CHAPTER-VII

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Depression, loneliness, suicide, despair, frustration, anxiety, trauma, a sense of defeat, tension, stress, fear and vengeance are increasing at an alarming rate and trigger the deathwish. Awareness of these problems including depression has certainly increased, although, resistance to their cure remains strong. And while depression has become a catch-all hold-all phrase for all manner of mental illnesses-including schizoid behaviour - it is also something that people are realizing it can no longer be cured by a burst of shopping, spring cleaning or even going out with the boys or girls. Rooted in the changing social structure and the ever-increasing pressure to perform in a fast-paced world, these are concerns that demand to be addressed by researches and professionals.

Mental illness, which now affects between 10 to 25 percent of the nation’s population, could be a case of depression, a psychotic illness, substance abuse or a personality breakdown. Depression, which constitutes almost 70 percent of all mental illnesses, has taken an alarming proportions, nudging the medical world awake. The prevalence of depression coupled with its association with suicide, has made it the target of extensive research efforts in different parts of the world into its causes, treatment and possible prevention

155
The prevalence of depressive disorders with high economic and emotional costs and the possibility of its continuing as a major mental health problem for years to come, demand the attention of researchers as well as professionals, particularly in the context of psychiatrically normal adults, adolescents and children. The purpose of the current research was to examine depressive symptomatology among psychiatrically normal male and female adolescents, using multiple depressive measures.

The present study was designed with the following objectives;

1. To ascertain the incidence of depression among male and female adolescents.
2. To examine gender differences in depressive tendencies, adolescence.
3. To examine correlates of depressive tendencies among males and females, and
4. To study attribution and coping strategies from the point of view point of depressive symptoms.

HYPOTHESES

PHASE-I

1. The depressive measures derived from different self-report depression scales are not identical.
2. It is hypothesized that given gender difference in symptom expression, modest gender difference in mean level of depressive symptoms are expected, with girls likely to score somewhat higher than boys.
3. It is also hypothesized that a negative self-schema would be positively correlated with depression in both males and females.

4. It is further hypothesized that poor body-image would be more strongly correlated (positively) with depression in case of female adolescents than male adolescents.

5. Depression would be associated negatively with social support in both males and females.

6. Depression would be associated positively with neuroticism, psychoticism and introversion.

**PHASE-II**

It was hypothesized that for coping with depression, adolescents would emphasize those strategies of coping which may be effective in dealing with emptiness, boredom, isolation and lack of social contact.

**SAMPLE**

Participants were 300 adolescents (150 males, 150 females) studying in IX, X, XI and XII grades of different schools/colleges. The age of 150 male adolescents ranged from 12 to 19 years (M = 14.90, SD = 1.55), whereas for 150 female adolescents the age ranged from 12 to 19 years (M = 14.90, SD = 0.90).

The sample was delimited to the subjects who were available to participate in this study, thus, limiting the assumption of randomization.
TESTS USED

The following tests were used:

(A) Measures of Depressive Tendencies/Symptoms

1. The Minnesota Multiphasic Personality Inventory - D (Depression) Scale (Hathaway & McKinley, 1967).

(B) Measures of Cognitive Dysfunction

3. Hopelessness Scale (Beck, Weissman, Lester, & Trexler, 1974).

(C) Measures of Personality

1. IPAT Neuroticism Scale Questionnaire (NSQ : Scheier & Cattell, 1961).
2. Eysenck Personality Questionnaire (Eysenck & Eysenck, 1975).

(D) Measures of Social Support

Social Support Questionnaire (SSQ : Sarson, Levine, Basham, & Sarason, 1983).

(E) Measures of Body Image

Scoring of Tests

The tests were scored strictly in accordance with the procedure suggested by the authors of different tests.

As a result of scoring different tests, several measures mentioned below were obtained.

I. Three measures of Depression
1. Depression scores obtained by scoring MMPI-Depression Scale;
2. Depression scores obtained by scoring Beck Depression Inventory;
3. Depression Scores obtained by scoring Zung Self-Rating Depression Scale.

