EUROPEAN ACADEMIC RESEARCH
Vol. II, Issue 6/ September 2014

Impact Factor: 3.1 (UIF)
DRJI Value: 5.9 (B+)

ISSN 2286-4822
www.euacademic.org

Parenting Pattern Leads to Adolescents' Depression through Academic Load in Competitive and Regular Course Examinations

SANJAYA KUMAR
Dean-Academic & Nodal Officer
NIMS University, Rajasthan
India
ALKA KUMARI
M.Phil.(Education)
School of Education
Lovely Professional University, Punjab
India

Abstract:

Attributed to biological and hormonal changes, adolescence ensures psychosocial, behavioural, and sexual maturation. Adolescents' performance in academics specifically during preparation for senior secondary examination and competitive examinations is attributed to a significant number of factors that often jeopardize children, adolescents and youths world over. During this phase of life, students are in double bind—being challenged by variety of mental and physiological changes; and being pressurized by substantial amount of academic (disproportionate) loads/burdens due to preparation for senior secondary school examination and competitive examinations. Based on available researches conducted earlier (being cited later part of the article), it may be concluded that academic stress, anxiety disorder, suicidal ideation and planning, parenting style/pattern, lack of mother-child (healthy) interactions are commonly and frequently studied variables in relation to adolescents depressive disorder by researchers in India and abroad. Interestingly, reviewed literature (from 2001 through 2014) fails to reveal any systematic attempt in which depressive behavior is examined through academic performance across parenting styles/patterns of adolescents who are

preparing for competitive examinations. Though academic stress as one of the most frequently studied variables, without analyzing and examining academic load of competitive and regular examinations, it seldom possible to predict any sort of kinship between depression and academic stress— since preparation for senior secondary examination seeks subjective orientations on every concept of each subject undertaken for the studies; and competitive examinations, by and large demand objective orientations of some common subjects (aligned with school curricula) along with some extra papers (these are either subjects or courses/combination of subjects). Drawing experiences from literature (studies that are being cited later part of the article), researchers hypothesize "a significant kinship exists between parenting pattern and depressive disorders of adolescents who are taking up regular and competitive examinations"; which was verified through a study on 300 adolescents of Pathankot city of Punjab. Being designed with descriptive survey method, data were collected with the help of Beck Depression Inventory (BDI-II;1996) and Parenting Pattern Scale (Bharadwaj et.al.;1995); and collected data were further analyzed with the support of Pearson's Coefficients of Correlation. The study being documented by Lovely Professional University mentions prevalence of severe and moderate level of depressive disorder demonstrated by 10% and 30% of adolescents respectively. The result of the study established low negative relationship between parenting pattern and depression; and it is implicit that better parenting pattern, lesser is the depressive experiences, and poor parenting pattern leads to depression. Keeping association between parenting pattern/style and depressive disorder, the study recommended that parenting through family life education could help parents in nurturing mental health of adolescents during preparation for competitive examinations. Depressive disorder is pervasive and has become a critical challenge since adolescents and young adults (youth) population is projected to be highest by 2016-20, therefore scholars of this article advocated certain strategies that are believed to be having healing effects and it is concluded that unless policies are well practiced, not only depressive disorders but also other forms of mental disorders will continue to have their ill-effects on our society by raising individuals that cause national wastage, in terms of not being able to produce and seeking support and welfare measures that put unwanted burden on public funds and governance.

Key words: Parenting pattern, depression, academic performance, and competitive examinations.

Introduction

Widely researched by psychologists, sociologists and educationists; well perceived by educated (semi-educated and literate) population, frequently assessed by counselors, a catch phrase commonly used by teachers in secondary and senior secondary school classrooms, often underestimated and over estimated by parents, and above all adolescents and young adults get victimized by the phrase "depressive disorder", is the most common 'mental disorder' (APA, 2013) and is synonymous with 'mood disorder' (NIMH, 2014). World Health Organization (2001) reported its experiences on depression and stated that" depression is the most common psychiatric disorder and fourth major causes of disease worldwide." Depressive behavior is manifested in many forms at a later stage, but in the beginning(evolution stage) it is immediately caught in the eyes of parents, well wishers, friends, relatives etc, and a mood that appears always to be blended with "unhappiness" and persistently demonstrate a state of "sadness". Bare statistics on depressive disorder being noticed across literature being published by researchers in various states in India and countries beyond reveal that it is prevalent (globally) irrespective of state, gender, localities, family structure, parenting pattern/style, social, economic and educational status. It is worth submitting that there are two major reference points deemed crucial and needs to be discussed in order to widen the perspective that originates the present piece of research—if depressive disorder, mood disorder, disorderly in domestic, social and professional contexts is prevalent in almost all countries then (a) how happiness is ranked across countries; and (b) how countries are rated across Human Development

