CHAPTER - I
INTRODUCTION
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Early in life, individuals develop a wide variety of concepts and attitudes about themselves and their world. Some of these concepts are anchored to reality and form the basis for a healthy personal adjustment. Others deviate from reality and produce vulnerability to possible psychological disorders. People’s concepts realistic as well as unrealistic are drawn from experiences, from the attitudes and opinions communicated to by others, and from identifications. Among the concepts that are central in the pathogenesis of depression are people’s attitudes toward self, environment and future. People’s self-concepts are clusters of attitudes about themselves, some favorable and others unfavorable. When an individual makes negative judgments about himself, this tends to develop negative self-concepts for example “I am weak,” “I am inferior,” “I am unlovable,” and “I cannot do anything right.” These negative self-concepts emerge with great force in depression (Beck & Alford, 2009).

Depression is also called “the common cold of mental disorders”; it is widespread, complex and multifaceted disorder that is difficult to describe concisely (Roesch, 2004, p. 58).

Depression is a condition in which one feels blue or sad. But these feelings are usually for a short period of time. Depression interferes with daily life activities of an individual. It is a common but serious illness (National Institute of Mental Health, 2011).

According to Global Burden of Disease (Institute for Health Metrics and Evaluation, 2013), depression is a major cause of disability across the regions and it causes fatigue, suicide, decreased ability to do work and decreased ability to attend school.

It is one area of theory and research in which cognitive factors, that is, the manner of perceiving, construing, anticipating and evaluating events, behaviours and their consequences have been emphasized. In this context much of the impetus has come from the theoretical and empirical work of Beck (1967). Indeed, the recent empirical literature on the psychology of depression is dominated by studies
addressing Beck’s cognitive theory, which attributes depressive states to a low rate of response-contingent positive reinforcement. The cognitive approach focuses on self-castigation, exaggeration of external problems and hopelessness as the most salient symptom. Beck (1967, 1976) has provided the most comprehensive exposition of the cognitive view of depression. Beck proposed that dysfunctional cognitions are at the core of depressive constructions about the self, the environment and the future. The depressed person is seen as having a negative view of himself, of the world and of the future. The depressed affective state is secondary to these negative cognitions.

Beck and Alford (2009) discusses that the vulnerability of a depression-prone person is attributable to the constellation of enduring negative attitudes about self, world and future. Even though these attitudes (or concepts) may not be prominent or even discernible at a given time, they persist in a latent state like an explosive charge ready to be detonated by an appropriate set of conditions. Once activated, these concepts dominate the person’s thinking and lead to the typical depressive symptomatology. These cognitive distortions are seen to develop from early life experiences and to be triggered by present environmental conditions or events, thus leading the person to view the self, the world and the future in a negative way. Beck believes that the activation of these maladaptive thought patterns leads to the affective, motivational and physical symptoms of depression.

Even for professionals, the use of the term depression can vary. In 1987, Kendall, Hollon, Beck, Hammen and Ingram reported that the professional use of the term ‘depression’ has several levels of reference: symptom, syndrome and nosological disorder. Depression itself can be a symptom, e.g. being sad. As a syndrome, it is a constellation of signs and symptoms that cluster together. For depression to be a nosological category careful diagnostic procedures are required during which other potential diagnostic categories are enclosed.

According to Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994) in order to make a diagnosis of depression at least five out of nine possible symptoms must be present. These include depressed mood, diminished pleasure or interest in activities, significant weight loss or gain, insomnia or hypersomnia, agitation, fatigue or loss of energy.
thought of worthlessness or inappropriate guilt, diminished concentration ability, and thought of death or suicide.

The prevalence of depression increases during the age of 15 through 18 (Birmaher, Ryan, Williamson & Brent, 1996; Petersen et al., 1993). Harrington (1998) indicated that even relatively mild depressive symptoms can result in impaired functioning. Therefore, those with mild depression during adolescence also need to be considered at increased risk for negative outcomes, both during this developmental period and into adulthood.

Depression during the teen years comes at a time of great personal change when boys and girls form their identity apart from their parents, grappling with gender issues and emerging sexuality, and make their own independent decisions for the first time in their lives. Depression in adolescence frequently co-occurs with other disorders like anxiety, eating disorders, substance abuse and increased risk for suicide (Weissman et al., 1999; Shaffer et al., 1996).

Theory and research suggest that increases in depressive symptoms observed during the transition to adolescence are probably related in some way to the significant changes that occur in interpersonal functioning during this same time (Hankin & Abramson, 2001; Rudolph & Hammen, 1999).

People with depressive illnesses do not exhibit the same symptoms. The severity, frequency and duration of symptoms depend upon the individual and his or her particular illness. In general people with depression exhibit different symptoms like persistent sadness, anxious or empty feelings, feelings of hopelessness or pessimism, feelings of guilt, worthlessness or helplessness, irritability, restlessness, loss of interest in activities or hobbies once pleasurable including sex, fatigue and decreased energy, difficulty in concentrating, remembering details and making decisions, insomnia, early-morning wakefulness or excessive sleeping, overeating or appetite loss, thoughts of suicide, suicide attempts, aches or pains, headaches, cramps or digestive problems (NIMH, 2011).

The most common symptoms reported for individuals with minor depression in the Epidemiologic Catchment Area (ECA) data set are recurrent thoughts of death, insomnia, feeling tired all the time, trouble concentrating, poor appetite and feelings of worthlessness (Judd, Rapaport, Paulus & Brown, 1994).
According to *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* of the American Psychiatric Association (APA, 2000), the probability during one’s lifetime of developing a major depressive disorder is 5-12% for males and 10-25% for females. At any given point in time (point prevalence), 2-3% of the male and 5-9% of the female population suffer from major depression. The child and adolescent epidemiological literature generally agrees that rates of depression are similar in pre-pubertal boys and girls, and that rates of depressive disorders begin to rise in girls at sometime between childhood and age 15 (Reinherz et al., 1993; Angold & Rutter, 1992; Nolen-Hoeksema, 1991; Fleming & Offord, 1990; McGee et al., 1990).

Cyranowski, Frank, Young and Shear (2000) found that prepubescent boys are more likely to be depressed than girls but during adolescence between the age of 11 and 13 years, this trend in depression rates is reversed. By the age of 15, girls are depressed approximately twice than the boys and this gender gap persists for the next 35 to 40 years. Piccinelli and Wilkinson (2000) reviewed the studies on gender differences in depression and found that the gender differences began at mid-puberty and continued through adult life.

Understanding the etiology of depression among adolescents is one of the most important goals of depression research (Kistner, 2006). The adolescents lived in intertwined subsystems and experienced these subsystems (Bronfenbrenner, 1989), namely; family, school, peer and work (Hill, 1983).

Relationships have been found between parents’ belief in their ability to influence their children’s developmental course and their success in doing so (Trusty, 1998; Coleman & Karraker, 1997), between family environment and the choice of career by adolescents (Penrick & Jepsen, 1992; Wilson & Wilson, 1992), between certain family variables like; economic hardship and stress (Conger, Conger & Scaramella, 1997; Conger, Ge, Elder, Lorenz & Simons, 1994; Conger, Conger, Elder & Lorenz, 1993), and adjustment difficulties of adolescents, including problems in family decision-making and adjustment at school (Aunola, Sattin & Nurmi, 2000; Dornbusch, Ritter, Mont-Reynard & Chen, 1990), and on peer orientation and substance abuse (Bogenschneider, Wu, Raffaelli & Tsay, 1998). Family psychiatric history and parental depression (Birmaher et al., 1996;
Downey & Coyne, 1990) have been associated with a child’s risk for developing depression (Weissman & Jensen, 2002). Some studies have shown positive correlation between authoritarian or coercive parenting and adolescents’ lack of adjustment, distress and problem behaviours (Kim, Hetherington & Reiss, 1999; Steinberg, Lamborn, Darling, Mounts & Dornbusch, 1994; Barnes & Farrell, 1992; Steinberg, Mounts, Lamborn & Dornbusch, 1991). The adolescents from family environments characterized by warmth, caring, communication, understanding and support showed fewer psychological health symptoms (Seiffge-Krenke, 1995).

