Depression among Adolescents as a Function of Social Support and Parental Bonding

Dr. Narinder Singh,

Gold Medalist (M.A. Psychology),

Assistant Professor, Govt. Home Science College,

Sector-10, Chandigarh,

Satneet Singh,

M.D. Tver State Medical Academy, Tver, Russia.

Adress: Dr. Ranjeet Singh, ENT Spl. HNO1657,

Ward No. 5, opp. BZSFS School,

Sirhind, Dist. Fathehgarh Sahib, Punjab.

Abstract

Depression is an emotional and mental disorder that affects person's activity, thoughts, sense of well-being and behavior. Its rise within adolescents has become a matter of concern and has put emphasis on exploring related elements that could result in depression. The objective of this study was to investigate the effect of parental bonding and social support on depression among adolescents. To explore this relationship total of 160 adolescents (80 boys and 80 girls) in the age range 14 - 19 years were selected from various schools. Reynolds Adolescent Depression Scale (William Reynolds, 2002) was applied to find out the severity of depressive symptoms in adolescents. Social support questionnaire (SSQ) (Sarason, Levine, Basham, & Sarason, 1983) was administered to assess social support. Parental Bonding Instrument (Parker, Tupling and Brown, 1979) was applied to evaluate the children's perceptions of the parent -child relationship in terms of parental behaviors and attitudes. Multiple regression analysis was used to analyze the data. It was found that social support (β=-0.60), father care (β=-0.22) and mother care (β =-0.12) were negatively contributing to adolescent depression. Father overprotection (β =0.44) and Mother overprotection (β=0.20) are positively contributing to adolescent depression. Observed findings have vital implications in observing an adolescent for signs of depression and its etiology.

Keywords: Depression, Social Support, Adolescents, and Parental Bonding.

Depression among Adolescents as a Function of Social Support and Parental Bonding

Depression includes strong mood swings involving sadness, discouragement, despair or hopelessness that lasts for weeks, months or even longer. The term 'depression' is used in common language to describe a range of happenings from an insignificantly noticeable and temporary mood decrease to a profoundly impaired and even life-threatening disorder. Depression is a mood disorder that has four sets of the symptoms namely emotional, cognitive, motivation and physical. An adolescent need not have all of these symptoms to be diagnosed as depressed. The intensity of depression depends on the extent and severity of these symptoms. Sadness and feeling of rejection are the most silent emotional symptoms of depression. The individual feels hopeless and unhappy, he/she often has caring spells, and many contemplate suicide.

An equally preserve is a loss of gratification or pleasure in life. Activities that used to bring satisfaction become dull and joyless; the depressed adolescent gradually loses interest in going to school, hobbies, recreation, and family activities. The depressed adolescent has low self-esteem, negative thoughts, loss of motivation, the feeling of the hopelessness about the future, change in aptitude, loss of energy and sleep disturbance. The mood change may be temporary or long lasting. It may range, from minor feeling of sadness to a profoundly negative view of the world and an inability to function effectively (Sarason & Sarason, 2002).

The suffering faced by an adolescent with depression and the young lives lost to suicide indicate a great burden of this sickness on young adults, families, and society. Improved recognition, treatment, and prevention of depression are critical public health priorities. An adolescent suffering from a major depressive disorder must either have a sad mood or a lack of interest or pleasure in daily activities for a consistent period of at least two weeks. The change in mood should be different from the person's normal mood. The change in mood must negatively impair social, occupational, educational or other important functioning. For instance, an adolescent who has missed school or work because of their depression, or has stopped attending usual social engagements or attending school altogether. In the contemporary society, mental illness, which now affects between 10 to 25 percent of the Indian population, could be a case of depression, psychotic illness, substance abuse or a personality breakdown. Gender also play a role in depression it is found to be high in females than in males (Carson, Butcher & Mineka 1998). While a negative social and family support could be a cause for depression, a positive social and family support is very helpful in dealing with depression.

Social support refers to information or actions (real or potential) that lead individual to believe that they are cared for, valued, or in a position to receive help from others when they need it. Social support has been conceptualized as a coping resource that affects the extent to which a situation is appraised as stressful (Lazarus & Folkman, 1984) and enables a person under stress to change the situation, to change the meaning of the situation or to change his or her emotional reactions to the situation (Thoits, 1986). Social support is associated with better psychological health in general and reduces the negative psychological consequences of exposure to stressful life events (Cohen & Wills, 1985).