Indices (HDI)? The World Happiness Report (2013) revealed that "Denmark is the Happiest Country" of the world, Norway is rated next (to Denmark). But in terms of HDI, Norway tops the list in the category of "very high human development" while Denmark is ranked as 10(UNDP-HDR, 2014). It is evident that happiness may be one of the major prerequisites for human development but not the only criterion. A question that peeped through the ongoing discussion –is depressive disorder prevalent among Danish and Norwegian adolescents (?), and if so, then how do Norway and Denmark report on psychosocial correlates of depressive disorder? The study reported by Munk-Jorgensen et al. (2006) affirmed that "The age-standardized rates for generalized anxiety disorder ranged from 4.1 to 6.0 percent for males and from 3.7 to 7.1 percent for females; for major depressive episode the rates ranged from 7.2 to 11.5 percent for males and from 9.9 to 14.2 percent for females. Of the total percentage of cases of generalized anxiety disorder in general practice (4.8 percent for males and 6.0 percent for females), only one-third to one-half of the cases were identified by the general practitioners." Though inferences could not be drawn, however a study on Norwegian adolescents (12-14 years) reported by Sund, Larsson, and Wichstrom (2003) revealed that "Correlations between the total sum of stressful events/daily hassles and the total sum of MFQ (Mood and Feelings Questionnaire) were moderately high, rs=.49 and rs=.53, respectively. Depressive symptoms were more strongly correlated with school-related stress among boys than girls, whereas the correlation between daily hassles and depressive symptoms was higher for girls than boys." The introduction accentuated need for further deliberations in terms of comprehensive conceptual framework on the issue being designed for the purpose of present research.

Conceptual Framework

The present study has been designed to examine networked concepts that are relating to depression among adolescents in specific (including children and young adults in general) in agreement with their parenting pattern, academic performance, and competitive examinations. The Reuters Health published (on 15th April 2014 in its home page) an interesting finding (revealed through a research conducted by Dr. Garfield, a pediatrician and researcher at Northwestern University Feinberg School of Medicine in Chicago) recently published that " Becoming a father may rise a young man's risk of depression that affects about 5 to 10 of dads in U.S. It is clear that depressive disorders affect human development across all stages, and more so with adolescents. It is used interchangeably (synonymously) with mood or mental disorder. Diane (1996) cited Beck's Cognitive therapy on depressive behavior and concluded that "depressive disorder is explained in terms of deppressogenic thinking schema (triad) related to 'the self, the future, and the world'." Keeping the Beck's Cognitive theory in full view, it may be submitted that persistent negative rating on self, and continuous failure in achieving success concurrently, leads individuals to conclude at every moment that future is bleak, and so as self, whole world facing similar kinds of experiences. It may be accepted as valid for adult stage depressive feelings that either congenital or acquired (environmental) or often both, even though genetic and environment interaction research has always been inconclusive about it. It may be concluded that depressive disorders are universal (globally prevalent) affect all genders (male, female and transgender; though transgender are more vulnerable than female and female are more vulnerable than male—on the basis of deprivation and exclusion) across various stages of human development (early days deprivation is more sensitive than

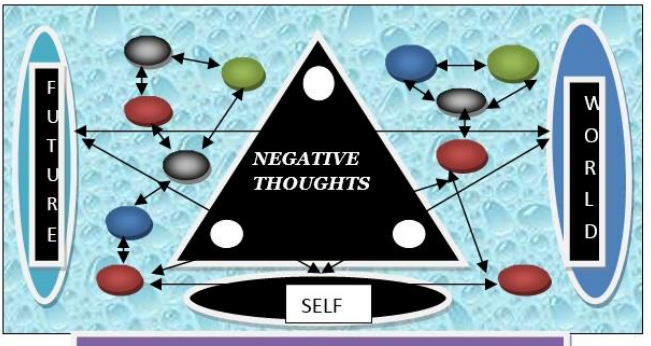
later days, children, adolescents, young adults, adults, and geriatric stage is more prone to depression); socio-economic status(severity of depression among above average and rich is high than below average and below poverty but the types of depression vary significantly); educational status(chances of more severity in depression among more educated than uneducated); and religious and linguistic minorities(minority has low voice to fight for religious justice).

It is more likely that adolescents may get depressed easily. Adolescence as a dramatic phase brings a number of crucial issues in the form of developmental characteristics. Each of such characteristics is peculiar and unique in nature leaving a long-term effect on personality. Biological transformations of puberty, educational transition from elementary to secondary school and psychological shifts that accompany the emergence of sexuality—are the potent issues that are often kept at bay from discussions on development and welfare of adolescents (Sanjaya Kumar and Prasamita, 2009). Adolescents' performance in academics specifically during preparation for competitive examinations is attributed to a significant number of factors that often jeopardize adolescents world over. Those who focus strategically gain and succeed in their academic life and those who fail become victims of psychological disorders and often become physically and neurologically challenged. No wonder that there is more than dozens of potent factors that adversely affect adolescents and seize their performance to take competitive examinations. Individual, parents and institutions are primary; while peers, neighbourhood or community are secondary fuelling factors for depressive disorders. Growth and development are significantly higher than other stages of human development—is a widely accepted fact by psychologists, pediatricians, geneticists and human development experts world over. What matters most for adolescents is the There exist a significant gap in parents' own understanding/perception of adolescents while dealing with