At adolescent stage, peers exerted more influence on adolescents (Albert, Chein & Steinberg, 2013). Adolescents spend almost one-third of their free time interacting with peers, more than twice the time they spend with their parents (Larson, Richards, Moneta, Holmbeck & Duckett, 1996; Larson & Richards, 1991), resulting in increased feelings of closeness and intimacy with peers during adolescence (Furman & Buhrmester, 1992). Many studies have examined the effects of social network membership on various outcomes of adolescents (Ueno, 2005; Kiesner, 2002). Social network have been found to be an important environment in which socialization occurs, for both positive and negative developmental outcomes. For example, social networks have been associated with antisocial behaviour and delinquency (Dishion, McCord & Poulin, 1999), but also with positive academic outcome (Espelage, Holt & Henkel, 2003). It is well known fact that peer relationships and the social environment have an important role in adolescents’ psychological and behavioural development (Hoffman, Sussman, Unger & Valente, 2006). As adolescents become increasingly independent from their families and oriented more towards peers, susceptibility to peer influences increases (Aseltine, 1995; Chassin, Presson, Sherman, Montello & McGrew, 1986; Glynn, 1981). Some longitudinal studies have linked depression to other problem behaviours, such as high rates of smoking, alcohol use, substance use, unhealthy eating, risky sexual behaviour, and less physical activity (Keenan-Miller, Hammen & Brennan, 2007; Franko et al., 2005; Haarasilla, Marttunen, Evans & Aro, 2004; Hallfors et al., 2004). Substance use is one of the ways to self-medicate against depressive symptoms and also to attract the attention and approval of peers (Brage, 1995; Sadler, 1991).
Peer relations constructs, such as low peer acceptance and social support have been associated with dysphoria and depressive symptoms among adolescents and have also been found to predict later depression (Boivin, Hymel & Bukowski, 1995; Coie, Terry, Lenox, Lochman & Hyman, 1995; Panak & Garber, 1992; Kupersmidt & Patterson, 1991). In a study of 458 adolescents in Taiwan, Liu (2002) noted that as peer support increases, the positive relationship between dysfunctional attitudes and depression weakens. Stevens and Prinstein (2005) found that best friends’ reported level of depressive symptoms was prospectively associated with adolescents’ own depressive symptoms and with adolescents’ own negative social cognitions. Adolescents with low peer status in the classroom social network also reported higher depressive symptoms (Okamoto, 2010; Falci & McNeely, 2009; Brendgen, Vitaro & Bukowski, 2000).

Adolescents tend to develop closer relationships with peers than parents. Their friendships are found increasingly characterized by higher level of loyalty, intimacy and closeness than preadolescents, and there has been adequate evidence of decreased parental involvement (Laursen & Collins, 1994; Collins & Russell, 1991), increased negative affect and frequent intense parent adolescent conflicts, as source of stress (Montemayor, Eberly & Flannery, 1993; Watson & Pennebaker, 1989).

Krishnakumar and Geeta (2006) conducted study to find out the risk factors and clinical features of depressive disorder in children in Kerala. Results of the study showed that stress in school and family caused depression. Also some clinical features were observed which includes less interest in play, excessive tiredness, low self-esteem, concentration problems, behaviour symptoms (e.g. anger and aggression), low level of school performance, and suicidal thoughts and wishes. Shalev et al. (1998) found in their study that more than 40% of people with post-traumatic stress disorder also had depression 4 months after the traumatic event. Depression negatively impacts the growth and development and school performance of adolescents. It also affects peer or family relationships of adolescents (Bhatia & Bhatia, 2007). Stressors and the associated stress are also categorized as academic, medical, general etc. depending upon the context of origin and understanding of the person relevant to the domain of activity (Compas, Connor-Smith, Saltzman, Thomsen & Wadsworth, 2001).
Learning related stress arises from task-demands as these have to be done within time schedules, interpersonal relations, discipline norms, and evaluations. Technological and societal changes have induced greater competition among students and teachers. The increased accountability, the eroding of the bases of professional authority, the undervaluing of profession, love of coaching or tutoring have led to increased stress (Singhal, 2004).

Adolescents experience many developmental changes within and around them. These changes necessitate making adjustments and choices based on rational decision-making. One of the developmental transitions include making decisions pertaining to educational and career choices that can have important implications for their future. The process of career exploration and decision-making can be particularly stressful time in an adolescent’s life (Taveira, Silva, Rodriguez & Maia, 1998). It also causes school dropout or decrease in academic achievement and motivation (Fleming, Boyle & Offord, 1993).

The contextual factors of career-related decisions compound the difficulties for adolescents. High school can thus, be a turbulent time for youth, which causes an enormous amount of stress and confusion, and may lead to academic and emotional concerns during high school. In reaction to this stress, adolescents may attempt to place the responsibility for making a career decision onto others and even may delay or avoid making a choice, which could ultimately lead to a less than optimal decision (Gati & Saka, 2001). Making the right career choice requires effort and thought. Some individuals seem to make this choice easily, at least apparently, while others experience problems and difficulties in it (Gati, Krausz & Osipow, 1996). A number of studies have assessed symptom related concepts such as general symptom distress, depression and anxiety in the context of vocation related thoughts in more general populations. Also significant correlation was found between indices of indecision and dysfunctional career thoughts (Austin, Dahl & Wagner, 2010; Saunders, 1997). Other research studies found a significant positive correlation between Beck’s Depression Inventory and dysfunctional career thoughts, supporting the assumption that depression was not only related to career indecision but it also related to the functionality of career related thoughts (Degenhart, 2004; Saunders, Peterson, Sampson & Reardon, 2000).
1.1 Depression

Depression in children is characterized not only by unresponsive and unhappy faces but also by other characteristic behaviour. These include anhedonia, social withdrawal, decreased school work, poor appetite, sleep difficulty, excessive fatigue, retardation of language and hypoactivity, and lowered self-esteem or guilt (Poznanski, Cook & Carroll, 1979).

Depression is defined as disrupting a person’s thinking processes, emotional reactions and day-by-day behaviours (Williams, 1984; Farby, 1980).

According to Watson and Clark (1984), depressed mood is a part of broader set of negative feelings but a lack of positive affect and a loss of emotional involvement with other people, objects or activities, constitute specific features that distinguish depressed mood from normal feelings of sadness or mere demoralization and from other negative affects such as anxiety. Depressive syndrome refers to a constellation of observable symptoms (of which depressed mood is only one component) such as tearfulness, irritability, death thoughts, loss of appetite, disturbances of sleep, lack of energy etc. that tend to cluster together. At the individual level, a depressive syndrome is recognized when the behavioural characteristics reach a given threshold that signals a significant deviation from the normal.

