild depression with 12.50% and moderate depression with 25%.

Therefore, Table 12 shows us another result which is the distribution of the final evaluation by sex that identifies a minimum depression of 6.25% in men and 56.25% in women, in mild depression 12.50% in women and in moderate depression 6.25% in men and 18.75% in women, finally 0% in severe depression in men and women.

Finally, the work shows the relevance in relation to the institutional research line such as health, nutrition and wellness, as well as the career line of attention to priority groups.

CONCLUSIONS

In conclusion, moderate and severe depression was identified in the students of the Instituto Educativo de Cuenca. To achieve this, the instrument selected was the Beck Depression Inventory, a widely recognized and validated psychological assessment instrument that was administered to the entire student population of the mentioned extension. Such administration not only allowed us to identify the presence of depressive symptoms, but also to catalog their severity, which provides a detailed and quantitative perspective of the levels of depression observed in the students evaluated.

After the initial identification of the levels of depression, the next phase of the research consisted of the application of the semi-structured interview to a group of 16 selected students who voluntarily participated in the therapeutic process. This last type of qualitative tool provides detailed and in-depth information on the individual experiences of the

ILLUSTRATIONS, TABLES, FIGURES

Depression Scales	Score range (BDI-II)	No. of students	Percentage (%)
Minimal	0-13	75	61,47%
Slight	14-19	19	15,57%
Moderate	20-28	16	13,11%
Severa	29-63	12	9,83%
Total		122	100%

Table 1. *Classification of youth and adults by depression scales*

Note: It was applied to a total of young and adult students, N = 122. Most of the students (61.47%) show minimal depression scales, while 9.83% report severe depression.

Depression Scale	Men	% Men	Women	% Women	Total Students	Total
Minimal	45	37%	30	25%	75	61%
Slight	8	6,56%	11	9,01%	19	16%
Moderate	5	4,01%	11	9,01%	16	13,11%
Severa	1	0,81%	11	9,01%	12	9,83%
Total	59	48,38%	63	51,62%	122	100%

Table 2. Distribution of depression scales by sex

Note: Of the students evaluated, 9.01% of females are in both the moderate and severe depression scales, in contrast to males, who have 4.01% in moderate depression and 0.81% in severe depression. Likewise, men have a higher proportion in minimal depression (37%) compared to women (25%).

Depression Scale	15-30 years	%	31-45 years old	%	46-60 years	%	> 60 years	%	Total (n)	Total (%)
Minimal	47	38,52%	23	18,85%	4	3,27%	1	0,81%	75	61%
Slight	15	12,29%	4	3,27%	0	0%	0	0%	19	16%
Moderate	10	8,19%	5	4,10%	1	0,81%	0	0%	16	13,11%
Severa	10	8,19%	1	0,81%	1	0,81%	0	0%	12	9,83%
Total	82	67,21%	33	27,03%	6	4,91%	1	0,81%	122	100%

Table 3. *Depression scales according to age groups*

Note: The percentages obtained indicate that the most affected groups are those between 15 and 30 years of age, with the highest levels of moderate (8.19%) and severe (8.19%) depression. In second place is the 31 to 45 years age group, with 4.10% in moderate depression and 0.81% in severe depression. The groups aged 46 to 60 years present very low scales (0.81%).

Depression Scale	Yes they work (n)	% Yes working	Not wor- king (n)	% Not working	Total (n)	Total
Minimal depression	61	50,00%	14	11,47%	75	61%
Mild depression	16	13,11%	3	2,46%	19	16%
Moderate depression	14	11,47%	2	1,64%	16	13,11%
Severe depression	10	8,20%	2	1,64%	12	9,83%
Total	101	82,78%	21	17,22%	122	100%

Table 4. *Depression scales in students according to employment status*

Note: In the moderate and severe depression scales, a significantly higher percentage belongs to students who work. In moderate depression, 11.47% corresponds to those who work, compared to 1.64% for those who do not. In severe depression, the figures are 8.20% for those who work and 1.64% for those who do not.