psychological issues of their wards; so as other associated factors responsible for children adolescents and young adults' depressive disorders. During adolescence through young adulthood, students find these days as quite important and meaningful for their entire life, reason being they search for pathways and determine a career that allows them to survive with self respect and dignity. This type of positive experiences are not encountered by all, and "all those who experience adolescence period positively have never been failed in their life"— a precision that has ever been verified by academe in India (after searching across literature over a period of more three decades). During this stage, all of them by and large adopt a peculiar mood that finds to be suitable and convenient for them but perceived as slight deviated from mean score on mood of similar age. The stage is so tender since emotionality reaches its highest stage thus inviting choosy thoughts (through day dreams tuned with peer and media influence) that are volatile since understanding, nurturing and channelizing positive (pleasurable) energy is not always every adolescent's cup of tea (i.e., not feasible for all groups of adolescents due to inter- and intra- individual differences). When mind is distracted illogically, level of concentration becomes poor, stubborn (not easily convinced) thoughts start appearing frequently, biological needs are not met adequately, some form of affiliation with attitudinal and behavioural problems is noticed on one hand, adolescents and young adults, on the hand, are too fast in information acquisition and information processing (pace of intelligence and cognitive abilities gets increased due to extension in thought process from concrete to abstract reasoning). Physical appearance gets changed, physical competencies get doubled, and sexual desires (sexuality) start growing and bodily changes become problem for some while some of them feel proud of their physique. Supporting this claim, Kim and Kim (2001) reported that "Body Mass Index (BMI) and perception a body weight problem as

potential predictor of level of self-esteem and depression in Korean female adolescents." Often tagged as the stage of "highest pleasure" by some while others prefer to tag as "highest pain", how so ever it is known by its name, presence of adolescence is absolute/true and quite natural as well as a normal phenomenon. Academic stress, anxiety disorder, manic-depressive disorders are some potent health related complications coupled with loss of interest, irritation, agitation, swinging moods, loss of appetite and sleeplessness are some of the critical symptoms that are demonstrated by adolescents those who take up two different types of examination pattern—regular Board/Council's examination(especially at Senior Secondary stage), and competitive examinations that believed to be highly critical for adolescents' life and livelihood. Since the concepts in majority of subjects at secondary/senior secondary stage of learning skills, learning second language as English in India, learning Hindi by students of southern part, learning Sanskrit by students of some state, subjective oriented preparation for senior secondary examination and objective oriented preparation for entrance and competitive examinations put tremendous pressures on a large section of adolescents that lead towards academic stress and after certain period of time academic stress gets transformed to depression. The NIMH (Washington, D.C; 2013) reveals bare facts on American children and adolescents that "About 11 percent of adolescents have depressive disorders by age 18 according to the National Comorbidity Survey-Adolescent Supplement (NCS-A). Girls are more likely than boys to experience depression. The risk for depression increases as a girl child grows older." According to the World Health Organization (WHO), major depressive disorder is the leading cause of disability among Americans age 15 to 44. Because normal behaviors vary from one childhood stage to another, it can be difficult to tell whether a child who shows changes in behavior is just going through a temporary "phase" or is suffering from depression."

It is believed that parents are always dearer and nearer to their children. Parenting style/pattern matters most during these days since individuals constantly search for self identity. Ego centrism makes them argumentative, rigid and develops aggressive, rivalry and bullying behavior. Parents (though in too small number of cases) become responsible for taking wrong decisions on career choice which cause adolescents for suicidal ideation. Authoritative and strict parenting style brings enormous influence on cognitive functioning, and emotionality since heightened, adolescents suffer mentally and emotionally. This invites undesired worries, and in order to come out of such chronic phobia, many adolescents become victims of drug abused, habitual smokers and alcoholic. Since many educated have no fair knowledge on adolescents, they fail to understand personal or emotional problems/setbacks of adolescents, and by the time they realize, they found it difficult. There is an inner voice of each and every adolescent, understanding such voice and taking up right measures could save millions from depressive disorders.



BECK'S COGNITIVE TRIAD – THEORETICAL MODEL

Since it is believed and practiced that "face is the index of individual's mental/physical health", mood-depression-mental disorders are initially reflected on face, and common behavior, and parents (teachers and friends) identify/notice such changes. Since parents are the nearest and dearest to all children

through youth to adult stage, parenting pattern matters a lot for mood/depressive/mental disorders across ages, in simple terms, parental love and affection has healing effects on children, adolescents, and often on adolescents. Therefore, parenting pattern as a critical variable for rearing and educating children is no more to be overruled. Because many of our children during this phase of period are highly guided by parents (girls get trained through their mothers and boys are hardly trained on any aspect excepting study and hobbies where they are supported by either father or mother), and due to our own understanding and perception about adolescent stage which is further guided across a number of moral, cultural and social ethics. Thereby parents are praised/ blamed for performance demonstrated by their wards. Does parenting pattern vary? Does this variation attributed to genders or educational status of parents or perception of parents about young children in general including their own wards? Questions bear no uniform response, it is not due to the individual differences rather a number of factors, and enlisting all such factors is cumbersome. Parents are authoritative and dominant while others are democratic and participatory; some parents demonstrate both authoritative and democratic attitude—no matter how good or poor is the parenting style, its influence in adolescents can ever be ruled out. More meaningful relationship is between parents adolescents; more compatible is the relationship between them at later stage of life.