The National Institute of Mental Health (NIMH, 1985) described depression as a disorder of the brain. Modern brain imaging technologies are revealing that in depression, neural circuits responsible for the regulation of moods, thinking, sleep, appetite and behaviour fail to function properly, and that critical neurotransmitter-chemicals used by nerve cells to communicate are out of balance. Genetic research indicates that vulnerability to depression results from the influence of multiple genes acting together with environment factors. There is a high degree of variation among people with depression in terms of symptoms, course of illness and response to treatment, indicating that depression may have a number of complex and interesting causes. In contrast to normal emotional experience of sadness, passing of mood states, depression is extreme and persistent can interfere significantly with an individual’s ability to function.

According to DSM-IV-TR (APA, 2000), mood in a major depressive episode is often described by the person as depressed, sad, hopeless, discouraged or
down in the dumps, loss of interest or pleasure is nearly always present, at least to some degree. Individuals may report feeling less interested in hobbies, “not caring anymore.” Appetite is usually reduced and many individuals feel that they have to force themselves to eat. The most common sleep disturbance is insomnia (typically middle) i.e. waking up during the night and having difficulty returning to sleep. Psychomotor changes may include agitation (inability to sit still, pacing, pulling or rubbing of skin) or retardation (slowed speech, thinking and movement), decreased energy, tiredness and fatigue are common. The sense of worthlessness or guilt may include unrealistic negative evaluations of one’s worth or guilty preoccupations or ruminations over minor past feelings. Such individuals report impaired ability to think, concentrate or make decisions. Frequently there may be thoughts of death, suicidal ideation or suicide attempts. These thoughts range from a belief that others would be better off if one is dead, to specific plans of how to commit suicide.

“Depression is an emotional state marked by great sadness and apprehension, feelings of worthlessness and guilt, withdrawal from others, loss of sleep, appetite and sexual desire, and either lethargy or agitation” (Ronald & Kahn, 2004, p. 175).

According to Academic Dictionary of Psychology (Chopra, 2005), “Depression is a mood disorder characterized by intense feelings of sadness that persist beyond a few weeks. Two neurotransmitters-natural substances that allow brain cells to communicate with one another are implicated in depression: serotonin and norepinephrine” (p. 75).

According to Comprehensive Dictionary of Education (Ahmad, 2008), depression is a negative emotion frequently characterized by sadness, feelings of helplessness and sense of loss (p.144).

According to Beck and Alford (2009), depression may be defined in terms of the following attributes:

i. A specific alteration in mood like sadness, loneliness, apathy.
iii. Regressive and self-punitive wishes such as desire to escape, hide or die.
iv. Vegetative changes like anorexia, insomnia, loss of libido.
v. Change in activity level, for example retardation and agitation.
Depression is an emotional state marked by great sadness and apprehension, feeling of worthlessness and guilt, withdrawal from others, loss of sleep, appetite and sexual desire, loss of interest and pleasure in usual activities (Kring, Davison, Neale & Johnson, 2010).

Depression may be defined as the condition of feeling sad or despondent. It is a mood disorder characterized usually by anhedonia, extreme sadness, poor concentration, sleep problems, loss of appetite, and feelings of guilt, helplessness, hopelessness and a lowering or reduction in physiological vigor or activity (The American Heritage Dictionary, 2011).

According to Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (APA, 2013), “Depressive disorder is a mood disorder characterized by the presence of sad, empty or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual’s capacity to function” (p. 155).

1.1.1 Signs and Symptoms of Depression

Depression is as old as man. Depression is a universal experience; the emotions of sadness and grief are an intrinsic facet of the human condition. The word depression is used in many ways to describe a mood, a symptom, a syndrome (a collection of signs and symptoms) as well as specific group of illnesses. The central symptoms of depression are sadness, pessimism and self dislike, along with a loss of energy, motivation and concentration (Mendels, 1970). The core signs and symptoms such as low mood, pessimism, self criticism, and retardation or agitation seem to have been universally accepted. Other sign and symptoms that have been regarded an intrinsic to the depressive syndrome include autonomic symptom, constipation, difficulty in concentrating, slow thinking and anxiety. The symptoms of depression are described under four major headings i.e. emotional, cognitive, motivational, and physical and vegetative manifestations (Beck & Alford, 2009).

(i) Emotional manifestations: The term emotional manifestations refer to the changes in the patient’s feelings or overt behaviour directly attributable to his or her feeling states. This includes dejected mood (feeling blue or sad, hopeless and miserable), negative feelings towards self (disappointed in themselves, self dislike or hate), reduction in gratification (no enjoyment in
life, feel bored much of the time and no enjoyment from activities that were formerly pleasurable), loss of emotional attachments (with parents, siblings and friends), crying spells (increased tendency to weep and cry, cry for no apparent reasons and sometimes weep but without tears), and loss of mirth response (lost sense of humor).

(ii) **Cognitive manifestations**: The cognitive manifestations of depression include a number of diverse phenomena. It includes low self-evaluation (viewing themselves as deficient in ability, performance, intelligence, health, strength, personal attractiveness, popularity, financial resources, and excessive reaction to errors, exaggerate the degree of error, feel worthless or total failure), negative expectations (hopelessness, pessimism, frustration, regarded future as unpromising or black), self-blame and self-criticism, indecisiveness (difficulty in making decisions, changing decisions, vacillating between alternatives, making wrong decisions, incapable of making decisions and do not even try), and distortion of body image (through the idea of personal unattractiveness).

(iii) **Motivational manifestations**: Motivational manifestations include consciously experienced strivings, desires and impulses that are prominent in depression. These patterns can be inferred from observing the patient’s behaviour. It includes paralysis of the will (loss of positive motivation, loss of derive and initiation in planning a specific task, loss of desires, no desire to do those things which are essential in life), avoidance, escapist and withdrawal wishes (wish to break out the routine of life, regard duties as dull, meaningless or burdensome, escape from activities, avoid or postpone the task, strong desire to end the life as a way of escaping from situation which is intolerable), suicidal wishes (wish to die, show indifference toward living, sometimes suicidal wishes are direct, frequent and compelling), and increased dependency (increased desire to receive help, guidance, direction rather than relying on someone else).

(iv) **Vegetative and physical manifestations**: The physical and vegetative manifestations are considered to be evidence for basic autonomic or hypothalamic disturbance that is responsible for the depressive state. It includes loss of appetite (desire for food may be mostly gone, most of the
times miss the meal and sometimes forced to eat), sleep disturbance (difficulty in sleeping, waking half an hour earlier than usual, sometimes sleep more than usual), loss of libido (loss of interest in sex or sex desire, sometimes sexual desire heightened, loss of interest in other people), and fatigability (increased tiredness, body feels as though it is weighted down, too weak to move, run down, feel tired more easily than usual, feel tired when awakened in the morning and sometimes feel too tired to do anything).

There are some other signs and symptoms of depression which are discussed below under the following heads (Beck & Alford, 2009):

(a) Delusions: Delusions in depression may be grouped into several categories like worthlessness (e.g. when one say “I am totally useless,” “I am the most inferior person in the world”), sinner or devil (when one person believes that he has committed a crime for which he deserves punishment, feels like a bad sinner or devil), nihilistic delusions (e.g. when one says “All is lost,” “The world is empty” etc.), somatic delusions (one feels like his body is deteriorating or he has some incurable disease), delusion of poverty (e.g. when one says “All my money is gone. What will I live on? Who will buy food for my children?”).

(b) Hallucinations: Some persons perceive those things which are not present like “I conversed with God,” “I heard people talking through my stomach,” “Voices told me to walk backward” etc.