Main causes	Family members	Health	Labor	Academics	Social
No. of Responses	14	7	7	5	5
Percentage (%)	87,50%	43,75%	43,75%	31,25%	31,25%

Table 5. *Factors contributing to student depression.*

Note: Family factors stand out as the main cause influencing depression in the 16 students (87.50%). On the other hand, health and work factors have a moderate and equivalent impact (43.75%). Academic and social causes, although less significant, share an equal percentage of incidence (31.25%), evidencing their role in the problem.

Category	Frequency (n)	Percentage (%)
Treatment received	2	12,50%
No treatment	14	87,50%
Total	16	100%

Table 6. *Proportion of students who have undergone treatment for depression*

Note: According to the data, of the 16 students participating in the therapeutic process, only 12.50% reported having received any treatment for depression, while 87.50% reported not having done so. This result shows a low access to psychological treatment in this population.

1. Presentation:
   - Warm and respectful welcome to establish trust.
   - Attendance registration and confirmation of participants.
   - Brief explanation of the work methodology and the objectives of the therapeutic plan.
2. Central Theme: Building alternatives and strengthening ties.
3. Technique: Collaborative narratives and relational questions.
4. Objectives:
   - Promote group cohesion through participatory dynamics.
   - Promote a collective reflection on the difficulties, exploring joint solutions.
5. Methodology:
   - Active participation: Each member has the opportunity to contribute his or her perspective.
   - Creating a safe environment: Relaxation techniques and initial dynamics to reduce tensions.
   - Active listening and positive feedback: By the therapist and group members.
   - Use of questions: Coping and relational questions to explore the problem and its impact on group dynamics.
6. Procedure:
   1. Start with a dynamic presentation: "I am called and I love myself for...".
   2. Relaxation technique: "Conscious breathing" to reduce tensions.
   3. Collaborative narratives: Sharing personal stories about the problem and building a group narrative.
   4. Generation of alternatives: Participants propose ideas to address the problem.
   5. Closing: Group feedback and homework assignment: make a diary of emotions to identify emotional patterns and reflect on them.
7. Materials: blackboard, markers, attendance register, handouts, pens and computer.

Table 7. Structure of the First Session of the Therapeutic Process

1. Presentation:
- Initial greeting and attendance verification.
- Group review and reflection on the previous session and homework assignments.

2. Theme: "Exploring and leveraging my strengths".

3. Technique: Solution-oriented group dynamics.

4. Objectives:
- Reflect on emotions and behaviors in problem solving.
- Encourage self-discovery and self-confidence through the exploration of internal resources.

5. Methodology:
- Active participation, group dynamics and individual reflections.
- Use of open-ended questions to stimulate analysis and creation of solutions.
- Active listening and emotional validation by the therapist to promote a supportive environment.

6. Procedure:
- Introduction of the session and objectives.
- Reflection on emotions and learnings of the week.
- Group dynamics for problem solving with exchange of solutions.
- Socialization of results and collective learning.
- Closing with positive feedback and homework assignment: Task: Identify personal and family qualities.

Materials: blackboard, markers, attendance register, handouts, pens and computer.

Table 8. Structure of the Second Session of the Therapeutic Process: Strengthening Personal Resources

1. Presentation:
Activate collective consciousness, verify full presence.
To explore in a deep dialogue about the previous encounter, weaving it with the current task, merging ancestral teachings with recent objectives.

2. Theme: "Moving towards change".

3. Primary Technique: Questioning and Probing through Analysis to Approach

4. Objectives:
- Identify and commemorate personal assets.
- Explore emotional turbulence and create tactics to deal with it.
- Stimulate collective connection to forge responses to the challenges identified.

5. Methodology:
- Interactive experience: Emphasize the dynamic involvement and collective synergy.
- Relational dimensions: Assess the magnitude of the impact of the challenges and encourage feasible responses.
- Committed listening: The healer recognizes experiences, building a space of trust.
- Collective connection: Encourage exchange among members to disseminate thoughts and tactics.

6. Procedure:
1. Explain the objectives of the session.
2. Review homework, analyzing learning and difficulties.
3. Apply the scaled questioning technique to evaluate problems and explore solutions.
4. Sharing group reflections and generating possible coping strategies.
5. Provide positive feedback and close the session by assigning a new task focused on self-care activities.