Keeping above cited discussion in the backdrop, the present study precisely deals with four major concepts (that are considered as variables)—depression, parenting pattern, adolescents, academic performance in competitive examinations. These concepts are operationally defined as—

- Depression – It is the most common "psychiatric disorder and fourth major causes of disease worldwide" (World Health Organization; 2001) and is "the most common 'mental disorder' (APA, 2013) and is

synonymous with 'mood disorder' (NIMH, 2014). Diane (1996) cited Beck's Cognitive therapy on depressive behavior and concluded that "depressive disorder is explained in terms of deppressogenic thinking schema (triad) related to 'the self, the future, and the world'." "Depression is considered to be a disorder since it deals with mood/feelings, and it is considered as a disease since affects individuals psychologically, neurologically and physiologically." In the context of the present study, depressive behavior was examined against twenty-one constructs[as cited in the Beck Depression Inventory(II)1996], these include a set of symptoms of depressive behavior, such as, 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.

- Parenting pattern—It may be defined as "the method/process/style that parents adopt to ensure holistic development of individuals from infancy through adolescents to adulthood through informal and non-formal educational interventions relating to general behavior, social etiquette, family, social, ethical norms, study habits, learning styles, participation in hobbies, co-curricular and curricular activities, choosing career, getting married, and political participation etc." Parenting pattern highly depends upon level of social-economic—educational status of parents where it is the parental attitude and perception that matters most. "Parenting style captures two important elements of parenting: parental responsiveness and parental demandingness(Maccoby & Martin, 1983) . Parental

responsiveness(also referred to as parental warmth or supportiveness) refers to " the extent to which parents intentionally foster individuality, self-regulation, and self-assertion by being attuned, supportive, and acquiescent to children's special needs and demands"(Baumrind, 1991). Based on parenting style/pattern, Baumrind (1991) and Darling (1999) grouped parents into four major categories—indulgent, authoritarian, authoritative, and uninvolved. In the context of the present study, parenting pattern was scaled through Bharadwaj et al. (1995) across eight dimensions—rejection / acceptance, carelessness/protection, neglect/indulgence, Utopian expectations / realism, lenient standard /moralism, freedom/discipline, faulty role/ realistic role expectations, and marital conflict/marital adjustment.

- Adolescence— it is defined as "the period that appears between puberty to young adulthood stage." It is the most significant transitional stage between childhood to adulthood, and spans over a decade time (i.e. from 9/10 years to 18/19 years). In the context of present study adolescents are those who fall within the age bracket of 15 to 19 years.
- Academic performance in Competitive Examinations— It is defined as " the academic output or academic results of adolescents in examinations that are oriented towards certain vocations, such as, Union Public Service Commission(UPSC), Banking Service Recruitment Board(BSRB), Service Selection Board(SSB), Railway Recruitment Board(RRB), Staff Selection Commission(SSC), Lower Division Clerk, and National Defense Academy(NDA); and examinations that are oriented towards career through IIT/JEE, JET, CET, PMT, AIEEE, MAT, AIPMT etc.

Theoretical Framework

Scientific insights purported with theoretical framework facilitate communications in research, and therefore an attempt has been made to discuss theoretical propositions based on which literature related to the current psycho-somatic–social problems prevailing across countries have been reviewed. It is essential to examine how world academe conceptualizes depressive (mood and feelings) disorder, and it is found that clinical approaches adopted by medical scientists (Pediatrics psychiatrists, pediatricians, Clinical Psychologists, and Applied Psychologists) is the primary reference and key research resource which is later extended by evidenced/case based researches in the branch of Educational/Counseling Psychology, in industrial and corporate sectors in the form of Organizational Behaviour/Industrial psychology. Since clinical practices are away from the community, preventive & social medicine scientists tried with epidemiological studies on depressive behavior and supplied insights in terms of prevalence, nature, and type of depressive behavior. This systematic process of growth in knowledge on depression in general and adolescents' depression in particular have been governing our thoughts and actions (Prevention, Treatment, Care) and cases on depressive disorder (CDD) are treated at one parlance, despite of our knowledge on inter and intra individual differences; and prevailing discrepant views on Genetic-Environment Interaction, vis –a-vis variation in magnitude or severity. It is concluded that clinical approach by medical scientists have been employed to comprehend adolescents' depressive disorder because of which medical scientists never purport their findings with any theories since clinical approach deals with precision, logic and rationality. Since communication between scientific insights and social policies and welfare measures is inadequate (as evidenced by a fact "80% of total world population are inadequately (socially)

protected" (UNDP, 2014), world academia fails to have comprehensive knowledge on adolescents' depression due to lack of trans/multi disciplinary researches. Depressed psyche of Diasporas, being documented by great authors reveal that socio-cultural constructs are too significant that it attacks or affects depressed at post-therapeutic intervention (treatment) stage. Though pediatrics, clinical psychology, psychiatry, human physiology, neurologist, neuroscientists have brought out volumes of researches, there is still enough grounds are left to be unearthed, a network based research across disciplines could suffice every context to deal with depressive behavior. Hence, anthropological, social, and religious explanations are essential to describe and define adolescents' depression.