(c) Retardation: Retardation means reduction in spontaneous activity. In retardation depression, the person stays in one position longer than usual and uses minimum of gestures and his movements gradually becomes slow down. He walks slowly.

(d) Agitation: The main characteristic of agitated person is ceaseless activity. They cannot sit still but move about constantly in the chair. They feel restlessness and disturbance in wringing the hands, clenching or unclenching fingers. They may rub their scalp or skin until the skin is worn away.

Variation in symptoms

According to DSM-IV-TR (APA, 2000), it was found that “Certain symptoms such as somatic complaints, irritability and social withdrawal are
particularly common in children, whereas psychomotor retardation, hypersomnia and delusions are less common in prepuberty than in adolescence and adulthood” (p. 354). Some cultural symptoms also mark depression among individuals for example: “Complaints of ‘nerves’ and headaches (in Latino and Mediterranean cultures), weakness, tiredness, or ‘imbalance’ (in Chinese and Asian cultures), problem of the ‘heart’ in (Middle Eastern cultures), or of being ‘heartbroken’ (among Hopi) may (all) express the depressive experience” (p. 353).

1.1.2 Types of Depression

There are several types of depressive disorders. Usually they are distinguished by their prevalent features, duration and severity of symptoms. The most common are major depressive disorder and dysthymic disorder. According to NIMH (2011), depression has different types which are discussed below:

(i) **Major depressive disorder**: It is also called major depression and is characterized by a combination of symptoms that interfere with a person’s ability to work, sleep, study, eat, and enjoy one’s pleasurable activities. Major depression is disabling and prevents a person from functioning normally. Some people may experience a single episode of depression in their lifetime, but more often a person may experience multiple episodes.

(ii) **Dysthymic disorder**: It is also called dysthymia and is characterized by long-term (two years or longer) symptoms that may be less severe and do not disable a person but can prevent a person from functioning normally or feeling well. People who suffer from dysthymia may also experience one or more episodes of major depression during their lifetimes.

(iii) **Minor depression**: It is characterized by having symptoms for two weeks or longer that do not meet the full criteria for major depression. Without treatment, people suffering from minor depression are at high risk for developing major depressive disorder.

(iv) **Bipolar disorder**: It is also called manic-depressive illness. Bipolar disorder is not as common as major depression or dysthymia. It is
characterized by cycling mood changes from extreme highs (e.g. mania) to extreme lows (e.g. depression).

Some other forms of depressive disorder exhibit slightly different characteristics than those described above or they may develop under unique conditions. These are described as below:

(v) **Psychotic depression**: It occurs when a person has severe depressive illness along with some form of psychosis, such as a break with reality, hallucinations and delusions.

(vi) **Postpartum depression**: It is also called postnatal depression and is diagnosed if a new mother develops a major depressive episode within one month after delivery. It is estimated that 10 to 15% of women experience postpartum depression after giving birth.

(vii) **Seasonal affective disorder (SAD)**: It is characterized by the onset of a depressive illness during the winter months, when there is less natural sunlight. The depression generally lifts during spring and summer. SAD may be effectively treated with light therapy, but nearly half of those with SAD do not respond to light therapy alone. Psychotherapy and antidepressant medication can reduce SAD symptoms, either alone or in combination with light therapy.

According to *DSM-IV-TR* (APA, 2000), Depression is categorized as a core symptom in most of the mood disorders and consistently comes under account for affective and depressive disorders. Various types of mood disorders are presented in the following Table 1.1 which is adopted from *DSM-IV-TR* (APA, 2000).
<table>
<thead>
<tr>
<th>Disorder</th>
<th>Characterizations</th>
</tr>
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<tbody>
<tr>
<td><strong>Depressive Disorders</strong></td>
<td></td>
</tr>
<tr>
<td>Major Depressive Disorder</td>
<td>One or more Major Depressive Episodes (i.e. at least two weeks of depressed mood or loss of interest accompanied by at least four additional symptoms of depression)</td>
</tr>
<tr>
<td>Dysthymic Disorder</td>
<td>At least two years of depressed mood for more days than not, accompanied by additional depressive symptoms that do not meet criteria for a Major Depressive Episode.</td>
</tr>
<tr>
<td>Depressive Disorder Not Otherwise Specified</td>
<td>Included for coding disorders with depressive features that do not meet criteria for Major Depressive Disorder, Dysthymic Disorder, Adjustment Disorder with Depressed Mood, or Adjustment Disorder with Mixed Anxiety and Depressed Mood (or depressive symptoms)</td>
</tr>
<tr>
<td><strong>Bipolar Disorders</strong></td>
<td></td>
</tr>
<tr>
<td>Bipolar I Disorder</td>
<td>One or more Manic or Mixed Episodes, usually accompanied by Major Depressive Episodes</td>
</tr>
<tr>
<td>Bipolar II Disorder</td>
<td>One or more Major Depressive Episodes accompanied by at least one Hypomanic Episode</td>
</tr>
<tr>
<td>Cyclothymic Disorder</td>
<td>At least two years of numerous periods of Hypomanic symptoms that do not meet criteria for Manic Episode and numerous periods of depressive symptoms that do not meet criteria for a Major Depressive Episode</td>
</tr>
<tr>
<td>Bipolar Disorder Not Otherwise Specified</td>
<td>Included for coding disorders with bipolar features that do not meet criteria for any of the specific Bipolar Disorders</td>
</tr>
<tr>
<td><strong>Other Mood Disorders</strong></td>
<td></td>
</tr>
<tr>
<td>Mood disorder due to a general medical condition</td>
<td>A prominent and persistent disturbance in mood that is judged to be a direct physiological consequence of a general medical condition</td>
</tr>
<tr>
<td>Substance-induced mood disorder</td>
<td>A prominent and persistent disturbance in mood that is judged to be a direct physiological consequence of a drug of abuse, a medication, another somatic treatment for depression, or toxin exposure</td>
</tr>
<tr>
<td>Mood Disorder Not Otherwise Specified</td>
<td>Included for coding disorders with mood symptoms that do not meet the criteria for any specific Mood Disorder and in which it is difficult to choose between Depressive Disorder Not Otherwise Specified and Bipolar Disorder Not Otherwise Specified (e.g., acute agitation)</td>
</tr>
</tbody>
</table>
1.1.3 Causes of Depression

There is no single cause of depression because several factors may play a part in the onset of the disorder. It results from a combination of factors like genetic or family history of depression, psychological or emotional vulnerability to depression, life events or environmental stressors, and biological factors which are discussed below:

(i) Genetic and family history: A family history of depression does not necessarily mean children or other relatives will develop major depression but those persons who have a family history of depression have slightly higher chances of becoming depressed at some stage in their lives. Genetic research suggests that depression can run in families and in some studies of twins it was found that if one twin develops the disorder, the other has a 40 to 50% chance of also being affected. Other factors, such as traumatic childhood or adult life events, may act as triggers. The onset of depression may also be influenced by what we learn as children. Some people may have been exposed to the depressive symptoms of their parents and have learned this as a way of reacting to certain problems. Growing up with one parent, who is suffering from depression, also puts a child at a 10% risk of developing the disorder. If both parents are depressed, there is a 30% risk of developing depressive disorder (Bartha, Parker, Thomson & Kitchen, 1999). Also it was found that children of depressed parents are more than three times as likely as children of non-depressed parents to experience a depressive disorder (Birmaher et al., 1996; Birmaher, Ryan, Williamson, Brent & Kaufman, 1996).