Social Support

Social support has also been described as "those social interactions or relationships that render individuals with actual assistance or that embed individuals inside a social system believed to give love, caring or sense of attachment to a valuable social group or dyad" (Hobfoll, 1988). This definition

eloquently encompasses the two major facets of social support that have dominated research in the last two decades: Received social support and perceived social support. Received social support refers to naturally occurring helping behaviors that are being provided. Whereas perceived support refers to the belief that such helping behavior would be provided when needed. In a nutshell, received support is helping behavior that did happen, and perceived support is helping behavior that might happen (Barrera, 1986). Individuals who receive high levels of social support they appear to be more resistant to the unfavorable psychological effects of environmental stressors than those who receive low levels of social support (Lepore, Evans, & Schneider, 1992). A supportive early family environment has been positively correlated with good adjustment and healthy psychological development (Vaillant, 1977).

It is not uncommon that young adult changes their place of living and in turn their social circle very often. Every change demand an adjustment to new environment where social support is a significant factor linked with the degree of culture shock and it should be taken into attention in order to shield against or help to overcome any psychological distress experienced by adolescents (Pantelidou& Crai g, 2006).

Parent-Child Relationship

Increasing evidence shows that depressive symptoms in adolescents are associated with the quality of the relationship between adolescents and their parents. They tend to experience high levels of depressive symptoms when they sense their parents to have less warmth and high in control (Hale et al., 2005) and also when they experience frequent disagreements with their parents (Sheeber, Hops, Alpert, Davis, & Andrews, 1997). High parental rejection, high parental control, overprotection, parental harshness, low parental warmth or care, high family conflict, inconsistent discipline and hostility are associated with depression in adolescents (Heaven, Newbury, & Mak, 2004; Zuniga de Nuncio, Nader, Sawyer, & Guire, 2003). High levels of self-criticism in adulthood were related to retrospective reports of poor parent-child relationships (particularly with mothers) (Brewin, Firth-Cozens, Furnham, & McManus (1992). The rejection accounted for approximately 8% of the variance in childhood depression, and control accounted for approximately 5% (McLeod, Weisz, & Wood 2007).

The quality of a parent-child relationship is determined by the interactions between parent and children. The negative family interactions can lead to a self-condemnation by adolescents. They may blame their depressive and aggressive behaviors on their parents' rejecting attitudes, and on the other hand parents may justify their rejecting attitudes on their children's behaviors. But instead of blaming, it is more a question of faulty interactions that are self-perpetuating; negativity generates negativity as it were. It is due to this reason researchers are focusing more towards bidirectional interaction models instead of interactions that are only in a unidirectional manner. (Spoth et al. 2006) The study of negative parent-child interactions can be distinguished into two general groups: the unidirectional models (i.e., child or parent effects models) and the bidirectional models (1.e., child-parent interaction effects models). The bidirectional model of child-parent interactions helps to explain how both children's problem behaviors and negative parental upbringing behaviors can jointly affect each other. In other words, child's problem behaviors and negative parental upbringing behaviors are considered as a complex, integrated whole; in which each member exert a continuous and reciprocal impact on the other. Studies of negative child-parent interactions have shown that early adolescent problem behaviors and negative parental upbringing behaviors frequently enhance one another. (Spoth et al. 2006)The early adolescent problem behaviors and negative parental upbringing behaviors were reciprocally and strongly related to one another.

Adolescence stage is associated with substantial changes in self. The various biopsychosocial changes during adolescence make it a vulnerable period for the development of internalizing problems especially depression. Depression in adolescents is one of the most neglected psychological disorders within this period of development. The prevalence rates of depression in adolescents are rising globally and in Indian adolescents as well. It is crucial to study this issue in adolescents about family factors especially the parent-child relationship which is thought to provide a blueprint for the child's development. The focus of the present study was to explore depression in adolescents about their social support and parental bonding.

Methods

Sample

The purposive sample of 160 adolescent (80 boys and 80 girls) in the age range 14 – 19 was used in present study. They were selected from various schools. The majorities of the participants were from upper/middle-class families and lived with both parents. Consent was taken from their teacher as well as from all the participants to collect the required data. After getting all the information, participants were debriefed.

Procedure:

Subjects were contacted through their teachers. Consent was taken from their teacher as well as from all the participants to collect the required data. Sincere efforts were made to establish rapport with the subjects for eliciting authentic information. After taking consent from participants, Reynolds Adolescent Depression Scale (William Reynolds, 2002), Social Support Questionnaire (SSQ; Sarason, Levine, Basham, &Sarason, 1983) and Parental Bonding Instrument (Parker, Tupling and Brown, 1979) were administered in small groups. After getting all the information, participants were debriefed, and confidentiality was assured. It was revealed that the subjects were motivated to fill the questionnaires. Efforts were done to ensure that the subjects do not fake their responses. After scoring, multiple regression analysis was applied to the obtained data to determine the relative contribution of social support and dimensions of parental bonding in predicting depression among adolescents.

