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Perceived Interpersonal Support as Protective Factors for Adolescent Depressive Symptoms

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Abstract

Depression is a serious and life-threatening disorder that is affecting a large number of adolescents every year. Understanding possible protective factors may help to understand the disorder and aid in developing more effective prevention programs and treatments. Using data collected by The National Longitudinal Study of Adolescent Health, perceived parent, teacher, and friends support were examined as possible protective factors for the development of depressive symptoms in adolescence. Multiple regression analysis was performed on a sample of 18,787 adolescents between ages 10 and 19. Results indicated that higher levels of perceived interpersonal support predicted lower levels of depressive symptoms in the population [$F(3, 18793) = 637.292, r^2 = .092, p < .001$]. Perceived parental support was the strongest significant predictor of depressive symptoms ($\beta = -.167, t = -20.826, p < .001$), followed by perceived teacher support ($\beta = -.153, t = -22.890, p < .001$), and perceived friends support ($\beta = -.106, t = -14.377, p < .001$). These results suggest that it may be beneficial for prevention programs and treatments of adolescent depression to attempt to increase these forms of interpersonal support. Possible prevention and treatment programs, limitations of the study, and areas of interest for future research are discussed.

Introduction

Mood fluctuations are a part of everyday life for every one of us, especially during adolescence. All people have moments where they feel down or apathetic and we have all experienced happiness in our lives. Abnormally low mood levels, called depressions, may be a normal part of life as well. Feeling depressed is a naturally occurring phenomenon that is universally experienced by anyone who has lost a loved-one, been fired from a job, or been through an emotional break-up of any kind. There is a point, however, where depression becomes a serious, life-threatening problem. According to the *Diagnostic and Statistical Manual for Mental Disorders*, that point is when the “symptoms cause clinically significant distress or impairment in important areas of functioning” (4th ed., text rev; *DSM-IV-TR*; American Psychiatric Association, 2000).

Adolescents between ages 12 and 19 are especially susceptible to experiencing depressions during one of the most drastic and significant times of transition in a person’s life. Most adolescents naturally experience more extreme and frequent mood swings than they did in childhood (Arnett, 1999). A study from 2001 found that up to 50 percent of adolescents reported having experienced depressive symptoms in the last six months, compared to about 20 percent of adults (Kessler, Avenevoli, et al., 2001). But adolescents are also more prone to develop clinically significant depression as well. The national prevalence rate of major depression for adolescents is just under 8 percent (Birmaher, Brent, et al., 1998), while only 2 to 4 percent of adults suffer from the disorder (Kessler, Avenevoli, et al., 2001).

These statistics are particularly alarming because of depression's high comorbidity with many medical, psychiatric, and substance abuse disorders. Studies have shown that many physical ailments occur alongside depression or are exacerbated by the stress that depression places on the mind and body (Kupfer, Frank, 2003; Rohde, Lewinsohn, et al., 1991). Individuals with depression normally lack the necessary coping skills to overcome stressful events, which leads to an increase in activation of the Hypothalamic-Pituitary- Adrenal Axis. This activation results in increased levels of cortisol, which has profound negative effects on immunosuppression and memory (Taylor, 2012). Depression is correlated with heart attacks, as 40-65% of patients who have experienced myocardial infarction also suffer from depression (Lesperance, Frasura-Smith, et al. 1996). Comorbid psychiatric disorders are also very common, as approximately two thirds of children and adolescents with major depressive disorder also have another mental disorder (Angold, Costello, et al., 1999). Furthermore, depression in adolescence is also associated with an increased risk of substance abuse (Birmaher, Brent, et al., 1998; Swendsen, & Merikangas, 2000) and using drugs and alcohol as an adolescent not only has harmful, possibly life-threatening physical effects, but also increases risk for serious injury or accidental death (Windle, Miller-Tutzauer, et al., 1992). The most frightening comorbidity, however, is with suicide. Major depressive disorder is the leading cause of youth suicidal behavior (Brent, 2001; Kann, Kinchen, et al., 2000) and suicide is the third leading cause of death among all adolescents (Guyer, MacDorman, et al., 1998).