(ii) Psychological factors: Personality style and the way one has learned to deal with problems, may contribute to the onset of depression. If a person who has a low opinion of about his self and worries a lot, elevated levels of anxiety, overwhelmed by stress, a negative outlook and pessimistic view of life, high self-criticism, negative attributional style, poor school performance, over dependent on others, is a perfectionist and expects too much from others or tends to hide feelings, then he may be at greater risk of becoming depressed (Bartha et al., 1999; Beasley & Beardslee, 1998).
(iii) **Life events or environmental stressors:** Family and social context in which child is living also play an important role in the development of depression. Some studies showed that early childhood trauma and losses, such as the death of parents, or adult life events, such as the death of a loved one, separation or divorce between parents, the loss of a job, retirement, serious financial problems, increased family conflict and low socioeconomic status can lead to the onset of depression (Richardson & Katzenellenbogen, 2005; Bartha et al., 1999). Prolonged difficult life events increase a person’s chances of developing a depressive disorder. Living with chronic family problems can also affect a person’s mood and lead to the development of depressive symptoms. The ongoing stress and social isolation conditions also lead to depressive symptoms (Bartha et al., 1999). Sexual abuse, physical abuse and neglect are also the risk factors those contribute to depression among adolescents (Kaufman, 1991). Rejection and teasing by peers also contribute to adolescent depression (Haines, Metalsky, Cardamone & Joiner, 1999; Lewinsohn et al., 1994; Cole, 1990).

(iv) **Biological factors:** Depression may appear after the unusual physiological changes such as childbirth and viral or other infections. This has given rise to the theory that hormonal or chemical imbalances in the brain may cause depression. The fact that depression can be treated by antidepressant medication and electroconvulsive therapy (ECT) tends to support this theory. Seasonal affective disorder (SAD) is a better example of how biology and personality may work together to influence the depression. Research has found that people suffering from seasonal affective disorder seem to be highly sensitive to their own feelings and events around them, and these reactions are amplified by seasonal changes in light levels (Bartha et al., 1999).

To sum up, depression is caused by many factors. Although the investigator wants to see the influence of all these factors on depression, but due to time limitation the investigator has selected the variables of family environment, peer group influence, academic stress and career decision-making to see how these variables account for depression among adolescents.
1.1.4 Prevalence of Depression among Adolescents

Depressive symptoms are the familiar part of adolescents' experience (Steinberg, 1999). Prevalence figures from India provide varying estimates of psychiatric disorders in children, namely 2.5% (Nandi, Ajmang & Ganguly, 1975), 35.6% (Lal & Sethi, 1977), 33.7% (Dervasigamani, 1990) and 10.54% (Sarkar, Kapur & Kaliaperumal, 1995). These wide variations in the prevalence rate appear to be due to the differences in the methodologies used in these studies. A large proportion of the adolescents about 30-40% experienced depressed mood at any point in their development, 5-6% experienced significant level of depressive syndrome and 2-3% experienced depressive disorders (Costello et al., 1988).

Research in the last decade have shown that rates of depression increased from 8 to 20% (Gorenstein, Andrade, Zanolo & Artes, 2005; Steinhausen & Metzke, 2000) and this leads to increase in suicide rate, psychiatric co-morbidity, academic failure, poor peer relationships, substance abuse and severe depression (Lewinsohn, Hops, Roberts, Seeley & Andrews, 1993). 15% of adolescents admit to having suffered from depression at some time or other and increases with age with a preponderance of girls over boys (Essau & Petermann, 2000).

Ganguli (2003) examined the growth, beliefs, emotions, ambitions and relation with parents or teachers among 230 adolescents (grade 8th and 9th) in rural area near Pune. Results of the study showed that changes of mood were felt by 57 male students (58.76%) and 61 female students (60.9%). The study further explored that female students felt more depression (80.4%) as compared to males. The most common cause of depression was found to be feeling loneliness.

Nair, Paul and John (2004) conducted study to find out the prevalence of depression among adolescents in Kerala. Results of the study demonstrated that 22.4% of school going girls and 12.8% school going boys had depression. Also it was found that school dropout girls had severe depression (11.2%) which was greater than the school going girls (2.8%). Depressive mood if lasts for 3 years in adolescence leads to adult depression and psychological problems at later stage (Devine, Kempton & Forehand, 1994).

Dahlin, Joneborg and Runeson (2005) found 12.9% prevalence of depressive symptoms among medical students, which was higher than in the general population and females (16.1%) were more depressed as compared to males (8.1%).
Pillai et al. (2008) found that adolescents showed 0.5% depressive disorders, 1% anxiety disorder, 0.4% behavioural disorder and 0.2% attention-deficit hyperactivity disorder.

Mohanraj and Subbaiah (2010) conducted study to examine the prevalence of depressive symptoms among urban adolescents in south India. 509 boys and 455 girls studying in 10th, 11th and 12th class participated in the study. Beck Depression Inventory was used for data collection. Results of the study showed that 39.2% were non-depressed, 37.1% reported mild depression, 19.4% reported moderate level of depression and 4.3% showed severe depression. Also no significant gender differences were found on depression but a higher proportion of the girls i.e. 27% reported moderate to severe depression than boys i.e. 21%.

A study conducted in south India explored that 79.2% adolescents were depressed out of which 41.2% were found to be suffering from moderate depression followed by mild depression (26.6%). Also it was observed that prevalence and severity of depression significantly increased with age of the individuals (Joseph, 2011).

Black, Roberts and Li-Leng (2012) conducted study on a sample of south Australian adolescents (age 13-18 years) to find the prevalence of depression. Results of the study revealed that 18% adolescents screened positive for depression, 41% reported low mood much of the time and 20% showed occasional mood disorder or more frequent self-harm. Also it was found that females (23%) were more on depression as compared to males (11.8%).

Sidhu and Singh (2012) conducted study to examine the prevalence of depression in late childhood. A sample of 1000 students was taken for the study. For the data collection Beck Depression Inventory was used. Results of the study showed that 30% females and 36% males in late childhood showed signs of minor depression. Also it showed that 2% females and 1.2% males exhibited signs of major depressive disorder.

In Karnataka, a study was conducted to find out the prevalence of depression in a sample of medical students (N = 400) by using Beck Depression Inventory. From the results it was found that males (53.7%) were more depressed as compared to females (46.3%). According to BDI cut off scores, 29.8% were normal, 27.8% were mildly depressed, 29.3% as moderately depressed, 7.5% as severely depressed and 6.7% as very severely depressed (Kumar, Jain & Hegde, 2012).
In West Bengal, prevalence rate of depression among adolescents was found to be 45.3%, which was mostly of the mild type (34%), 6% moderate and 5.3% severe type depression (Gupta & Basak, 2013).

In a sample of Delhi, those persons who inject drugs exhibited depression, anxiety and suicidal ideation, and prevalence of symptoms of depression among these adults was 84% and 54% had moderate to severe depression. It was also found that most common symptom of depression was self-blame and feelings of worthlessness (Armstrong et al., 2013).

1.1.5 Theories of Depression

The theories of depression that have been most tested and applied to the psychotherapeutic treatment on the mood disorders include the interpersonal and cognitive behavioural formulation. Most of the theoretical perspectives are dealing with either conscious modification of the behaviour or to resolve the subconscious conflicts of human mind. Other theories include Freud’s psychoanalytic theory, evolutionary theories, existentialism, neurological and neuropsychological perspectives, biochemical theory, and animal models (Beck & Alford, 2009). Description of theories is given as follows:

(i) Behavioural theories

Several behavioural theories of depression have been advanced. Early behavioural psychologist formulated theories in this area were Ferster (1974), Seligman and Groves (1970), Seligman (1974) and Lewinsohn (1974).