Tools Used

REYNOLDS ADOLESCENT DEPRESSION SCALE: (RADS-2): - RADS-2 was developed to find out the severity of depressive symptomatology in adolescents in clinical settings (William Reynolds 2002). The RADS-2 is a 30-item self-report scale that includes subscales which assess the current level of an adolescent's depressive symptomatology with four basic dimensions of depression: Dysphoric Mood, Negative Self-Evaluation, Negative Affect, and Somatic Complaints. In extension to the four subscale scores, the RADS-2 yields a Depression Total score that represents the overall severity of depressive symptomatology. The items are scored on four point rating scale ranging 1 (almost never) 4 (most of the time) the total score ranges from 30 to 120. A higher score indicates greater depression. The reliability and validity of test is adequately established (internal consistency = 0.86 test-.retest = 0.8 validity criterion = 0.83).

Social Support Questionnaire (SSQ; Sarason, Levine, Basham, &Sarason, 1983): Social Support Questionnaire (SSQ) developed by Sarason, Levine, Basham, &Sarason, (1983) have 27 items. All of the 27 items asks a question to which a two-part answer is inquired. The items ask the subject (a) to list the people to whom they can turn and on whom they can rely in certain sets of circumstances and (b) indicate how satisfied they are with these supports on a 6 point Likert scale (very dissatisfied, fairly

dissatisfied, a little dissatisfied, a little satisfied, fairly satisfied, very satisfied). According to authors, The Social Support Questionnaire has been seen to have a number of desirable psychometric properties. It was observed to have (a) stability over a 4 week period, and (b) high internal consistency among items.

PARENTAL BONDING INSTRUMENT (PBI):- The parental bonding instrument is a 25 item instrument designed to assess the children's perceptions of parent -child relationship in terms of parental behaviors and attitudes (Parker, Tupling and Brown 1979),. The author recognized two variables as important developing parent-child bonding: (a) overprotection and (b) care. Out of 25 items, 12 measure children's perception of their parents as caring with another end of the spectrum being rejection or indifference, the left 13 items assess children's over-protectiveness with the extreme opposite being encouragement, independence. The care subscale provides maximum scores of 36 and overprotection subscale a score of 39. The scale yields information on four dimensions i.e. father care, mother care, father overprotection, mother overprotection. The participant's responses are scored on a four-point Likert- type scale varying from "very like" (0) to "very unlike" (3). Few of the test items are reversely scored. The parental bonding instrument demonstrated high internal consistency with split-half reliability coefficients of .88 for care and .74 for over protection. The parental bonding instrument showed the good concurrent validity and correlated significantly well with independently rated judgments of overprotection and parental care (Parker, Tupling & Brown, 1979).

Results

Stepwise Multiple Regression Analysis was conducted to determine the value of variance in the dependent variable that could be estimated by the different variables (Social Support and Parent-Child relationship dimensions) and the impression of each independent variable in the prediction of the dependent variable. Total Depression scores on RADS-2 were taken as the criterion

Table 1: Showing Step-wise Multiple Regression Analysis for Adolescent Depression.

Variable	R	R^2	$R^2\Delta$	p	β
Social Support	.60	.36	.36	.00	-0.60**
Father Overprotection	.69	.48	.12	.00	0.44**
Father Care	.72	.51	.03	.00	-0.22**
Mother Overprotection	.74	.54	0.03	.00	0.20**
Mother Care	.75	.56	0.02	.00	-0.12**

**significant at 0.01 level (N=160)

In the regression table revealed that Social Support (β=-0.60) is negatively contributing to adolescent depression. Father Overprotection is positively contributing to adolescent depression (β =0.44). Father Care (β=-0.22) is contributing negatively towards adolescent depression. Mother Overprotection (β=0.20) is contributing positively towards adolescent depression. Mother Care (β =-0.12) is negatively contributing to depression in adolescents.

Discussion

It is revealed that Social Support (β=-0.60) is negatively contributing to adolescent depression, and it is the strongest factors that predict the absence of depression. The reason behind could be that the presence of social support might have worked as a buffer against depression and its absence might have increased the chances of depression among the teenage students. A dominant perspective is that lacks in social support increase the risk for depression (Monroe, 1983; Windle, 1992). Theoretically, the understanding that one is accepted and valued in one's interpersonal environment bolsters esteem, confidence, and efficacy, which guard against depression.