Knowing the well-documented, negative effects of depression in adolescence and the high prevalence of the disorder in the population, it is evident that more effective methods of prevention, interventions, and treatments are needed. Major depression in adolescence is

notoriously under diagnosed (Hirschfield, Keller, et al., 1997) and it is estimated that more than 70 percent of children and adolescence with depression or other mood disorders do not receive the appropriate diagnosis and treatment (Hoagwood & Olin, 2002). These problems with diagnosis and prevention could be due to a lack of information about depression specific to adolescence, including possible risk and protective factors. The Risk and Protective Factor Model of Prevention suggests that it is necessary to determine and address factors that predict problem behaviors in order to promote positive development and prevent negative outcomes (Pollard & Hawkins, 1999). This theory argues that prevention programs should focus on diminishing risk factors, or characteristics of personality, peer groups, school, community, or family environments that are known to predict increased likelihood of the negative behavior, and promote protective factors that provide a positive influence or mediate the effect of exposure to risk factors, resulting in a reduced likelihood of the problem behaviors (Pollard & Hawkins, 1999; Arthur, Hawkins, et al., 2002). While it is clear that not each of the determined risk and protective factors will prove to have a causal relationship with their outcome, identification of possible mediator variables could provide significant insight into possible prevention programs (Pollard & Hawkins, 1999).

In accordance with the Risk and Protective Factor Model, the present study has identified three possible protective factors for the development of depressive symptoms in adolescence: perceived parental, social, and friends support. While the importance of relationships on mental health is universal to almost every theoretical perspective in psychology, this study

plans to focus on the direct effect of these interpersonal relationships as buffers for the development of psychopathology in adolescence, such as depression.

The first protective factor examined in the present study is perceived parental support. The relationship between parent and child is one of the most researched subjects in psychology. According to early psychodynamic theory, the attachment between child and parent in infancy is the basis for the nature of social interactions later in life. If an infant's needs are not met or there is a lack of responsive, lively interactions then a secure attachment will not form which could cause disruptions in future adult relationships (Day, 2008). Likewise, Behavioral Psychology suggests that psychopathology, such as depression, is caused by "the acquisition and reinforcement of maladaptive behaviors, the lack of opportunity to learn adaptive or appropriate behaviors, and/or unavailable or inadequate reinforcement of those adaptive or appropriate behaviors" (Parritz & Troy, 2011, p. 19). Since parents are our first and most significant relationships, the majority of our learning comes from them, and in turn, our development of psychopathology. Some more recent theories of psychopathology, such as the Family Model, put even more significance on the relationship between child and parent. Parents are responsible for meeting many of a child's needs, including nurturing and socializing, promoting education, and providing financial support, and they can succeed or fail at meeting any or all of those needs (Emery & Kitzmann, 1995). In the Family Model, psychopathology is understood in the dynamics of a particular family, and interventions usually include parents and siblings (Parritz & Troy, 2011). The importance of the parent-child relationship in popular theories and the documented negative consequences of poor parental support (Stice, Ragan, et

al., 2004; Wills, Resko, et al., 2004) advocate for the study of perceived parental support as a protective factor for adolescent depressive symptoms.

The second protective factor investigated in the present study is perceived support from teachers. While the majority of learning in infancy and childhood comes from the home and parents, the school becomes the center for most learning and social interactions in adolescence, where teachers often serve as mentors to their students. Mentoring programs have become very popular in the United States, however, a 2002 meta-analysis of mentoring program evaluations found that for the average youth there was only a modest or small benefit of program participation as a whole (Dubois, Holloway, et al., 2002). The analysis also found, though, that certain programs were more beneficial than others. The important characteristic was the strength of the mentor-student relationship that was formed. Similarly, research has shown that when students perceive their teachers as more caring, they are more likely to put forth more effort and achieve more in the classroom (Muller, 2001). This supports the idea that if teachers can make a significant impact on students' expectations and achievements, then they may also be able to impact self-esteem and efficacy in the same manner as a mentor.

The final protective factor examined in the present study is perceived support from friends. Friendships have an obviously important influence on adolescent behaviors and attitudes, but there are differing theories on whether that influence is generally positive or negative. Some argue that friendships in adolescence allow individuals to develop more effective coping abilities and social skills while others suggest that the influence by peers often leads to delinquent behavior. Most researchers agree, however, that the relationship is bidirectional

and most likely each friendship carries both positive and negative influences (Berndt, 1992).

