Disorders in which anxiety or depression is the predominant feature constitute a large part of contemporary psychiatric practice. As such depression is a matter of social and public health concern with high social, emotional and economic costs. Although there is considerable agreement regarding depression as a common and significant problem for the general population and the client in psychotherapy in particular, the literature regarding possible symptoms and correlates of depression is extensive and sometimes conflicting. There are theories and research in the literature which stress or examine particular symptoms and factors related to depression which have been recognized for thousands of years.

The concept of depression has been broadened to include milder forms. Clinicians and researchers have debated whether the concept of depression refers to a single disease that varies from mild to severe along a continuum or whether it consists of a set of discrete subtypes that differ in phenomenology, pathophysiology, and ultimately etiology (Kendell, 1976; Eysenck, 1970). This debate has yielded a number of different methods for subtyping depressive disorders, such as endogenous vs. reactive, psychotic vs. neurotic, and primary vs. secondary (Nelson & Charney, 1980; Akiskal, Rosenthal, Kashgarian, Khani, & Puzantian, 1979).

In spite of considerable agreement on the phenomenology of the clinical syndrome of depression, no complete satisfactory explanation has yet been offered to account for the mechanisms underlying the wide variations in symptomatology and course. The identification of psychosocial factors that may cause depression has proven to be an arduous task. The difficulty of demonstrating causal relationships in naturalistic research has been compounded by an overreliance on cross-sectional research which has been successful in demonstrating differences between depressed and non-depressed individuals; that is, it has identified abnormalities in the functioning of depressed individuals that are present during depressive episodes. Many of these abnormalities, such as dysfunctional cognitions, distressed relationships, anaclitic personality types, and behaviors, have been implicated in the etiology of depression by theorists of various orientations. However, some of these problems in functioning may be symptoms, or concomitants of depression that appear with the onset of depressive episodes and disappear with remission.
In the context of the above presentation, it can be stated that depression is among the most common and debilitating psychological conditions afflicting modern society (Struijs et al., 2013; Ho et al., 2013; Alloy, Abramson, Keyser, Gerstein, & Sylvia, 2008; Kessler, 2002). With a lifetime prevalence estimated at 5–12% for men, and 10–25% for women, depression has negative consequences for millions of individuals and their families (APA, DSM-IV-TR, 2000). Classified as a mood disorder, depression is characterized by affective, physical, and motivation symptoms including low mood, insomnia, and impaired concentration. The impact of this disorder touches on many aspects of daily functioning, including interpersonal relationships, academic and vocational performance and physical health (DSM-IV-TR, 2000)[cf. Morley & Moran, 2011, p.1071].

A careful review of the overview reveals that with respect to the examination of pathogenesis of depression among adolescents, numerous variables viz. Cognition, personality, affect, self-esteem and aggression have gained the lion’s share of research attention with a consequent neglect of the developmental approach to predict variation in depression symptomatology. There is paucity of research to date which has directly tested the hypothesis of a relation between developmental level and depressive symptom patterns in the non-clinical population. In this context, two studies by Kovacs & Paulaskas (1984) and Ginicola (2007) are noteworthy. Participants in these studies were psychiatric inpatients aged 4 to 16 with a diagnosed depressive disorder. All children were diagnosed by trained clinicians using DSM criteria. Four trained raters reviewed children’s records for depressive symptoms as defined by the DSM-IV TR (A.P.A., 2000). Although the results of these studies indicate that a developmental approach is useful in understanding children’s depressive symptoms, the results are limited to psychiatric inpatients and cannot be generalised to non-clinical population. Even in non-clinical population, depression can be found in a wide range of individuals, from infants to the elderly.

In the context of the above observation, the current study expanded on the existing limited literature by examining adolescents’ unique experience of depression, using a developmental approach to predict variation in symptomatology. The purpose of the current study was to refine and replicate the association between developmental level and depressive symptoms in non-clinical sample of male and female adolescents.
The study starts with the following objectives:

1. To examine the role of developmental level in the experience of internalizing symptoms of depression.
2. To examine the role of developmental level in the experience of externalizing symptoms of depression.
3. To examine gender differences in the experience of internalizing symptoms in relation to developmental level.
4. To examine gender differences in the experience of externalizing symptoms in relation to developmental level.

The following hypotheses were formed on the basis of above mentioned review of literature:

1. It is expected that internalizing symptoms would be more prevalent at high developmental level.
2. It is expected that externalizing symptoms would be more prevalent at low developmental levels and gradually change to internalizing behavior over time.
3. Male and female adolescents differ on the relevance of internalizing as well as externalizing symptoms in relation to developmental level.

SAMPLE

The sample of the current study was delimited to the students of Govt. Secondary schools of Chandigarh. In all there are 18 Govt. Secondary Schools in Chandigarh (Appendix 1). Out of these 18 schools, 6 schools were selected by making use of random sampling procedure. From these six schools, 200 male and 200 female adolescents in the age range of 12-18 years were selected by making use of purposive incidental sampling procedure. For the selection of sample the focus on students studying in Chandigarh was because of the fact that the rate of psychiatric disturbance among adolescents has increased in the recent past.