7. Materials: blackboard, markers, attendance register, handouts, pens and computer.

Table 9. *Structure of the Third Session of the Therapeutic Process*

1. Presentation:
   - Welcome and initial greeting.
   - Verification of attendance.
   - Introduction to the topic of the session and connection with the progress or changes observed since the last meeting.

2. Main theme: "Strengthening change".

3. Technique
   - Positive Narratives and Relational Reflection.
   - Consolidate the progress achieved and maintain the momentum towards further improvements.

4. Objectives:
   - To help participants prioritize their own needs.
   - Develop a resilient mindset in the face of life's challenges.
   - Reinforce the achievements reached during the therapeutic process.

5. Methodology:
   - Review of previous assignments and group feedback.
   - Participatory dynamics such as:
     - "The three questions for a happy life."
     - Plenary of experiences: Space to share learning and reflections on the progress made.
   - Use of reflective questions to explore how participants have applied what they have learned.
   - Evaluation, application of Beck inventory.
   - Closing with a motivational message and assignment of a short activity to reinforce the change.

6. Procedure:
   1. Explanation of the objectives of the session.
   2. Group discussion on the changes experienced.
   3. Reflective dynamics to promote self-esteem and emotional well-being.
   4. Group feedback and application of the Beck Depression Inventory.

Close by using an inspirational phrase that connects with the purpose of the personal change.

7. Materials: blackboard, markers, attendance register, handouts, pens and computer.

Table 10. *Fourth Session: "Strengthening Change".*

SCORING	DEPRESSION SCALE	N° STUDENTS	PERCENTAGE
0-13	Minimal	10	62,50%
14-19	Carry	2	12,50%
20-28	Moderate	4	25%
29-63	Severa	0	0%
TOTAL		16	100%

Table11. Final evaluation of participants after completion of the therapeutic process.

Note: Of the 16 students who voluntarily agreed to participate in the therapeutic process, in the final evaluation we have 62.50% in minimal depression, 12.50% in mild depression and 25% in moderate depression.

Depression Category	Men (n)	Men (%)	Women (n)	Women (%)	Total (%)
Minimal	1	6,25%	9	56,25%	62,50%
Slight	0	0%	2	12,50%	12,50%
Moderate	1	6,25%	3	18,75%	25%
Severa	0	0%	0	0%	0%
Total					100%

Table 12. *Distribution of the final evaluation according to category of depression and sex*

Note: The table shows that, in the final evaluation of the depression scale, the highest percentages correspond to the category of minimal depression (6.25% in men and 56.25% in women). Mild depression represented only 12.50% of the total (in women exclusively). As for moderate depression, 6.25% in men and 18.75% in women were identified. No cases of severe depression were recorded in either group.

participants, making it possible to identify the causes of depression in each particular case. Through this interview, it was possible to understand more accurately the students' lived experiences, identifying a series of causes that contributed to the appearance and persistence of depressive symptomatology. Among the multi-causal factors we can mention family problems, work problems, health problems, social problems and academic problems.

Thus, considering the complexity in addressing the problem, a psychological intervention plan was developed with strategies that address the needs of the students who participated in the therapeutic process. I also chose a Solution Focused Brief Systemic Therapy approach that focuses on strengths, not problems; furthermore, the participants were taught to do the same. In short, achieving this goal involves helping the trainees identify their own strengths so that they can overcome their depression problems. During the four sessions, I used techniques based on this school. As a result, the trainees could find energy and self-reliance to address their problems and improve their emotional life.

Finally, a final evaluation was made by the participants of the therapeutic process through which the effectiveness and results of the psychological intervention and the application of strategies were measured.

The final evaluation showed that the emotional state and general well-being of the participants improved significantly. More specifically, depression levels were reduced, and students were able to manage their emotions and daily challenges more effectively. In addition, students developed stress management skills and increased their level of resilience, which will translate into students' ability to deal with future stressful and difficult situations in an isolated manner. Therefore, the results not only confirmed the effectiveness of the therapeutic process based, but also demonstrated the importance of psychological help programs in the academic context, especially for students facing depression, as this program is essential for emotional and academic development. To conclude, this research and the development of the psychological intervention plan are effective tools for addressing depression in the population studied and a model to follow for future interventions in similar settings.

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