Etiology of psychosomatic disorders is connected to a number of theories. One of them is the somatic-weakness theory. "The somatic-weakness theory proposes that each person's body has genetically determined weak systems which break down when the person is under stress. The specific-attitudes theory proposes that particular childhood experiences arouse specific psychological conflicts and that the symptoms reflect these conflicts" (Herman and Lester, 1994). Disciplines other than medical science, are of immense importance at pre-treatment/care and post treatment/care stage of adolescents with depressive disorder include, anthropology, sociology, philosophy, cognitive psychology, human development, and educational sciences. Three major cognitive theories mainly govern knowledge on depression" (Lakdawalla, Hankin, and Mermelstein; 2007) –Beck's theory, Hopelessness theory, the Response Stylish theory. Lakdawalla et al. (ibid.), after verifying these theories across evidences on children and adolescents' depression, submitted that "the relative paucity of research on developmental applications of such theories reveals that surprisingly little is known about their hypothesized etiologic mechanisms in children and adolescents." Another popular approach that deals with depression by convergence of

cognitive and behavioural theories (in the form of Cognitive—Behavioural Therapy {CBT}) commonly practiced by clinical psychologists and pediatric psychiatrists. Learning and acquisition are primarily connected with cognitive functioning (which is purposefully governed by mind, brain, and neural network) thereby it falls within the category of cognitive psychology (one of the core branches of psychology within the main discipline of social sciences). Behaviour is defined as acts and actions, and actions are only generated by thoughts—the universal truth being verified on "law of attraction (a newly emerged Dynamic Network Theory on Human Survival and Sustainability across a dozen of major disciplines)". Behaviour is at the core of psychology, and knowledge on learning in the form of learning theories started growing from behaviorists' perspective (for example, Trial – Error/Pleasure – Pain theory of Edward L. Thorndike; Psychoanalytic Theory of Sigmund Freud). Both cognitive and behavioural theories are originated from core branch of psychology (studied under social sciences discipline), surprisingly when both theories are converged and blended with therapeutic interventions and started gaining popularity as Cognitive— Behavioural –Therapy (CBT), it became the part and parcel of psychiatric or clinical psychology that are classified under core medical sciences. Such disciplinary classifications are providing less comprehensive knowledge on depression, since a widened gap is prevailing between theories and practices. It is also true that more than a century old theories in psychology though has been governing cognitive functioning (thoughts and practices) based on which Medical Sciences and Counseling Psychology have devised many clinical and social interventions to treat with adolescents' depressive disorders, and practicing preventive and welfare measures. Despite of its own identity and stand-alone branch of knowledge within discipline of social science, and contributions directly in serving humanity in terms of "building self by breaking silence", "reintegrating with family members

and relatives", and "raising voice through a recognized community"—pediatric psychiatry practices dominate academe more than psychological insights and thereby a deterioration trend is noticed where old age controversies in psychology and psychiatry coupled with non-aligned thoughts between both branches of knowledge that holds back developments. In order to substantiate this claim, an article authored by Westaby, Pfaff, and Redding (who propounded Dynamic Network Theory, 2014) may be inferred, and it is worth cited that "Dynamic Network Theory (DNT)" –the theoretical perspective that explains "the way goal pursuit and resistant processes are influencing social networks. It is believed that the DNT theoretical perspective has immense influence (implications) on four major branches of psychology—Social Psychology, Industrial Psychology, Organizational Behavior and Counseling Psychology. Though psychology has theoretically described the power of 'goal striving and conflict mechanisms', recent developments being brought out in the field of sociology, organizational science, and information science are to be examined across social network frameworks. The field of psychology has also lagged behind in the study of social networks and performance." Equivocally, Duncan, Pollastri, and Smoller (2014) have pointed out that "there exist 'dandelion—orchid' effects that motivate (encourage) psychologist and geneticists to draw conclusions from different perspectives, a review on genome research concludes with a call for targeted collaboration, and prevailing discrepant views about Gene-Environment (Genetic-Environment) Interaction Research by Geneticists and Psychologists. These are to be converged (juxtaposed/interlinked) to draw optimum benefits to the case to come out from the grip of depressive disorder.

Though the Beck Depression Inventory (BDI) is popular and widely used tool for screening children and adolescents with depressive disorder, Beck's Cognitive Theory of Depression has been debatable (since its focus is on understanding

disorderly behavior)and it continued to be referred by scholars widely for depression as underlying dysfunctional beliefs. Beck argued through his theoretical constructs, "It is not true that depressive case/subject is having a negative view of oneself due to depression, rather depression is instituted by one's view of oneself. Another potent aspect of Beck's Cognitive theory on depression is "the Negative Cognitive Triad"— three pillars of negative thoughts on "the self, the world and the future." Despite of its limitations, Beck's Cognitive Theory of depression has become the first insight that referred by scholars drawn from various disciplines to gain comprehensive knowledge on depression; and the Beck Depression Inventory (BDI-II) and the Beck Cognitive Triad Inventory (CTI) have been best valid tools and have been employed by scientific communities.