Seligman and Groves (1970) suggested that the phenomenon of “learned helplessness” in animal models might be meaningfully analogous to clinical depression in humans. They experimented with normal dogs and found that when a normal dog receives escape-avoidance training, it quickly learns to avoid a shock by moving to the safe side and however when the dogs given inescapable shocks then instead of attempting to escape, such dogs would give up and passively accept the shock. They further researched the same paradigm on other animals. Based on this generalization, they theorized a specific arrangement of reinforcement contingency, that is, inescapable punishment, could be a causative factor in the lives of those who become clinically depressed.
Ferster (1974) theorized that depression may be a reduced frequency of “adjustive behaviour,” or behaviour that maximizes reinforcing outcomes. Put simply, the depressed person increased avoidance and escaping behaviour in situations where it is possible to obtain positive reinforcement and conversely develops a passive behavioural repertoire in circumstances where escape would be reinforcing.

Like Ferster, Lewinsohn (1974) suggested that operant behavioural theoretical concept “reinforcement” was sufficient to explicate the origins of clinical depression. He advanced the idea that depression is due to “low rate response-contingent positive reinforcement.” He used this basic construct to explain the other aspects of clinical depression, such as low rates of behaviour.

(ii) Cognitive and Evolutionary theories

Contemporary cognitive and evolutionary theories of depression have conceptual commonalities, including emphasis on continuity of normal and abnormal mechanisms. Skinner (1981) drew explicit analogies between the selection of species’ characteristics and selection of individual behaviour by its consequences or “contingencies of reinforcement.” Beck (1987) has theorized the nature of clinical depression (and mania) and to be an atavistic mechanism that may have been adaptive in earlier environment and but in general less so today. Thus, the evolutionary perspective can help to explain the distal causes of the nature of the depressive phenomenon.

Cognitive theory posits several interrelated theoretical construct including cross-sectional models, a structural model, the stress-vulnerability model, the reciprocal-interaction model and the psychobiological model. Through articulating the interrelationship of various system and levels of analysis, cognitive theory integrates diverse levels including the incorporation of evolutionary principles.

In this manner, depression and its related phenomena may serve adaptive survival functions within environments where it is advantageous to be pessimistic thus inhibiting specific functions.

The hopelessness theory of depression proposes that individuals who make negative inferences about causality, self and consequences in response to negative events will be most likely to develop depression in the wake of negative events (Abramson, Metalsky & Alloy, 1989). According to Nolen-Hoeksema’s (1987, 21
response styles theory, rumination represents another cognitive vulnerability factor in depression. People with a ruminative response style think repetitively and passively about the negative emotions elicited by negative events. Numerous studies confirm the prediction that ruminative response styles predict depression (Nolen-Hoeksema, 2000).

(iii) Psychoanalytic theories

Freud’s ‘Mourning and Melancholia’, published in 1917 further shaped his views of depression. According to Freud (1917), the loss of an “object” in a depressed individual originated due to unconscious internal processes whereas mourning an object of “loss” (i.e. death of a loved one) was more external and conscious. Therefore, melancholia or depression forces a person’s ego to remain in a state of flux or self-induced purgatory (i.e. loss of the self). Abraham (1911, 1916) has emphasized the significance of hostility and orality in depression. He considered depression as a result of fixation which can occur during a person’s psychosexual development. For example, if a child develops an oral fixation during childhood, there would be a greater chance of depression in later life.

A pioneer in object relations theory, psychoanalyst Klein (1948) believed a person developed depression due to an inability to release the feeling of the initial real or imagined loss of an object. If a person can’t resolve the feeling of loss, the ego resorts to defense mechanisms (i.e. denial or ”splitting”).

Jacobson (1954) conceived of the mechanism in depression not as in identification achieved from oral gratification, but as a regressive breakdown of ego identification in which reality testing is lost and the self-images are confused with other representations. The object representations no longer adequately reflect the actual objects.

(iv) Existential theories

According to Arieti (1959), depression is a state in which there is an arrest of insufficiency of all the vital activities. He viewed depression as a “pathetic immobility, a suspension of existence, syncope of time.” As a result patient feels a sense of incompleteness, emptiness, impotence and unreality.
Tellenbach (1961) described a series of specific situations in which the melancholic sense of orderliness and guilt is threatened. The interplay of these situations and the melancholics’ personality results in their getting increasingly tangled. In the depressive psychosis, the distance between being and aspiration becomes an abyss.

Schulte (1961) considered the inability to be sad as the crux of the melancholic experience. He states that melancholics have lost the ability to sympathized and be moved.

(v) Neuropsychological theories

Much more recently, Shenal, Harrison and Demaree (2003) reviewed the literature on neuropsychological theories of depression and speculated that dysfunction in any of three neurological divisions (left frontal, right frontal and right posterior) is associated with depression.

Their review included the prominent neuropsychological theories, including those on cerebral asymmetries in emotional processing. Combining theories of arousal, lateralization and functional cerebral space, they advanced a research model suggesting that (1) left frontal dysfunction is said to result in sparsity of positive affect; (2) right frontal dysfunction is posited to cause lability and emotional deregulation; and (3) right posterior dysfunction is theorized to result in bland affect or indifference.

(vi) Biochemical theories

The effectiveness of Monoamine Oxidase (MAO) inhibitors and tricyclic compounds has led to research on their biochemical effects. “The catecholamine hypothesis of affective disorders” explains that in depression the supply of active norepinephrine (at central adrenergic receptor site) is depleted. According to Schildkraut (1965), the MAO inhibitors probably act by directly inhibiting the enzymatic oxidative deamination of norepinephrine. Imipramine, on the other hand, might act by decreasing membrane permeability that block the intracellular release of the storage norepinephrine and by increasing cellular reuptake, thus diminishing the inactivation of free extracellular norepinephrine. The hypothesis thus had a definite quantity of consistent evidence supporting it.
1.2 Family Environment

Family is the most important socializing agent that influences the child’s life (Tewari, Morbhett & Kumar, 1981).

The human group centrally concerned with biological and social reproduction, and generally considered a universal unit of social organizations in its nuclear or primary form as constituted by a man, a woman and their socially recognized children (Harre & Lamb, 1983, p. 230).

According to Makstroth (1989), “Home is a microcosm where children can experience their effectiveness and power to make a difference through problem solving, service and cooperation. When parents engender respect for the ranges of people’s needs and lifestyles, children develop a sense of purpose and use their ability to benefit people of the world as well as themselves” (p. 170).

Family environment is the complex of social and cultural conditions, the combination of external or extrinsic physical conditions that affect and influence the growth and development of the members of family, the most instinctive fundamental social group which includes parents and their children (Ranhotra, 1996).

The family constituted an interpersonal social system held together by strong bonds of attachment, affection, caring, and yet exercised control, approval and discipline on each other’s actions (Harvey & Byrd, 2000; Parke & Buriel, 1998).

Webster (2001) defined environment as the surrounding or being surrounded; something that surrounds; all the conditions, circumstances and influences surrounding and affecting the development of an organism or group of organisms often contrasted with heredity.

According to Sinclair (2006), environment is all the circumstances, people, things and events around them that influence their life. It is the natural world of land, sea, air, plants and animals.

