



# ORIGINAL RESEARCH PAPER

# Psychology

## DEVELOPMENTAL IMPACT OF GENDER AND THERAPEUTIC CONDITIONS ON DEPRESSION : A STUDY ON ADOLESCENTS

**KEY WORDS:** Depression, Adolescents, Inner self integration therapy

**Kamal Khurana**

Researcher Scholar, Department of Psychology, Kumaun University Campus, Almora

**Aradhana Shukla\***

Prof. & Head, Department of Psychology, Kumaun University Campus, Almora  
\*Corresponding Author

### ABSTRACT

The aim of this study was to find out the impact of age, gender and therapeutic conditions on depression of adolescents. It was contended that variation in age, gender and therapeutic conditions would lay their impact on depression. Two hundred participants were tested under repeated measure condition and thus, the sample was framed under 400 observations. Findings were derived by analysis of variance and it was found that all independent variables laid their impact on depression independently and jointly. At last, implementation and indication of inner self integration therapy were discussed.

### Introduction

The image of adolescence as a time of storm and stress, intense moodiness, and preoccupation with the self has permeated both professional and lay perspectives on this developmental period. The belief that significant difficulties, including depression, during adolescence represent normal development has had two major effects on research and practice: **(a) Difficulties during adolescence were not considered as an important developmental variation, and (b) adolescent problems were often not treated because of the belief that the adolescent would grow out of them.** Although this view of adolescence is the one commonly reflected in the media and many professional descriptions of adolescence, it is not supported by research on this period **(Petersen, 1988a)**. In the late 1960s, there were reports showing that many adolescents traverse this period of life without significant psychological difficulties **(Douvan & Adelson, 1966; Offer, 1969)**. It is now known that the majority of adolescents of both genders successfully negotiate this developmental period without any major psychological or emotional disorder, develop a positive sense of personal identity, and manage to forge adaptive peer relationships at the same time they maintain close relationships with their families **(Powers, Hauser, & Kilner, 1989)**. Conversely, research in the 1970s focusing on those youth with problems demonstrated that psychological difficulties in adolescence frequently developed into serious psychiatric disorder in adulthood **(Rutter, Graham, Chadwick, & Yule, 1976; Weiner & DelGaudio, 1976)**. These and other studies demonstrated the inappropriateness of the belief that difficulties such as depression were normal manifestations of adolescence and pointed toward the need for assessment, diagnosis, prevention, and treatment at this age. These studies also highlighted the need for more research on the development of depression in adolescence.

Three approaches to the assessment and classification of adolescent psychopathology have been reflected in the literature on adolescent depression: **(a) depressed mood, (b) depressive syndromes, and (c) clinical depression.** Each approach reflects different assumptions about the nature of psychopathology, serves different purposes, and reflects a different level of depressive phenomena **(Angold, 1988; Cantwell & Baker, 1991; Compas, Ey, & Grant, 1992; Kazdin, 1988; Kovacs, 1989)**. For example, the study of depressed mood during adolescence has emerged from developmental research in which depressive emotions are studied along with other features of adolescent development. The depressive syndrome approach assumes that depression and other syndromes reflect the co-occurrence of behaviors and emotions as quantitative deviations from the norm. The clinical approach is based on assumptions of a disease or disorder model of psychopathology.

**Who Becomes Depressed in Adolescence?** There are no nationally representative epidemiological studies of depression in adolescents. As a result, little is known about the incidence of depression in various ethnic groups and social classes. At the same

