CHAPTER VII
Mental Health refers to the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adopt to change and to cope with adversity. Mental health is indispensable to personal wellbeing, family and interpersonal relationships, and contribution to community or society. Mental illness refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Alterations in thinking, mood or behavior spawn a host of problems—patient distress, impaired functioning, or heightened risk of death, pain, disability, or loss of freedom (DSM-IV, 1994).

Disability-adjusted life years (DAILY) was calculated using a sophisticated method for assessing the duration and severity of a disability, stated that depression will become a leading cause of disability in the coming decades, second only to ischemic heart disease by the year 2020 (Holsboer, 2001). The World Health Organization Global Burden of Disease study stated that depression is the single most burdensome disease in the world in terms of total disability-adjusted life years among people in middle years of life (Murray and Lopez, 1996). A substantial proportion of affective disorders follow a chronic and recurrent course causing immense personal distress and suffering to individuals and their families. Affecting disorders also contribute to premature mortality through suicide, adding to the community burden due to these conditions (Bhugra et al; 2005).

The word ‘depression’ in everyday parlance covers a wide range of emotional states that range in severity from transient moods of sadness to major psychotic episodes accompanied by increased risk of suicide. Depression in the form of a brief sad mood is a universal
experience and is a normal part of living that accompanies the losses, frustrations, failures, and disappointments that all of us face. Clinical depression in contrast, is a syndrome, or constellation of co-occurring psychiatric symptoms that affect about 20% of the population. Major Depressive Disorder, the psychiatric label for clinically significant depression, is characterized by at least a two-week period of persistent sad mood or a loss of interest or pleasure in daily activities, and four or more additional symptoms, such as marked changes in weight or appetite, sleep disturbance, psychomotor retardation, fatigue, feeling of guilt or worthlessness, and concentration difficulties (Gotlib and Rottenberg, 2001).

Keeping in view what has been said in proceeding paragraph, the current study intends to examine the effect of negative cognition, stress and gender on depression on the context of the intervening role of social support.

Sample
The subjects were drawn from Senior/ Senior Secondary Government and Public Schools located in Chandigarh. Participants were 300 adolescents comprising of 150 males and 150 female ranged from 15-18 years. The variables of marital status, employment status and urbanism were controlled since all the subjects were unmarried, unemployed and belonged to urban area. The majority of the subjects were from upper middle/middle class families. To be more precise, subjects were similar in age, education, income, martial status, employment status and area of residence. The characteristics of these subjects are similar to those of large segments of population and this should enhance the generalize ability of the findings.

1. Measures
The following measures were used:
    a. Measures of Depressive Symptoms:
        Zung Self-rating Depression Scale (Zung, 1965)
    b. Measures of Perceived stress:
        Perceived Stress Scale Cohen & Williamson(1988)
2. **Measures of Social support:**

The Social Support Questionnaire (Sarason, Sarason, Shearin & Pierce 1987).

1. Automatic Thought Questionnaire (Hollon & Kendall, 1980)

**PROCEDURE**

Prior to the administration of the tools, Permission was sought from the concerned authorities in charge of the schools. All the Subjects were apprised about the nature and purpose of research and their willingness ascertained before targeting them for participation. The respondents for testing sessions were contacted personally in their classrooms in order to obtain their co-operation and inform them about the testing schedule. Respondents were assured that the information given would be kept strictly confidential and will be used for research purpose only. There were about 8 to 10 respondents for each session. Participants were seated individually at desks, and were asked to remain silent while filling out the questionnaire. Respondents were given the questionnaires in a given earlier. The doubts of subjects were removed before permitting them to take the test. Each form was checked prior to administration to see if any omissions were there, and if so, the particular subject was asked to complete the questions. Question about the meaning of a word, format, etc. were addressed to the researchers. Participants were advised that they could stop at any stage during the session. Strict supervision was exercised in order to see that the subjects do not discuss or take help from each other while performing on the tests. The general testing conditions were satisfactory. Sincere efforts were made to establish rapport with the subjects in order to elicit reliable and authentic information.

Testing schedule started asking the participants to fill in the general information portion and then proceed on to responding to the tests one after another until all the questions were answered. The
sequence of administration was kept as confidential and used for research purposes only. Tests were administered strictly in accordance with the instructions given in response manuals and in classroom situation. There was no time limit for these tests. However, each of these tests approximately took twenty minutes to half an hour. Therefore, each testing session lasted about an hour and a half. As the questionnaire addressed sensitive items, at the conclusion of each session, participants were given contact telephone numbers of people who could assist if they wished to talk about any of the issues raised in the questionnaire. Students were debriefed at the end of the session. The scoring technique used for all given tests was done as per the instructions provided in the scoring manual of the different tests. Appropriate parametric and non-parametric tests were applied to analyze the data.