The positive influences of friendship are obvious. Adolescents report being in their most favorable moods when in the company of close friends (Larson & Richards, 1991). Likewise, supportive friendships allow adolescents to deal with stressors and can contribute to involvement in constructive youth activities, avoidance of antisocial acts, and better psychological well-being (Lansford, Criss, et al., 2003; Wentzel, Barry, et al., 2004). While the benefits of peer support are known, there have been few studies that directly compare friend support to other types of social support, like parent and teacher.

The purpose of the present study is to examine the connection between these interpersonal relationships in adolescence and psychological well-being. More specifically, we aim to look at whether perceived parent, teacher, and friends support can serve as buffers for the development of depressive symptoms in adolescence and to compare these mediator variables in order to be able to develop more effective prevention, intervention, and treatment programs for adolescents suffering from the disorder. It is hypothesized that each of the mediator variables will have a significant effect on depressive symptoms. It is further hypothesized that perceived parental support will account for the largest amount of variance of the three followed by perceived friends support and perceived teacher support.

Method

Sample

The data for this study were drawn from the National Longitudinal Study of Adolescent Health (Add Health), conducted at the University of North Carolina at Chapel Hill. Add Health is a nationally representative sample of 6-12th graders from more than 130 schools nationwide, with data taken in four waves over a fourteen-year period. Schools selected to participate in the study were selected to be representative of United States' schools with respect to region of country, urbanicity, size, type, and ethnicity. The current study used data from the weighted in-home interview (Wave 1) conducted between April and December of 1995 (Harris, Halpern, et al., 2009). Inclusion criteria included only those participants who fully completed the "Feelings Scale" and "Protective Factors" sections of the interview. The final sample size was 18,797. The age range of participants was 10 to 19 years old, with a mean age of 15.05 years. 26.5 percent of the participants were in middle school (grades 6-8) and 73.5 percent were in high school (grades 9-12). The population was 48.6 percent male and 51.4 percent female.

Measures

Depressive symptoms were assessed using a modified version of the Center for Epidemiological Studies Depression Scale (CES-D) (Radloff, 1977). The items "My sleep was restless" and "I had crying spells" were omitted by the interviewers and replaced with the item "You felt life was not worth living." The CES-D is a short, self-report scale designed to be administered in household interviews in the general population. The scale has been shown to have high

internal consistency, reliability, and validity (Radloff, 1977). The scale is also valid to be used in junior high school, senior high school, and college student populations (Radloff, 1991). Table 1 lists the “Feelings Scale” as administered by the interviewers.

Table 1:

<p>Instructions: These questions will ask about how you feel emotionally and about how you feel in general. How often was each of the following things true during the past week?</p> <p>never or rarely sometimes a lot of the time most of the time or all of the time</p>
1. You were bothered by things that usually don't bother you.
2. You didn't feel like eating, your appetite was poor.
3. You felt that you could not shake off the blues, even with help from your family and your friends
4. You felt you were just as good as other people.
5. You had trouble keeping your mind on what you were doing.
6. You felt depressed.
7. You felt that you were too tired to do things.
8. You felt hopeful about the future.
9. You thought your life had been a failure
10. You felt fearful.
11. You were happy.
12. You talked less than usual.
13. You felt lonely
14. People were unfriendly to you.
15. You enjoyed life.
16. You felt sad.
17. You felt that people disliked you.
18. It was hard to get started doing things.
19. You felt life was not worth living.

Harris, Halpern, et al., 2009

Perceived parent, teacher, and friends support was determined using questions from the “Protective Factors” section of the in-home interview. Participants were asked “How much do

you feel your teachers/parents/friends care about you?” and answered using a five-point Likert scale ranging from “not at all” to “very much.”

Analysis

A multiple regression analysis was performed to examine whether interpersonal support is a significant predictor of depression. Parent, teacher, and friends support were included in the regression model. Because of sampling procedures implemented by the Add Health investigators, the sample was weighted during the multiple regression analysis in SPSS according to the Add Health guidelines (Chantala, 2006).

Results

As expected, the results indicated that higher levels of perceived interpersonal support predicted lower levels of depressive symptoms [$F(3, 18793) = 637.292, r^2 = .092, p < .001$]. Each of the three measured types of interpersonal support showed significant results. Perceived parental support showed the strongest significant prediction of depressive symptoms ($\beta = -.167, t = -20.826, p < .001$). Perceived teacher support also predicted depression significantly ($\beta = -.153, t = -22.890, p < .001$), as well as perceived friends support ($\beta = -.106, t = -14.377, p < .001$).