Theories of human development influence significantly to understand how do adolescents grow across this stage of life and become successful adults(needs are fulfilled early and easily, become generous, critical in thinking and existentialism based thoughts and pragmatism based actions govern them they could do whatever they could think of, constructive and creative) and those who failed become victimized in the dynamic network frequent self evaluation/self esteem(in relation to performance of his/her age group in neighborhood, or class mates in school, often too critical and severe than adults), academic stress(both school and coaching), peer pressures, arousal of sexuality, acceptance and rejection motives, frequent manifestation ego, negative thoughts that overcrowd mind, sleeplessness, loss of appetite, leads to behavioural disorder that are accompanied with irritability, frustration, suicidal ideation, temper (emotionality)disorder/tantrum, withdrawal behavior, and as a consequence, a negligible form of emotional disturbance(which could be resolved with no cost and no effort) grow as a snowball embracing huge number of factors that make cognition dysfunctional. Theories on Human Development include biological, psychoanalytic, behavioral, and

cognitive developmental perspective. As rightly submitted by Salkind(2004) "primary theoretical models of human development including those from the biological, psychoanalytic, behavioral, and cognitive developmental perspective." It is implicit to cite here that these perspectives encompass a group of theories (family of theories) as mentioned in the book authored by Barbara and Philip (2007) that "Human Development theories that emphasize biological factors include Evolutionary theory, Psycho-sexual theory, and Cognitive Developmental theory. Theories that rely on environmental factors include Learning theories, Social Role theory, and Life Course theory. Theories that emphasize the interaction of person and environment include Psycho-social theory, Cognitive Social-Historical theory, and Dynamic Systems theory."

Jean Piaget coined cognitive development at par with adaptability (one's ability to adapt) which is further synonymous with intelligence. Assimilation and accommodation (as schema theorists, primarily David P. Ausubel, and Jerome S. Bruner) are two fundamental processes that help individuals to adapt to environment. Stages of cognitive development include sensorimotor, pre-operational, concrete operational, and formal operational. Cognitive development during sensorimotor stage is highly genetic factor based since child demonstrates inborn behavior, such as crying, smiling, and movement of limbs, etc. without external support and as precisely termed as maturation (developmental psychology). Cognitive development during pre-operational to formal operational stage is too critical because "acquisition" process starts through memory (children starts memorizing from 7 months onward) and "acquired behavior" is learned—"as learning or learned behavior essentially depends upon abilities to know, understand and retain [acquire or acquisition] "Learning to learn" is an essential prerequisite for four pillars of learning(Das ; 2014), and may be considered as first in the continuum and to be

followed with four pillars of learning as advocated by Delors Commission(UNESCO-1996), since learning to know is not transferred may be extended more towards beginning whereas meaningful learning depend upon "ability to do"(second pillars of learning as advocated by Delors Commission; ibid). Cognitive functioning (childhood through early adolescence) becomes logical in manipulating symbols related to abstract objects. During formal operational stage, thoughts become logical to use symbols related to abstract objects. This transition in cognitive functioning (manipulating symbols from concrete to abstract) is not smoothly accommodated by a large number of adolescents and young adults.

The above cited theoretical propositions relating to conceptual framework warranted evidenced based researches for optimization of external validity of the present piece of research.

Previous Research on Adolescents' Depression

Researches on depressive disorders of children, adolescents, and young adults(youth) are carried out vertically and horizontally encompassing all possible variables/factors that are tracked across various branches of knowledge—pediatrics to pediatric psychiatry, clinical psychology to cognitive psychology, medical sociology to social work, counseling psychology to neuroscience. Contributions are too large and so as variations among those (contributions), since psyche and physique both are equally important and interdependent, mood- feelings-behaviour are central in examining, assessing, comprehending depression in general. The findings/insights of pediatric psychologists have overwhelmed entire world in terms of devising/recommending assessment tools for screening/diagnosis of depressive disorder (by employing self-rated questionnaire/checklist for observation/interview schedule) that are designed mainly with two primary