time, there are increasing numbers of studies using the three approaches just described that provide some information on rates of depressive mood, syndromes, and disorders in some samples of adolescents. Depressed Mood Most of the studies conducted more recently assess what we have called depressed mood. The 30 studies we identified are based entirely on nonclinical samples. For example, **Achenbach (1991 a, 1991 b, 1991 c)** has reported the frequency of sad, unhappy, depressed mood based on a single item. On the basis of parents' reports, 10%-20% of nonreferred boys and 15%-20% of nonreferred girls experienced depressed mood in the previous six months on the basis of adolescents' self-reports, 20%-35% of boys and 25%-40% of girls experienced depressed mood. Although studies of depressed mood typically examine the phenomenon in relation to other problems or aspects of adolescent development, some investigators of depressed mood have identified a threshold above which a score is thought to be predictive of clinical depression. Using such scores, the median rate of depression in 14 studies was 35%, a much higher rate than that reported in studies examining clinical depression **(Kandel & Davies, 1982; Roberts et al., 1991)**. All but 3 of the 16 studies examining gender effects found differences, in all cases with girls reporting more depressed affect than boys. Of 10 studies examining age effects, most found no such effects; however, only 2 of these studies were actually longitudinal, following the same subjects over time. In two longitudinal studies, depressed affect decreased with age for boys but remained level across time for girls **(Block, 1991; Petersen, White and Stemmler, 1991)**. A different pattern of developmental change has also been reported: **Radloff (1991)** found dramatic increases in depressed moods between the ages of 13 and 15 years, a peak at approximately 17-18 years, and a subsequent decline to adult levels. This pattern has also been found with a measure of depressive episodes in which the midadolescence peak was higher for girls than for boys **(Petersen, White and Stemmler, 1991)**. Elevated rates of depressed mood in adolescence relative to adulthood have been reported in other studies as well **(Allgood-Merten, Lewinsohn and Hops, 1990; Larsson & Melin, 1990)**. Depressive Syndrome Research examining depressive syndromes has utilized a cutoff score corresponding to the 95th percentile in a nationally representative sample of adolescents to identify a clinical range **(Achenbach, 1991a, 1991b, 1991c)**. This score was identified as having the optimal power for discriminating between clinically referred and non referred samples with the lowest rates of false positives and false negatives. Thus, this approach to measuring depressive syndromes has established an empirically based rate of 5% of the normal population in the clinical range on a depressive syndrome at any given time. Clinical Depression Considering all published studies of clinical depression in adolescence **(Petersen, Compas and Brooks-Gunn, 1991)**, the percentage of adolescents receiving a diagnosis of depression varied from near zero in a large nonclinical sample of children aged from 10 to 11 years **(Rutter, Tizard and Whitmore, 1970)** to 57% in a clinical sample of children 8 to 13 years old **(Kovacs, Feinberg, CrouseNovak, Paulauskas, Pollack and Finkelstein, 1984)**.

Studies based on clinical samples naturally tended to yield higher depression rates (averaging 42%, median 48%, across six studies). Fourteen studies of nonclinical samples reported an average of 7% clinically depressed. These studies generally reported minimal information on the characteristics of the samples. Two studies of community samples provided examples of base rates of depressive disorders in the population, with **Kashani et al. (1987)** reporting 8% of the population with MDD and Rohde, **Lewinsohn, and Seeley (1991)** have reported approximately 3% of adolescents with MDD. Although there do not appear to be age variations in community samples within the adolescent decade, depressive diagnoses as well as depressed mood appear to increase dramatically in adolescence compared with childhood (**Fleming & Offord, 1990; Rutter, 1986**).