According to Comprehensive Dictionary of Education (Ahmad, 2008), “Family is a primary group organized around kinship ties and designed to regulate sexual behaviour and reproduce, nurture, protect and socialize the young” (p. 211).
1.3 Peer Group Influence

According to Dictionary of Education (Edwin, 2008), peers mean those people who are equal in age and status (p. 348).

The concept of peer group is used in two different senses i.e. first, as a term for a small group of friends or associates who share common values, interests and activities, second, as a term for virtually all persons of the same age, a definition which reflects the facts that schools tend to be age-graded. Peer group influence can therefore be the influence that friends exercise on one another or the influence exerted by a much wider category of age-mates. During adolescence the peer group plays an important part in providing social support and identity, although some of its pressures e.g. for conformity and social acceptability, may generate difficulties. Its effects may be important in the development of antisocial behaviour and delinquency although they are difficult to estimate (Harre & Lamb, 1983, p. 447).

Peers are the primary component of an adolescent’s social network and are relied upon more as sources of support and advice during this developmental period (Buhrmester, 1996; Brown, 1990).

Peer group is a like age-group that influences one’s self concept, self-esteem, attitudes and behaviour. Peer group relationships are important to children as well as adults (Kahn & Fawcett, 2004).

Hansell (1985) showed that peer status has been found to have effects on both physical health and general feelings of well-being. Both friendship ties and the overall structure of the school classroom, in addition to individual social status, have also been found to influence health (Ueno, 2005; Kiesner, 2002). This showed that the organization, structure and distribution of social status among a peer group can influence adolescent development.

1.4 Academic Stress

According to Comprehensive Dictionary of Education (Ahmad, 2008), “Academic means any system of formal education or a process whereby education is restricted by criteria of academic aptitude” (p. 4).

Stress has been defined following Lazarus’s model, as a state of imbalance when the demands made on the person in different areas of life exceeded his/her capabilities and resources (Lazarus & Folkman, 1984).
Stress is a construct which is inferred in order to account for some form of behaviour. Stress is usually viewed as a mediator, that is, an unobservable inferred construct which is hypothesized to account for a certain observable behaviour such as health or illness differences between individuals. Stress is a broad process that involves complex biochemical, physiological, behavioural and psychological dimensions, many of which are directly or indirectly related to health. Stress is the process by which environmental events threatens or challenge an organism’s well being and by which that organism responds to this threat (Gatchel, Baum & Krantz, 1989).

Stress is a negative emotional experience accompanied by predictable biochemical, physiological, cognitive and behavioural changes that are directed either towards altering the stressful events or accommodating to its effects (Baum, 1990).

Stress as an adaptive response mediated by the individual differences or physical processes that are a consequence of any external (environmental) action, situation or event that place excessive psychological or physical demands on the person (Invancevich & Matteson, 1993).

Jary and Jary (1995) defined stress as a state of tension produced by pressures or conflicting demands with which the person cannot adequately cope.

According to Singhal (2004), stress has been defined as a state of imbalance between one’s personal resources and the environmental demands, and manifested in the form of a number of psychosomatic factors, such as somatization (distress from perceptions of bodily dysfunction, like headache), obsessive compulsive (irresistible thoughts, impulses and actions, which are not connected to ego drives like forgetfulness), interpersonal sensitivity (feelings of personal inadequacy and inferiority related to others, such as critical of others), depression (low spirit and dejection) and anxiety (apprehension, distress and uneasiness).

Stress refers to a condition resulting from disturbances to physical or psychological well being (Goel & Goel, 2005).

Archer and Lamnin (1985) described academic stress as a stress arising from important factors like writing term papers, text anxiety, poor study skills, excessive academic load and classroom environment, which in turn forms a major part of general stress in adolescent students.
According to Gupta and Khan (1987), academic stress essentially relates to mental distress associated with some anticipated frustration on account of academic failure or even a realization of the possibility of such a failure.

According to Shah (1988), academic stress means a pervasive sense of urgency to learn all those things which are prescribed by the school.

According to Firman (1992), academic stress is anything that imposes an extra demand on a person’s ability to cope, often with something that is new and different in academics.

In the opinion of Endler, Kantor, and Parker (1994), academic stress contributes to major health hazards associated with problems of physical and mental stress-related ailments.

Academic stress is a type of stress that arises due to academic factors such as heavy school schedule, unrealistic expectations, and demands of parents and teachers, low academic performance, poor study habits, and not having enough time to deal with school’s multiple priorities (Banerjee, 2011).

1.5 Career Decision-Making

McDaniels (1978) defined career as a life style consisting of a sequence of work or leisure activities throughout one’s life time.

Storey (1979) defined career as the sequence of work-related activities and associated attitudes, values, and aspirations over the span of one’s life.

According to the National Career Development Association (Sears, 1982), career is the totality of work and leisure in which a person is involved in his or her whole life.

Raynor and Entin (1982) pointed out that the term career is a combination of phenomenological and behavioural conceptions. It reflects one’s self-perception within one’s social context with regard to one’s social past and present experiences as well as future plans.

Career is the life-long sequence of work, education, and leisure experience (Leeman, 1984).

Career is defined as, “Time extended working out of a purposeful life pattern through work undertaken by the person” (Reardon, Lenz, Sampson & Peterson, 2008, p. 6).
Taylor (1965) described decision-making as the choice among alternative courses for action.

Nutt (1976) described decision-making as the process of selecting a particular alternative for implementation.

Decision-making is the process whereby some sort of choice is made between alternatives by evaluating the information which is favorable or unfavorable to each alternative (Harre & Lamb, 1983, p. 139).

Decision-making is defined as “Problem-solving, along with the cognitive and affective processes needed to develop a plan for implementing the solution and taking risks involved in following through to complete the plan” (Sampson, Reardon, Peterson & Lenz, 2004, p. 6).

Career decision involves a choice among occupational alternatives. Which alternative is chosen, depends on the career decision maker’s preference for various factors or criteria on the basis of which he or she compares and evaluate the possible alternatives. The large number of alternatives available to the decision maker, the uncertainty concerning future preferences and the complexity involved in combining personal and occupational information suggest that a better understanding of the way in which career decisions are made and the process underlying thus is of theoretical as well as practical significance (Gati, Shenhav & Givon, 1993).

Crites (1974), Super (1983) and Savickas (2000) defined career decision-making as the process by which individuals make career and educational decisions contend that it is the main assessment task of career counseling. It examines how people make career decisions (decision-making style); the precursors that may influence or impede career choice (career indecision) and individual’s beliefs that they can successfully accomplish behaviours that will lead to desired outcome (decision-making self-efficacy beliefs).

According to Swanson and D’Achiardi (2005), career choice or career decision-making may be defined as a process-oriented construct that deals with how clients make career decisions or the circumstances surrounding those decisions. The client’s standing on this construct influences their level of decidedness or indecision.
i. **Career decidedness or career certainty:** Career decision status is the certainty or indecision about one’s career choice (Osipow, Carney, Winer, Yanico & Koschier, 1976). Two key constructs of the present study were career decidedness and career indecision as measured by the career decision-making inventory (Singh, 1999). Career decidedness means the confidence a student feels about choosing an educational major and in making a career choice or refers to the degree to which individuals feel confident or decided about their occupational plans (Osipow et al., 1976). Career certainty refers to one’s degree of certainty of having made a career decision (Gauy, Sencal, Gauthier & Fernet, 2003). Shashikant (2007) defined career certainty as the confidence student feels about choosing an educational major and in making a career choice.

ii. **Career indecision:** Career indecision is defined as the indecision with regard to career choice (Osipow et al., 1976). Chartrand et al. (1994) defined career indecision as a developmental problem within the career maturation process that results from a lack of information about self or the world of work. According to Gauy et al. (2003), career indecision refers to an inability to make a decision about the career that one wish to pursue or it is a temporary state in an individual’s career direction.