constructs—"mental and physical wellbeing" and "homeostasis" of children, adolescents and young adults. In addition to this, pediatric psychiatry has successfully established treatment and care at post-treatment stage; thus enabling cases of mood-depression-mental disorders to track back to normalcy (normality) and re-channelize their competencies. Since scientific insights on depression are noticed across disciplines other than medical science, pediatric psychology may not be the only reference to bring comprehensiveness in depression related insights. It is in this context worth cited that sociological and environmental factors (outside of "self") account much more significantly towards mood-feelings-depression- mental disorder than cause of evils "within self". Sociology and social work, branches of knowledge within the discipline of "social sciences and humanities" purposefully examined depressive behavior in relation to environmental factors, such as, family, home, neighborhood, school and institutions at large. Sociological investigations further extended with anthropological explanations (using ethnography method and anthropometric assessment techniques) on depressive behavior, where cultural aspects are given utmost weight. Though anthropometric techniques highly reliable and valid; widely and frequently employed techniques by social scientists, environmentalists, educationists, and geneticists; disparities in views among researchers are noticed more than parities and continue to remain inconclusive. It is apparent that reviewing annals of research evidences and discourses on depressive behavior is cumbersome and could hardly be narrated within the context of present piece of research. Therefore, literature review was restricted to studies being reported or published over a period of twenty-five years (i.e. between 1990 and 2014). Studies that demonstrate abreast kinship with current research threads (parenting pattern through academic stress cause depression in adolescents and young adults) may be classified into three major categories— epidemiological studies, socio-psychological

correlates, and clinical pediatric psychology/ psychiatric/bio-medical intervention (therapeutic) based /counseling psychology based treatment and care. Studies that led researchers to adopt scientific approach in designing the present research in optimizing its external and internal validity include Vandana (2014); Jayanthi and Rajamanickam (2014); Arun et al.(2014); Ravidra et al.(2014); Shereen (2014); Fastralina et al.(2013); NIMH(2013); Sergio Barroilhet et al.(2012); Widuri and Nora(2012); Wendy(2012); Sund, Larsson and Wichstrom (2011), Salini(2007), Eley et al.(2004); Sund, Larson and Wichstrom (2003); Morrell and Murray(2003); Schumacher(2002), Hudson and Elek(2000). Studies of 90's witnessed similar approaches in examining adolescents' depressive behavior include Ingersoll; Lamarine; Cicchettic and Toth; Rice and Leffert, Fuller, Reynolds, Birmaher, White, Kendal.

Socio-psychological variables such as academic stress, anxiety disorder, low self esteem, examination phobia, peer influence, acceptance/rejection attitude/mental set, parenting pattern/style (including parent-child interaction, valuing and caring children, investment on education, inter-personal relationship, mentorship etc) are considered to be primary level determinants of adolescents' depressive behavior. Vandana(2014) reported that academic stress aggravates depressive bahviour of adolescents while peer group influence has no effects on it. Jayanthi and Rajamanickam (2014) concluded that "low self-esteem is a risk factor for depression since it fuels it among adolescents. Researchers suggested that adolescents with low self esteem are to be identified earlier and prompt interventions will prevent future psychiatric illness. Arun et al.(2014) reported that 29.9% had evidence of depression having cut off score> 13 in depression subscale of SCL 80 and most of students in depression syndrome group were found to be suffering from mild category 22.9% followed by moderate category 7%. Depression is found to

be associated with increasing age, low socio-economic status and urban students. Researchers concluded that strengthening of school health services though regular screening of adolescents for depression will provide impetus for detection, prevention and management of adolescent depression. Ravindra et al. (2014) examined depression in Professional and Non-professional students and reported that urban professional course students demonstrate high level of depression as compared to non-professional course students. Pessimism, fatigability and dejected or sadness were significantly correlated to gender, location and type of course compared to other areas of depression scale.

It is well researched that the depression which is primarily a peculiar state of mind that is exhibited through symptoms that are behavioural and physical too. "Temper tantrum, and bullying" may be classified as behavioural while abdominal pain, gastrointestinal disorders, menstrual disorders are related to health and physical illness. Abdominal pain, headache and insomnia are some of the critical health related issues that cause worriness in adolescents and their parents being explored by Fastralina, Simbolon, and Lubis(2013). It is worth mentioning that "yesterday's believe on depression was that it is never experienced by children and adolescents/teens with depression were often dismissed as being moody or difficult. But today, depression is causing heart disease, diabetes and other diseases" (NIMH, 2013). Suicidal behaviours and depressions are prevalent phenomena among adolescents, and are considered a public health problem. Sergio et al. (2012) determined the prevalence of depressive symptoms and suicidal behaviours and the relationship between both phenomena and reported that the lifetime prevalence of suicidal ideation and planning was 21 and 14% respectively. All levels of suicidal behavior were more frequently reported by women and clinically significant depressive symptoms were present in 23.5% of adolescents. Widuri and Nora (2012) studied the