Preadolescent or adolescent onset of clinical depression is considered to be a serious risk factor for adult depression and perhaps other major mental disorders as well (**Harrington, Fudge, Rutter and Pickles, 1990; Kovacs, Feinberg, Crouse-Novak, Paulauskas and Finkelstein, 1984; Kovacs, Feinberg, Crouse-Novak, Paulauskas, Pollack and Finkelstein, 1984**). Variations by Gender, Ethnic Group, and Cohort All the evidence suggests that increases in depressive disorders and mood are greater for girls than for boys during adolescence (**Kandel & Davies, 1982; Kashani et al., 1987; Petersen, Kenned and Sullivan, 1991**). The gender difference that emerges by age 14-15 years appears to persist into adulthood. Many scholars have considered whether the gender difference is a true difference in depression or whether it can be explained by artifacts such as different styles of responding to questions and differences in openness. These examinations have concluded that the gender difference appears to be a true difference in the experience of depression (**Gove & Tudor, 1973; Nolen-Hoeksema, 1987; Nolen-Hoeksema, Girgus and Seligman, 1991; Weissman & Klerman, 1977**). Men and women may have different response styles in which men distract themselves, whereas women ruminate on their depressed mood and therefore amplify it (**Nolen Hoeksema, 1987**). Sex role socialization in early adolescence, related to the biological changes of puberty that heighten an identity with one's gender, is thought to produce the observed change in these gender differences by midadolescence. Another explanation for increased experience of depression among girls is that girls experience more challenges in early adolescence (**Petersen, Sarigiani and Kennedy, 1991**). For example, girls are more likely than boys to go through puberty before or during the transition to secondary school (**Petersen, Kennedy and Sullivan, 1991; Simmons & Blyth, 1987**). In addition, several studies have reported that parental divorce is more likely for girls than for boys in early adolescence (**Block, Block and Gjerde, 1986; Petersen, Sarigiani and Kennedy, 1991**). Both less effective coping styles and more challenges may increase the likelihood of depression among girls. Studies are needed that simultaneously test these and other hypotheses. Rates of depression and depressed mood may be higher among adolescents in some ethnic groups or other subgroups. For example, in a review of community studies of adolescent depression, **Fleming and Offord (1990)** reported that in two of five studies where race was examined, African-American adolescents had higher rates of depression and depressed mood than Whites. In a study of one of the largest multiethnic samples of adolescents, **Dornbusch, MontReynand, Ritter, Chen, and Steinberg (1991)** reported that Caucasian and Asian-American youth reported more depressive symptoms than African-American or Hispanic-American adolescents, even after controlling for levels of stressful life events. Given other findings (**Fitzpatrick et al., 1990**), it is probably wise to note **Hammen's (1991)** conclusion that there is no evidence for Black-White differences in depression among adults. Rates among Native-American adolescents appear to be elevated (**Beiser & Attneave, 1982; May, 1983**) high rates have been reported especially among Native Americans in boarding schools (**Kleinfeld & Bloom, 1977; Kursh, Bjork, Sindell and Nelle, 1966; Manson, Ackerson, Dick, Baron and Fleming, 1990**). Furthermore, adolescents living in rural areas may be at a greater risk for depression compared with those in

urban or suburban areas (**Sarigiani, Wilson, Petersen and Vicary, 1990; Petersen, 1991; Petersen, Bingham, Stemmler and Crockett, 1991**), although **Hammen (1991)** concluded that there are no urban city variations among adults. Gay and lesbian youth have a two- to threefold risk of suicide (**Gibson, 1989**), and they are probably at greater risk for depression. The National Institute of Mental Health Epidemiological Catchment Area studies have suggested historical increases in depression (**Weissman, Leaf, Holzer, Myers and Tischler, 1984**). Rates of depression have increased significantly since World War II (**Klerman, 1988**). These historical changes in rates of depression may have had an especially strong impact on the adolescent population. This was supported by a recent study by **Ryan et al., (1992)**, who found similar increases in depressive disorders in more recently born cohorts of pre pubertal siblings of depressive pro bands. Although it has been speculated that these increases were baby boom effects (**Klerman, 1988**), recent cohorts continue to show higher rates of most of these problems, suggesting that it is not simply due to a larger cohort of youth (**Gans, Blyth, Elsby and Gaveras, 1990**). In summary, although much more work is needed on the epidemiology of depression in adolescence, existing evidence suggests increased risk of depression in recent decades. Girls and other groups—such as Native Americans and homosexual youth—may have increased risk of depression, but too few studies have considered subgroup variations, with the exception of gender, to permit inferences about depression in subgroups of adolescents.

Keeping these views in consideration, this study was planned and it was aimed to :

- ascertain the impact of chronological age on depression. It was assumed that variation in chronological age would cause variation in the magnitude of depression
- find out the relative impact of gender on depression. It was assumed that variation in gender would cause variation in the magnitude of depression.
- to find out the difference between the scores of depression as affected by pre-therapeutic and post therapeutic conditions,. It was contended that magnitude of depression will be found reduced in post therapeutic conditions.

In order to check these objectives and hypothesis, this study was planned.

## Method

Two hundred participants ranging between 18 – 26 years, participated in this study. They hailed from New Delhi and Almora and the were arranged according to the requirement of 2 x 2 x 2 factorial design with repeated measure on the last factor. In this way two hundred observations were made under age and gender variables and 400 hundred observations were made under therapeutic conditions because every participant was tested twice. The participants were placed under the eight treatment conditions with two age groups (18–21 years) and (22–26 years), two gender (male and female) and two testing conditions (pre therapeutic condition and post therapeutic condition). The schematic presentation of experimental design is given in table 1.