The stress-buffering model (by Windle, 1992) states that the positive social support alleviates the relation between stressful life situations and depression. Deficits in distinguished support have predicted future increases in depressive symptoms during adolescence (Stice&Bearman, 2001; Windle, 1992). Theorists have also proposed that support and depression are reciprocally related (Lazarus &Folkman, 1984). Bowlby's theory of attachment (1980) relies heavily on the analysis of social support that when social support is available very early in life in the form of an attachment figure. Bowlby believes children become self-reliant, learn to function as a supporter of others, and have a decreased likelihood of psychopathology in later life.

It was observed that the dimensions of parental bonding instrument were significant predictors of depression. Father Overprotection is positively contributing to adolescent depression (β =0.44). Father Care (β=-0.22) is contributing negatively towards adolescent depression. Mother Overprotection (β=0.20) is contributing positively towards adolescent depression. Mother Care (β =-0.12) is negatively contributing to depression in an adolescent. Singh, Yadav, Dhiman, & Singh (2011) also revealed that Father Overprotection is positively contributing to depression in adolescent boys and Father Care dimension of a parent-child relationship is contributing negatively towards adolescent depression. According to theoretical viewpoints, parental overprotection may lead to anxiety by reinforcing beliefs in the dangerousness of the situation and the lack of capacity to avoid the danger (Rapee, 1997).

This indicates intrusive actions that highlight the closeness of the parent-child bond, such as limiting the child's independent activities, and unnecessary management, exhibit high levels of distress and neediness in children may prevent the formation of independent behavior on the part of the child, leading to infantilization (Parker &Lipscombe, 1981). In turn, this limits children opportunities to practice and improve their self-regulation and active coping skills and communicates the message that they are incapable and require parental assistance to handle normal life tasks.

The results of analysis also suggest that Father Care is a critical predictor of depression. Father Care dimension of a parent-child relationship is contributing negatively towards adolescent depression. Fathers' interactions exert a great influence on every domain of their children's functioning, beginning from infancy. Recent research proves how fathers impact their children's cognitive, social and emotional development. For example, in the first few days of life, many newborn babies turn their heads towards their father's voices versus the stranger's voice (Brazelton & Wesley, 1992). Fathers and mothers guide their children in similar ways concerning the development of morality, competence in social interactions, academic achievement, and mental health. Fathers' role may be especially critical in the psychosocial development of an adolescent boy. However, father involvement is of a different nature than mother involvement. In terms of relative frequency, fathers tend to spend more time playing with their children than mothers.

When children are in young age (0-4 years old), fathers tend to involve in more tactile and stimulating ventures. As children enter middle childhood age (the school-aged years), fathers are involved in more recreational activities such as outings and walks as well as private talks. Fathers also have a strong influence on their children's gender role development and are important role models for both girls and boys (Williams, Radin, & Coggins, 1996). The long-term outcome of fathers' direct involvement in the care of their children manifests through childhood and adolescence. For the children with a father figure, those who expressed greater father support had a greater sense of social competence and less depressive symptoms (Dubowitz, Black, & Cox, 2001). Overall regression analysis suggests that Social Support, Father Overprotection, and Mothers Overprotection are contributing positively to adolescent depression. Father Care and Mother Care are negatively contributing to adolescent depression scores. Father Care and overprotection are playing more important role in the depression of adolescent more than mothers care and overprotection.

Conclusion

It can be concluded that the present research investigation has indicated that parent-child relationship and social support are important determinants of depressive symptoms in adolescents. Adolescence is a challenging phase of life; however healthy parent-child relationship can cushion the effects of ruthless bio-psycho-social changes of this period. Thus, the findings implies that depression can be countered with the help of social support, and it has significantly important role to play particularly in adolescent years where rapid changes take place that requires social support as a stress buster mechanism for them. Adolescents need to be educated on how to make healthy appraisals of events and occurrences within and around them, and a healthy parent-child relationship can ensure better psychological health in adolescents.

References

Bowlby, J. (1980). Attachment and Loss, Vol. 3: Loss: Sadness and Depression. New York: Basic Books.

Brazelton, T. & Berry, M.D. (1992). Touchpoints: Your child's emotional and behavioral development. New York: Addison-Wesley Publishing Co.

Brewin, C. R., Firth-Cozens, J., Furnham, A., & McManus, C. (1992).Self-criticism in adulthood and recalled childhood experience. *Journal of Abnormal Psychology*, 101(3), 561-566.