ETHICAL CONSIDERATIONS:

1. All the subjects were apprised about the nature and purpose of research and their willingness ascertained before targeting them for participation.
2. Informed consent was obtained prior to the administration of the psychological assessment scales.
3. They were assured that had the right to withdraw to any time from the study.
4. The researcher assured that no attempt was made to invade into the personal identities of the subjects and it would not form the subject of research.
5. Respondents were assured that the information provided would be kept strictly confidential and will be used exclusively for research purposes only.
SCORING

The tests were scored strictly in accordance with the respective manuals of the various psychological scales and hand scoring was done by using separate keys for respective tests in the study. The Zung's Self-Rating Depression Scale (ZSRS) was used as a measure pertaining to depression and yielding a global score. The Social Support Questionnaire (SSQ) was used as a measure pertaining to social support and yielding two scores i.e., SSQ-S (satisfaction with available support: qualitative) score and SSQ-N (perceived availability of number of supportive persons: quantitative) score. The Automatic Thought Questionnaire (ATQ) was scored for the measure pertaining to negative cognition and yielding a global score. The perceived stress scale (PSS-10 item version) was scored for measure pertaining to stress and yielding a global score. Thus, as a result of scoring different tests, five measures were obtained. The scoring procedure of each of the scale has been provided below.

• ZUNG'S SELF-RATING DEPRESSION SCALE (ZSRS: ZUNG, 1965)

Affective, psychological and somatic features associated with depression are assessed by 20 items. Out of these 20 items included in the scale, 10 are worded symptomatically positive and 10 symptomatically negative. For each item, respondents indicate the frequency with which they have experienced a specific future in terms of symptoms or feeling described, during the preceding month by selecting one of the four response alternatives ranging from a 'a little of the time' to 'most of the time'. The response alternatives are given a score of 1 to 4 and 4 to 1 for positively and negatively worded items respectively. The scores range from 20 to 80, with higher scores indicating the presence of higher depressive symptoms. The maximum
possible ZSRS score is 80, while a score of 20 indicates the complete absence of depressive symptoms.

• **SOCIAL SUPPORT QUESTIONNAIRE (SSQ: SARASON, LEVINE, BASHAN, & SARASON, 1983)**

  Social Support Questionnaire (SSQ) consists of 27 items and each of the 27 items asks a question to which a two-part answer is requested. The SSQ yields two scores: (a) perceived availability of the number of supportive persons listed (SSQ-N), and (b) satisfaction with available support (SSQ-S) the number (N) score for each item of the SSQ is the number of support persons listed. The social support available to deal with given problem is rated on a scale ranging from a "very satisfied" to "very dissatisfied". This yields a satisfaction (S) score for each item that ranges between 1 and 6. The overall N&S scores are obtained by dividing the sum of N or S scores for all items by 27, the number of items included in the social support questionnaire.

• **AUTOMATIC THOUGHT QUESTIONNAIRE (ATQ: HOLLON & KENDALL, 1980)**

  The Automatic Thought Questionnaire is a self-report questionnaire that measures negative automatic thoughts. The respondents rate on a 5-point scale how often they have experienced depression related cognitions during the past week. The items are rated on a 5-point scale: 1 = "not at all," 2 = "sometimes", 3 = "moderately often", 4 = "often" and 5 = "all the time". Scores on the 30 items are summed to give total scores for ATQ negative. It yields a score ranging from 30 to 150, with higher score indicating more frequent negative thoughts.

• **PERCEIVED STRESS SCALE (PSS-10: COHEN & WILLAMSON, 1988):**

  The Perceived stress Scale (PSS) is the most widely used psychological instrument for measuring the perception of stress. The PSS-10 item scale scores are obtained by reversing responses
(e.g., 0 = 4, 1 = 3, 2 = 2, 3 = 1, & 4 = 0) to the four positively stated items (items 4, 5, 7, & 8) and then summing across all scale items. A short item scale can be made from the questions 2, 4, 5, and 10 of the PSS 10 item scale. The PSS is not a diagnostic instrument, so there are no cut-offs, with higher scores indicating higher intensity of perceived stress.

The results obtained as a consequence of applying 2x2x2x2 analysis of variance have mostly found support for the main effects of the variables involved, though the main effects of gender as well as negative cognition have been moderated by social support. The following findings were evident from the results obtained as a consequence of applying 2x2x2x2 ANOVA.

1. The main effect of negative cognition revealed the marked salience of negative cognition in depression. It was found that the subjects high on negative cognition scored markedly higher on depression than subjects low on negative cognition (Mean: 50.76 vs 36.14).

2. The main effect of perceived stress also revealed its significance from the viewpoint of severity of depression. It was found that the subjects high on perceived stress scored higher on depression than subjects low on perceived stress (Mean: 48.16 vs 39.04).

3. The main effect of gender also revealed its importance from the viewpoint of the presence of depressive tendencies. Females were found to be higher on depression than males. However, the main effect of gender was qualified by social support since the interaction of gender and social support was also found to be significant. The results further revealed that females were higher on depression than males in case of low social support. What is new here is the finding that gender differences were eliminated in case of high social support, suggesting thereby the
significance of social support in moderating the influence of gender on depression in male and female adolescents.

4. The significant main effect of social support revealed the salience of social support in depression. It was found that the subjects high on perceived social support scored markedly low on depression than subjects low on perceived social support (Mean: 38.56 vs 46.16). The results clearly support earlier researches concerning the influence of social support on psychopathology.