**Table 1 Overview of the investigation**

	A			
	A1	B2	B1	B2
C1				
C2				

## Legends:

**A=Chronological age**

A1=18-21 years

A2=22-26 years

**B=Gender**

B1=Male

B2=Female

**C=Therapeutic conditions**

C1=Pre therapeutic condition

C2=Post therapeutic condition

**Measure of Depression:**  
 In order to trace the pattern of depression in participants Qarim & Tiwari's depression scale was used. This scale consists of 96 five point items. Low scores indicates low level of depression and high score vice versa. Split half reliability is .62.

**The age and therapeutic condition interaction was also significant**  
 $(F, 1, 399 = 5.78 P < .05)$  and it can be seen in figure 2.

Procedure :

At first, the investigators contacted the students of DU and Kumaun University and after making proper effort, they requested them to go through the depression scale. During the rapport it was found that the participants were feeling blocked (sometimes) so they decided to administer all stages of Inner Self Integration Therapy. After sometime, it was reported that the participants were feeling relaxed and they themselves desired to appear again and check the status of their depression. The investigators co-operated them and the participants were subjected again to depression scale. Indeed it was a time taking and sheer confidential process, so data collection was done individually and best attempts were made to avoid external distractions

Results

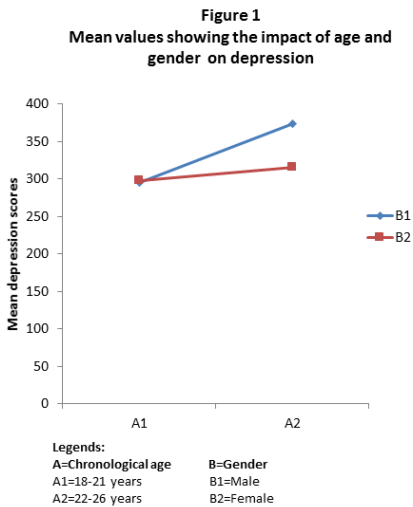
Obtained data were analyzed by three way anova and interpreted in terms of age, gender and therapeutic conditions of the affecters of depression. Findings are given in table 2.

Table 2 Summary table of analysis of variance showing the impact of age, gender and therapeutic conditions on depression

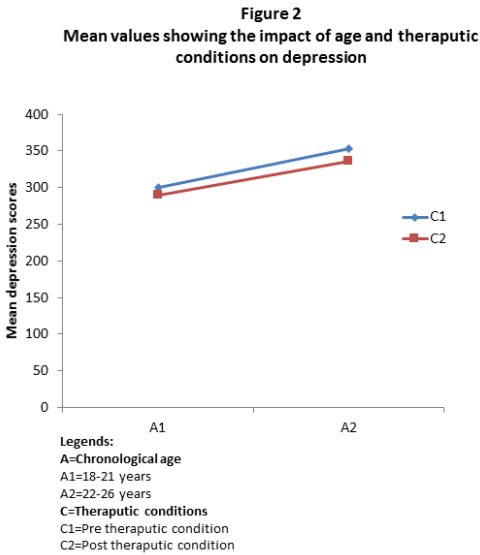
Sources of Variations	SS	df	MS	F
A	6.85	1	6.85	5.91
B	5.52	1	5.52	4.76
C	7.64	1	7.64	6.59
AB	7.74	1	7.74	6.68
AC	6.70	1	6.70	5.78
BC	6.61	1	6.61	5.70
ABC	6.02	1	6.02	5.19
Error	454.72	392	1.16	
( Within )		399		

Table 2 indicates that the first main effect of age was significant ( $F, 1, 199 = 5.91 P < .01$ ). It was noted that variation in chronological age caused variation in depression. The next main effect of gender was also significant ( $F, 1, 199 = 4.76 P < .05$ ) stating the fact that boys and girls found discrepant on their scores of depression. The third main effect of therapeutic condition was also significant ( $F, 1, 399 = 6.59 P < .01$ ) and it was resulted that the magnitude of depression under pre and post therapeutic condition was highly variant.