Inclusion Criterion

1. The participants belonged to non-clinical population.
2. The sample was selected from different Govt. Secondary schools of Chandigarh.
3. The consent of the participants was obtained.
4. Children and adolescents belonged to intact families.
Exclusion Criterion

Participants with current and past psychiatric inpatient service were excluded.

TESTS USED

The following tests were used in the current study:

A. Culture Fair Intelligence Scale – Scale II, Form A and Form B (Cattell, 1961)
B. Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961)

Procedure

The data were collected by administering the following standardized tools. The tests were administered in a uniform sequence as follows:

1) Cattell’s Culture Fair Test, Scale 2, Form A
2) Beck Depression Inventory
3) Cattell’s Culture Fair Test, Scale 2, Form B

Several groups consisting of 10-12 subjects in each group, were formed to collect the data. Subjects were provided, initially, Cattell’s Culture Fair Test, Scale 2, Form A, for 12 ½ minutes (as advocated in the manual) followed by the ten minutes interval, Beck Depression Inventory was administered and it was made clear to subjects that there is no time limit but they have to complete the inventory as soon as possible by giving their immediate response to every item. After the completion of Beck Depression Inventory, one full day interval was given to the subjects and the next day Cattell’s Culture Fair Test, Scale 2, Form B was administered on the same subjects. The scores on Form B were used for final analysis. Form A was used as practice test. All of them were assured that the information given by them would be kept confidential and would be used for research purpose only.

Scoring of the test

The tests were scored strictly in accordance with the scoring procedures as advocated by the authors. Manual scoring stencil was used to score the Cattell’s Culture Fair Test, Scale 2, Form A and B. The scoring was done to obtain scores on intelligence (mental age). Beck Depression Inventory was scored simply by noting the score rated on respective items,
in order to examine the prevalence (presence or absence) of the following depressive symptoms:

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Symptom</th>
<th>Item No.</th>
<th>Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sadness</td>
<td>2</td>
<td>Pessimism</td>
</tr>
<tr>
<td>3</td>
<td>Past Failure</td>
<td>4</td>
<td>Loss of pleasure</td>
</tr>
<tr>
<td>5</td>
<td>Guilty Feelings</td>
<td>6</td>
<td>Punishment feelings</td>
</tr>
<tr>
<td>7</td>
<td>Self dislike</td>
<td>8</td>
<td>Self criticalness</td>
</tr>
<tr>
<td>9</td>
<td>Suicidal thoughts and wishes</td>
<td>10</td>
<td>Crying</td>
</tr>
<tr>
<td>11</td>
<td>Agitation</td>
<td>12</td>
<td>Loss of interest</td>
</tr>
<tr>
<td>13</td>
<td>Indecisiveness</td>
<td>14</td>
<td>Worthlessness</td>
</tr>
<tr>
<td>15</td>
<td>Loss of energy</td>
<td>16</td>
<td>Changes in sleeping pattern</td>
</tr>
<tr>
<td>17</td>
<td>Irritability</td>
<td>18</td>
<td>Changes in appetite</td>
</tr>
<tr>
<td>19</td>
<td>Concentration difficulty</td>
<td>20</td>
<td>Tiredness or fatigue</td>
</tr>
<tr>
<td>21</td>
<td>Loss of sex interest</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Analysis

For the purpose of analysis, in the first instance, the participants were classified into two categories, referring to low and high mental age using Cattell’s Culture Fair Intelligence Test, Scale 2: Form B. Further, the responses of the participants in two categories were analyzed in the context of the presence or absence of a depressive symptom (on each item of Beck Depression Inventory). This was done separately for male and female participants.

Furthermore, in order to ascertain the association between developmental level as revealed by mental age and prevalence (absence/presence) of depressive symptom as measured by each item of the Beck Depression Inventory, $\chi^2$ was employed. This was done separately for male and female participants because the past research has shown that gender is an important parameter of psychopathology. Gender difference in depression is among the most robust of findings in psychopathological research.
Main Findings

The present study revealed the following main findings:

(1) For male adolescents, eight depressive symptoms were found to be prevalent (present) at low developmental level. 6 out of 8 relevant depressive symptoms (75 percent) referred to externalizing symptoms which included in their purview several symptoms like crying, loss of energy, irritability, tiredness or fatigue, loss of interest, and loss of interest in sex. These symptoms are behavioral and action oriented. Thus, for male adolescents the bulk of evidence was in favor of presence of externalizing symptoms at low developmental level.

(2) For female adolescents, the evidence in favor of the presence of depressive symptoms was less compelling. 4 depressive symptoms were found to be prevalent (present) at low developmental level. 2 out of 4 relevant depressive symptoms (50 percent) referred to externalizing symptoms like crying and tiredness or fatigue. The remaining two symptoms referred to internalizing symptoms like guilt feelings and worthlessness.