Carson, R.C., Butcher, J.N., & Mineka, S. (1998). Abnormal psychology and modern life. New York: Longman.

Cohen, S., & Wills, T.A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin*, 2, 310-357.

Dubowitz, H., Black, M.M., Cox, C., Kerr, M.A., Radhakrishna, A., Litrownik, A., English, D., Schneider, M., & Runyan D. (2001). Father involvement and children's functioning at age 6 years: A multi-site study. *Child Maltreatment*, 6(4), 300-9.

Hale, W. W., Van Der Valk, L., Engels, R., & Meeus, W. (2005). Does perceived parental rejection make adolescents sad and mad? The association of perceived parental rejection with adolescent depression and aggression. *Journal of Adolescent Health*, 36, 466-474.

Heaven, P. C. L., Newbury, K., & Mak, A. (2004). The impact of adolescent and parental characteristics on adolescent levels of delinquency and depression. *Personality and Individual Differences*, 36, 173-185.

Hobfoll.S.E. (1988).The ecology of stress. Washington DC: Hemisphere.

Lazarus, R., & Folkman, S. (1984). Stress, appraisal, and coping. New York: Springer.

Lepore, S.J., Evans, G.W., & Schneider, M.L. (1992).Role of control and social support in explaining the stress and hassles of crowding. *Environment and Behaviour*, 24, 795-811.

McLeod, B. D., Weisz, J. R., & Wood, J. J. (2007).Examining the association between parenting and childhood depression: A meta-analysis. *Clinical Psychology Review*, 27, 986-1003.

Monroe, S. M. (1983). Social support and disorder: Toward an untangling of cause and effect. *American Journal of Community Psychology*, 11, 81–97.

Pantelidou, S. & Craig, T. K. J. (2006).Culture shock and social support. *Social Psychiatry and Psychiatric Epidemiology*, 41, 777-781.

Parker, G., & Lipscombe, P. (1981).Influences on maternal overprotection. *British Journal of Psychiatry,* 138, 303-311.

Parker, G., Tupling, H., & Brown, L. B. (1979).A parental bonding instrument. *British Journal of Medical Psychology*, 52, 110.

Rapee, R. M. (1997). Potential role of childrearing practices in the development of anxiety and depression. *Clinical Psychology Review*, 17(1), 47-67.

Reynolds, W. (2002). Reynolds adolescent depression scale 2: Professional manual. Florida Avenue: Psychological Assessment Resources, Inc.

Sarason, I.G., & Sarason, B.R. (2002). Abnormal psychology: The problem of maladaptive behavior, 3rd Ed, Delhi: Pearson Education.

Sarason, I.G., Levine, H.M., Basham, R.B., & Sarason, B.R., (1983). Assessing social support: The social support questionnaire. *Journal of Personality and Social Psychology*, 44(1), 127-139.

Sheeber, L., Hops, H., Alpert, A., Davis, B., & Andrews, J. (1997). Family support and conflict: Prospective relations to adolescent depression. *Journal of Abnormal Child Psychology*, 25 (4), 333-345.

Singh, N., Yadav, R., Dhiman, C., & Singh, G. (2011).Adolescent depression in relation to cognitive distortion and parental bonding. *Journal of Mental Health and Human Behaviour*, 16(2), 80-87.

Spoth, R., Shin, C., & Guyll, M. (2006). Universality o effects: An examination of the comparability of long-term family intervention effects on substance use across risk- related subgroups. *Prevention Science*, 7(2), 209-224.

Stice, E., & Bearman, S. K. (2001). Body image and eating disturbances prospectively predict growth in depressive symptoms in adolescent girls: A growth curve analysis. *Developmental Psychology*, 37, 597–607.

Thoits, P.A. (1986). Social support as coping assistance. *Journal of Consulting and Clinical Psychology*, 54, 416-423

Vaillant, G.E. (1977). Adaptation to Life. Boston: Little, Brown.

Williams, E., Radin, N., & Coggins, K. (1996). Paternal involvement in childrearing and the school performance of Ojibwa children: An exploratory study. *Merrill-Palmer Quarterly*, 42, 578-595.

Windle, M. (1992).A longitudinal study of stress buffering for adolescent problem behaviors. *Developmental Psychology*, 28, 522–530.

Zuniga de Nuncio, M., Nader, P., Sawyer, M., &Guire, M. (2003). A parental intervention study to improve timing of immunization initiation in Latino infants. *Journal of Community Health*, 28, 151-158.