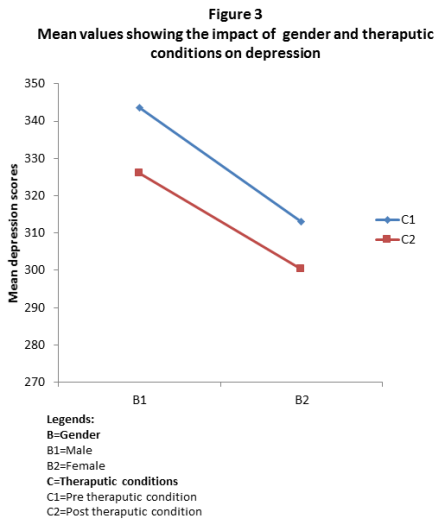
The age and gender interaction was significant ( $F, 1, 199 = 6.68 P < .01$ ) and it is depicted in figure 1.



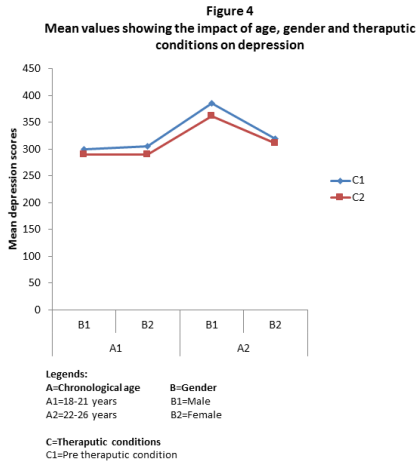
The age and therapeutic condition interaction was also significant ( $F, 1, 399 = 5.78 P < .05$ ) and it can be seen in figure 2.



The gender and therapeutic condition interaction was also significant ( $F, 1, 399 = 5.70 P < .01$ ) and it is clearly apparent in figure 3.



The three way interactions of age, gender and therapeutic condition was significant ( $F, 1, 399 = 5.19 P < .01$ ) and it is mentioned in figure 4.



The figure shows that all the variables have their impact on the magnitude of depression.

### Discussion

Data were analyzed by the three way Anova and interpreted in terms of age, gender and therapeutic conditions as effectors of depression. All main effects and interactions were significant and it was noted that depression was significantly affected by them.

Studies on depression have revealed that depressed individuals think that they get less impacted with the illusion of control as compared to the non-depressed individuals. The study done by **Alloy and Abramson (1979)** found that the depressed college students did not overestimate how much control they had over objectively uncontrollable events that occurred with high frequency or that were desirable and associated with success.

**Langer (1975), Golin, Terrell, and Johnson(1977)** studied that depressed college students didn't show an illusion of control in an objectively chance task in which elements typically associated with skill tasks had been introduced, whereas, non-depressed students did get impacted with this illusion of control. **Golin, Terrell, Weitz, and Drost(1979)** researched in the clinical setting and reported that similar to mildly depressed college students, more severely depressed inpatients who, in the main, were diagnosed as schizophrenics, showed a robust illusion of control. They found that depressed people are not as likely as non-depressed people to the illusion of control is consistent with theories of depression that portray the depressive as a person who believed that he or she is ineffective and powerless to obtain desired outcomes (**Abramson, Seligman and Teasdale, 1953 ; Lichtenberg, 1957; Melges & Bowlby, 1969; Seligman, 1975**).

Seligman divided his subjects into a depressed and non-depressed group on the basis of Beck Depression Inventory (**BDI; Beck et al., 1961**). A factor analysis of the BDI by **Weckowicz, Muir, and Cropley (1967)** identified three factors. **Klein and Seligman (1976)** founded that inventory "lumps affective, behavioural, cognitive and somatic symptoms together yield a single severity score. A scale of this sort doesn't map neatly into any of the distinctions proposed within depression". But the factor analysis conducted by **Weckowicz et al. (1967)** does indicate some parallels between their factors and the distinctions within depression that have been made. For instance they suggest that the Retardation factor may be measuring what is known as endogenous depression. A study done by Miller and Seligman (1973. 1976) suggests that if the BDI is to some extent measuring endogenous depression, it should not be used to classify the experimental subjects.

**Klein and Seligman (1976)**, proposed that his learned helplessness model may result in non-social change : "Certain depressives, displaying passivity, negative cognitive set, and other symptoms if learned helplessness, whose disorder began with loss of control over important events, might fully usually be classified as "helplessness depressives".

It is challenging to assess the rates of depression in college students because in some cases, when a student may be assessed as depressed due to presence of some symptoms of depression despite the clinical diagnostic criteria for depression are not present.