1.6 Rationale of the Study

Depression can take a variety of courses and chronicity, with relapse and recurrence relatively common over the life span (Kovacs, 1996; Keller, 1994). According to Garber (1984), adolescence is typically a time of emotional turmoil and mood fluctuations as a result of peer pressure, increasing expectations for adult behaviour and physiological changes. Major depressive disorder is a common disorder. It has a wide array of symptoms affecting somatic, cognitive, affective and social processes. Academic failure, poor peer relationships, behavioural problems, conflicts with parents, substance abuse and other authority figures are some of the consequences of major depressive disorder in adolescents (Hauenstein, 2003). A depressed youngster may experience a range of symptoms, some of which may be overt, such as irritability or distinctly sad appearance, and others may be covert, as illustrated by feelings of low self-worth, hopelessness, suicidal
thoughts and guilt. Depression in children and adolescents can cause significant impairment in daily functioning, personal and social involvement (Puig-Antich et al., 1985).

Major depression is prevalent in 0.5-1% of school aged children (5-13 years) over a six month period and increases to 3% in adolescents. The prevalence rate continuous to rise for boys’ up to the adolescence stage (Malhotra, Malhotra & Bhugra, 2005). According to Bhatia and Bhatia (2007) major depression affects 3 to 5% of children and adolescents. Khurana, Sharma, Jena, Saha and Ingle (2004) found 20.7% of children being high on hopelessness and 8% had depression. Also it was found that 15% of adolescents (age 11, 13, 15 years) reported symptoms of depression and 25% females reported depressive symptoms than males (10%) (Saluja et al., 2004). Charoensuk (2007) reported that the prevalence rate of depressive symptoms varied from 20 to 21% among Thai adolescents and negative thinking was found to be best predictor of depression among them.

The families having higher cohesion and expressiveness and low conflict showed less dependency and fewer psychological illnesses (Singhal, 2004). Authoritarian parenting has found to be associated with depression, anxiety, cognitive problems and substance abuse (Smith, Springer & Barrett, 2011). For adolescents, problem with family relationships, peer relationships and school achievement are the common cause of stress. Grade transitions, pubertal changes, pressure to conform and heightened temptation to indulge with friends in risky behaviours may be potentially stressful for the changing adolescent (Grant et al., 2000; Graber & Brooks-Gunn, 1996). Family psychiatric history and parental depression, primarily maternal depression (Birmaher et al., 1996; Downey & Coyne, 1990) have been associated with a child’s risk for developing depression (Weissman & Jensen, 2002).

Adolescent depression has been linked to serious psychological problems including suicide (Brown, Overholser, Spirito & Fritz, 1991; Kandel, Ravies & Davies, 1991), eating disorders (Petersen, Compa & Brooks-Gunn, 1992) and substance use (Kandel et al., 1991). Further, depressed adolescents feel less closeness and contact with friends, and more feelings of peer rejection have been related to adolescent depression (Petersen et al., 1992). The significance of
depression in adolescence gets further support from the fact that depression negatively affects adolescents’ development and functioning (Petersen et al., 1992; McConville & Bruce, 1985). Garber, Robinson and Valentiner (1997) found that among people who are unpopular or have poor peer relationships, depression is more prevalent.

Students are considered as doing nothing but study in which the family more or less assures all their inputs and relieving them from the psychological burden (Singhal, 2004). For the college students, stressors are inherent in the maintenance of grades, friends, limited opportunities of developing social circle, political freedom and lack of employment etc. (Beard, Elmore & Lange, 1982). The process of career exploration and decision-making can be particularly stressful time in an adolescent’s life (Taveira et al., 1998). High school students have to decide in a short amount of time, which area best suits their personality, values, abilities and interests. They struggle to balance the immense pressure of determining which path to pursue following their secondary education and their social life, extra-curricular activities and academic achievement. The contextual factors of career-related decisions compound the difficulties for adolescents. High school can thus, be a turbulent time for youth which causes an enormous amount of stress and confusion, and may lead to depression (Austin et al., 2010; Gati & Saka, 2001; Saunders, 1997). Depression is positively related to dysfunctional career thoughts and indecision (Degenhart, 2004; Saunders et al., 2000). According to DSM-IV-TR (APA, 2000), indecisiveness has been noted as one of the core symptoms of depression.

Moreover, there is a paucity of literature regarding the role of family environment, peer group influence, academic stress and career decision-making in depression among adolescents and also there exists lack of research in Indian context as little studies have been done in this part of country in the present combination of variables. The present study endeavors to fill these research gaps. Hence, research is needed to understand the relationship of the variables of family environment, peer group influence, academic stress and career decision-making with depression in a sample of adolescents (aged 14-17 years).
1.7 Statement of the Problem

The statement of the problem is:

DEPRESSION AMONG ADOLESCENTS IN RELATION TO THEIR FAMILY ENVIRONMENT PEER GROUP INFLUENCE ACADEMIC STRESS AND CAREER DECISION-MAKING

1.8 Operational Definitions

(i) Depression: In the present study, depression has been operationally defined as an emotional state of an individual that is marked by sadness, pessimism, past failure, loss of pleasure, guilty feelings, punishment feelings, self-dislike, self-criticalness, suicidal thoughts or wishes, crying, agitation, loss of interest, indecisiveness, worthlessness, loss of energy, changes in sleeping pattern, irritability, changes in appetite, concentration difficulty, tiredness or fatigue, and loss of interest in sex as measured by Beck Depression Inventory-II (Beck, Steer & Brown, 1996).

(ii) Family Environment: Operationally family environment means the environment of a home where father, mother, sister, brother and nearest relatives residing together with particular beliefs, values, rules etc.

(iii) Peer Group Influence: Operationally peer group influence refers to those motivating factors from the peer group (classmates and friends outside the class or school) which affect an individual (behaviour, values, attitudes, study habits etc).

(iv) Academic Stress: Operationally academic stress is defined as the stress due to studies or academics; the student faces in his/her educational life.

(v) Career Decision-Making: Operationally career decision-making is defined as the process of making informed career choices based on one’s personal experiences.

1.9 Objectives

The study was designed to attain the following objectives:

1. To study the nature of variables under study viz. depression, family environment, peer group influence, academic stress and career decision-making.
2. To study the relationship of depression with family environment among adolescents.

3. To study the relationship of depression with peer group influence among adolescents.

4. To study the relationship of depression with academic stress among adolescents.

5. To study the relationship of depression with career decision-making among adolescents.

6. To find out gender differences on the variables of depression, family environment, peer group influence, academic stress and career decision-making.

7. To find out differences among science, arts and commerce stream adolescents on the variables of depression, family environment, peer group influence, academic stress and career decision-making.

8. To find out the predictors of depression from among the independent variables of family environment, peer group influence, academic stress and career decision-making.

1.10 Delimitations

The study under investigation was delimited to the following:

1. The study was delimited to Government Model Senior Secondary Schools (co-educated) of Chandigarh affiliated to Central Board of Secondary Education (CBSE), New Delhi.

2. The study was delimited to XI class students only.

3. The study was further delimited to the variables of depression, family environment, peer group influence, academic stress and career decision-making.