Discussion

According to the Risk and Protective Factor Model, protective factors are mediator variables that provide a positive influence or reduce the influence of present risk factors, which results in a decreased likelihood of the negative behaviors (Pollard & Hawkins, 1999; Arthur, Hawkins, et al., 2002). The goal of the present study was to test the hypothesis that perceived parent, teacher, and friends support could act as protective factors for the development of depressive symptoms in adolescence and to compare the effect that each of the mediator variables accounted for. After analysis, the presented hypothesis was supported by the results that each of the variables had a significant buffering effect on depressive symptoms. The second proposed hypothesis that perceived parent support would account for more variance than perceived friends and teachers support and that perceived teacher support would have the least significant effect of the three was not supported by the results, as perceived friends support accounted for the least variance. The results of this study are consistent with most previous research findings that parental support has a more significant impact than peer support (Stice, Ragan, et al., 2004; Young, Berenson, et al., 2005), however, the finding that teacher support may have a larger buffering effect on depressive symptoms than peer support is relatively novel. These results could indicate that adult support in general is more influential than peer support. Teachers and parents are more respected and admired than friends during adolescence and, therefore, their support is more sought-after and valued. Implications of these findings could help to better understand the mechanism of depression in adolescence and develop more effective prevention and treatment programs.

With the knowledge that teacher support can serve as an effective protective factor for depressive symptoms in adolescence, there are many implications for prevention programs in schools. The findings of this study suggest that mentoring programs where teachers are placed in the role of mentor may be effective. Teachers already serve as role models to students who can look up to the achievement of their teachers and mirror their maturity. It might be possible to adapt already in-place, ineffective mentoring programs in schools to allow the teacher-student relationship to grow and have a more positive impact on the students' psychological well-being. Likewise, programs that help to educate teachers about being more sensitive and cognizant of students' feelings could help to foster more influential relationships. It is important to give teachers the tools to be more aware of their students' possible depressions so that earlier interventions may be utilized. If educated about the signs and symptoms of depression, teachers can help to recognize troubled youth earlier and minimize the intensity of the disorder. Classroom programs in which teachers educate students and parents about the risks and symptomatology of depression could provide help to prevent the occurrence of depressive symptoms or allow the disorder to be recognized earlier in its development. The results of this study indicate that it may be beneficial for prevention programs to attempt to increase parental, teacher, or peer support if possible.

Other implications of the present study include that treatments for adolescent depression may be improved if parents are involved and the relationship between parent and child is strengthened. The results of this study indicate that the parent-child relationship is very influential in adolescents' mood. Treatments that include the parents could focus on helping the parents to understand their role and to provide a positive atmosphere that promotes high

self-esteem and self-efficacy. Family therapy, for example, aims at treating the family as a whole to teach family members cognitive restructuring and reframing techniques to help improve communication and resolve conflicts (Day, 2008). These types of treatments may be able to tap into the influence of the parent-child relationship in order to promote better mental health for troubled adolescents.

Limitations of the study should be noted. The use of a longitudinal design, instead of the utilized cross-sectional design, could have provided more insight into the causality and directionality of the relationships studied. Also, all data was assessed using self-report, including the determination of support. It is important to make the distinction between perceived support and enacted support, as the presence of depression could alter one's perception of their social support. Fortunately, perceived support has been shown to have a strong correlation with enacted support (McCaskill & Lakely, 2000), even though the potential for difference still exists. It is also possible, as is with all prospective studies, that some extraneous variable has influenced the results.

Future research in this area should look into the mechanism by which these perceived supports influence the mood of adolescents. Research should attempt to identify what aspects of each of these relationships are the most influential to promoting good psychological well-being. Experiments and testing of prevention programs focused on increasing parent, teacher, and friends support should be assessed and efficacy determined. A longitudinal study in which developed depression is examined in relation to interpersonal support may be beneficial. Also, studies should use multiple measures of report, like parent, self, and observer report, of

support in order to rule out any possibility of bias. It may also be interesting for future research to look into other forms of interpersonal support, such as romantic or sibling relationships.

In conclusion, the results of this study are consistent with previous research that parent, teacher, and friends support can serve as protective factors for the development of depression in adolescence. The findings also provide insight into the relative influence of each type of support and suggest that there are some differences in the nature of support provided by parents, teachers, and friends that could have implications on possible preventions and treatments for adolescent depression and should be investigated further.

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