Richard Kadison, MD Chief Mental Health Services, Harvard quoted that "*Depression is probably the most common mental health problem that college students face these days.*" He said "*I think there is a general sense that we are seeing much sicker people in college now, we are hospitalizing more people and people are demanding more Allen live psychotherapysen lices.*"

When researchers assess some student as depressed only when the symptoms meet the diagnostic criteria for the disorders, there are two types of estimates – those representing depressive symptoms and others representing clinical depression. Mostly commonly used self- report measures (*Such as Beck Depression*

*Inventory*) do not cover all of the DSM depressive symptoms and do not produce clinical diagnosis. So researchers have to use spectrum of measurement techniques to assess college students for depression. There are so many other effectors like the risk level of depressed people their ideation about suicide, physical illness etc. They are given below:

**Risk factors in depression :** Depressed people are at high risks which can be negative and in some cases fatal. Depression is also linked to substance abuse. Few most severe consequence of depression is the risk of suicide. Other serious consequences include deterioration of health, indulgence in risky sexual behavior, negative performance in career. Depression also drastically impacts the quality of life, self-esteem and interpersonal relationships of the person.

**Suicide ideation:** 20 – 24 year olds who are depressed are at high risk of attempting suicide. Females have higher vulnerability to depression. As a result depressed females have greater risk for suicidal thoughts and attempts as compared to depressed males. On the contrast, depressed males are more likely to complete a suicide attempt. Depressed males at ages 20 – 24 are twice more likely to successfully commit suicide as depressed females of the same age.

**Physical illness:** Depression triggers impact on immunological function, which lowers the natural defense system of the body. As a result depressed people are more prone to getting physically ill. A study was conducted by medical students which found that people who had high levels of depression and very low coping skills report higher symptoms of physical illness. The study also revealed that symptoms in the research participants mainly included body pains, allergies, frequent colds, nausea, sleep problems and headaches. Also there have been researches that proved that if depression was intervened and prevented, ill health also got prevented. Another study was done on students who were identified as being at risk for depression. The study revealed that when these students were provided with therapeutic intervention designed to prevent depression, they experienced better health. It was found that there were fewer self-reported symptoms of illness, fewer doctor visits and fewer visits to student's health center. On the other hand those student who at risk of depression, but were not provided with therapeutic intervention designed to prevent depression, reported higher self-reported symptoms of illness, higher doctor visits and higher visits to students health center.

**Impact of gender:** Dealing with the significance of gender it is noted that, females are twice as likely as males to develop depression. Until puberty the difference in gender on the vulnerability to depression is not manifested until puberty. There is a gradual increase in vulnerability to depression among females between age 11 – 13 and by age of 15. Studies have suggested this two-to-one ratio of female to male depression. Studies have also found the reasons behind this greater risk of depression in females. A very common trigger for depression I females is sexual assault. As compared to males, females are more likely to be the victims of sexual assault. As a result there is an increase the risk of depression right at the onset following the event and also throughout the life span. A study found that 19 percent of females encounter childhood sexual assault. It was also found that even percent of males also encounter childhood sexual assault. Females are more likely than males to given drugs or alcohol before getting forced for unwanted sexual contact. Besides sexual abuse, females experience a lot more specific life stressors. Researches have revealed that females tend to have greater reactivity to stress as compared to males. This reactivity gets manifested in form of being less adaptive, or less effective coping and lower problem solving skills. Females are likelier to engage in avoidant coping and adopting a more pessimistic approach as a defense. Further such reactivity includes hopelessness, depression and increased ruminative thinking pattern, being inward-focused. Such behavior further aggravates the feelings of depression.

It was researched that females tend to indulge in self-blame when they are faced with negative life event. They perceive such events



as permanent and global, instead of resolving in the mind that they are transitory. With such a defense mechanism, the chances of depression getting triggered goes very high. Also in case of girls and young women, there are another set of pressures. They have a self-pressure and pressure from the society to project a feminine image. As a result they experience low self-esteem and decreased academic success and increased depression. Young women and girls are more likely than young males and boys to be dissatisfied with their body image and sense of attractiveness. This increases the risk for them to get into depression.

Findings in itself provide a clear impact of age, gender and therapeutic conditions. Better attempt are warranted to do something more for the enhancement of society.

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