II. Three measures of Cognitive Dysfunction
1. Negative automatic thoughts,
2. Dysfunctional attitude, and
3. Hopelessness.

III. IPAT Neuroticism Scale Questionnaire was scored for deriving scores pertaining to Factors I, F, E, and An.

IV. Four measures concerning psychoticism, neuroticism, extraversion, and social desirability were obtained by scoring Eysenck Personality Questionnaire.

V. Social Support Questionnaire was scored for measures, namely SSQ-N and SSQ-S scores.

Responses to 27 items on the SSQ were obtained by administering the questionnaire to the subjects who were asked to list for each item all the individuals who provided them support in the situation described. The
subjects were also asked to rate their level of satisfaction with the support received. The number (N) score for each item of the SSQ is the number support person listed. The social support available to deal with a given problem is rated on a scale ranging from very satisfied to very dissatisfied. This yields a satisfaction (S) score for each item (ranging from 1 to 6). The overall N and S scores were obtained by dividing the sum of N and S scores for all items by 27, the total number of items in the questionnaire.

VI. Thirteen measures were obtained from the multidimensional Body-Self Relations Questionnaire;

1. Appearance Evaluation;
2. Appearance Orientation;
3. Fitness Evaluation;
4. Fitness Orientation;
5. Health Evaluation;
6. Health Orientation;
7. Illness Orientation;
8. Body Areas Satisfaction;
9. Fat Anxiety;
10. Weight Consciousness;
11. Subjective Weight;
12. Current Dieting; and

Thus, as a result of scoring different tests, 29 types of score were available.
Analysis

The data were analysed to obtain the following information:
1. Frequency distribution, mean, standard deviation, skewness, and kurtosis for different measures.
2. Bivariate correlations between different measures.
3. Factor analysis for the measures of depression, dysfunctional attitudes, negative automatic thoughts, hopelessness, psychoticism, neuroticism, social desirability, extraversion, social support, and body image.

The analyses were done separately for: (a) male adolescents and (b) female adolescents.

Main Findings

The study revealed the following important findings:
1. The high scores of adolescents sample indicated that, majority of adolescents feel depressed, though not necessarily depressed in the clinical sense.
2. Modest gender difference in mean level of depressive symptoms occur with male adolescents scoring higher than female adolescents.
3. Negative cognitions referring to generalized hopelessness (negative view of future) and global negative self-evaluations (negative view of the self) have emerged as core correlates of depressive tendencies in both male and female adolescents.
4. Body image and social support have been found to be unrelated with depressive tendencies in both male and female adolescents.

5. The concurrent and discriminant validities of the self-report instruments of depression used in this study have been well documented.

6. Majority of the adolescents regardless of gender, attributed depression to personal failure, bleak future, circumstances and parental too much expectations.

7. Adolescents of this study emphasized making use of solitary activities (watching television, listening music, keeping alone, reading/writing) for coping with depression.

CONCLUSIONS

Cognitive interventions that are geared toward reduction of cognitive distortion might prove useful for helping adolescents to alleviate depression. Such cognitive interventions would train the adolescent to recognize maladaptive self-statements and cognitive processes that contribute to depressive feelings. The adolescent should be taught coping responses, self-instructions, and means of restructuring his or her cognitions in order to reduce these aversive feelings of depression.

Because cognitive stress-reduction training programs have been effective with adults, and because other similar
cognitive-behavioural procedures have been used effectively in later adolescence, such training may be a valuable approach for helping adolescents in school years to deal with maladaptive cognitions that contribute to depression. Continued research is needed to assess the effectiveness of this cognitive approach with diagnosed clinical cases or those adolescents in school years displaying depressive tendencies.

Furthermore, coping strategies employed by adolescents may not be effective in dealing with feelings of hopelessness and self blame. It is essential to inform adolescents as to how their coping strategies thwart efforts to alleviate depression. It is essential to provide them training to get rid of maladaptive cognitions.