relationship between mother and child communication with depression in adolescents and concluded a highly negative relationship between maternal communication and depressive behavior in adolescents. Yalcin Ozdemir(2012) examined the relationships between parental behavioural control, psychological control, self-esteem, life satisfaction, antisocial behaviours and depression among adolescents. Hierarchical regression analyses indicated that behavioural control positively predicted life satisfaction, self-esteem, and negatively predicted antisocial behaviours and depression. Psychological control was significantly and positively predicted antisocial behavior and depression, negatively predicted life satisfaction. Thombs, Roseman, and Kloda(2012) reported that depression is an important cause of disability among children and adolescents. Sund, Larsson and Wichstrom (2011) assessed current and lifetime prevalence and characteristics of adolescent Major Depressive Disorder(MDD) and Dysthymia and depression and double depression and reported that almost one in four subjects(23%) had life time depression. Prevalence of major depressive disorder (MDD), Dysthamia, Double Depression, and depression were found to be 2.6%, 1.0%, 0.6% and 6.3% respectively. Riitakerttu and Sari (2011) reviewed literature and spelt out that many studies have demonstrated a concurrent association between involvement in bullying and depression in adolescent population samples. Not only victims but also bullies display increased risk of depression, although not all studies have confirmed this for the bullies. Retrospective studies among studies among adults support the notion that victimization is followed by depression. Prospective follow-up studies have suggested both that victimization from bullying may be a risk factor for depression and that depression may predispose adolescents to bullying. Halvorsen et al.(2012) reported a mild and limited cognitive impairment during the course of a mild to moderate major depressive disorder among relatively young adults. Impaired processing speed should be

considered in further studies as a potential irreversible marker for recurrent depression. Brian et al. (2010) studied to determine whether a computerized battery of neuropsychological tests could detect neurocognitive difficulties in children and adolescents with depression. It was concluded that children and adolescents with depression have problems with reduced processing speed, memory for verbal information, and executive functioning on this computerized battery of tests, which represents a feasible method for neuropsychological screening.

Salimi Seyed-Hossein et al. (2007) assessed gender differences in depressive disorders among adolescents and confirmed significant gender differences favouring girl adolescents and researchers concluded that female adolescents are vulnerable to life stressors and tend to experience more negative feedback and interpretations than boys. Attari et al. (2006) explored that the incidence of depression is 0.9% in preschoolers, 1.9% in school age children, and 4.7% in adolescents. Eley et al.(2004) studied gene-environment interaction in adolescent depression and reported that environmental risk group was not a significant predictor while sex was found to be a significant predictor of the depression group. Sharonet al. (2003) explored neuropsychological functioning in patients with depression with reference to key clinical, etiological and genetic features. The differential relationships between clinical, etiological and genetic risks and neuropsychological performance support the presence of unique pathophysiological mechanisms in distinct subgroups of patients. These findings underscore the need to consider subtypes when investigating neuropsychological deficits in patients with depression. Schumacher (2002) cited that "depression may be one of the most overlooked and underestimated psychological disorders of adolescence. It is a 'syndromal disorder' that is more than just feeling sad, blue, or down in the dumps."

Ingersoll and Goldstein (1995) viewed that "during adolescence, complications of depression, such as, antisocial behavior may emerge, and depressed youngsters are likely to have increasing difficulty in school, possibly dropping out altogether. Many depressed teenagers also abuse drugs and alcohol. Finally, depression increases the risk of suicide, a leading cause of death among older adolescents. Depression in adolescents is more than just teenagers with "growing pains" or in a moody stage. The lifetime prevalence rate of major depression in adolescents has been estimated to range from 15% to 20%, which is comparable to the adult lifetime rate (Birmaher et al., 1996; Cicchetti and Toth, 1998). However Cicchetti and Toth(1998) reported that " the overall prevalence of depressive symptoms increases appreciably for both sexes at some point in early-to-middle adolescence, with girls manifesting significantly higher rates of symptoms. Adolescents with depression demonstrate a more variable course, exhibit more interpersonal difficulties, and more likely to over-eat and under-sleep, and more apt to demonstrate suicidal ideation (Lamarine, 1995). They may exhibit difficulties with academics, concentration, and peers; somatic complaints (e.g. headaches, stomachaches); nervousness; and substance abuse, rather than depressed mood (Rice & Leffert, 1997). Fuller (1992) suggested that adolescents exhibiting maladaptive behaviours, such as, hyperactivity, conduct disorders, or attention deficit disorders should be evaluated for depression. The diagnosis of depression with adolescents is based on adult diagnostic criteria (American Psychological Association, 1994). The depressive or mood disorders most seen with adolescents are Major Depressive Disorder (MDD) and Dysthymic disorders (Reynolds, 1992). Diane (1996) reported that depression varies differently for boys and girls from pre to late adolescence, and age effects appear to be different for boys and girls. Rates of depression for girls increased in a more stable way from pre to late adolescence. Results of Diane's study are consistent with

previous findings showing an increase in depressive symptoms from beginning to the end of adolescence (Rutter, 1986, 1991; Reynolds, 1992). Charles et a.(1992) determined whether different patterns of neuropsychological test performance would be present in depressed vs. non-depressed individuals infected by the Human Immunodeficiency Virus (HIV-1). The result suggested that the presence of clinically significant levels of depression in a non-elderly HIV-1 seropositive sample does not necessarily lead to significant neuropsychological dysfunction. Sackeim et al. (1992) examined patients with major depressive disorder manifest deficits in intelligence during affective episodes and following clinical improvement and concluded that a performance IQ deficit is characteristic of depressed patients regardless of affective state. Veiel(1997) presented a profile of neuropsychological deficits of clinically depressed (major depression) but otherwise unimpaired individuals. Based on a meta-analysis of all studies published since 1975 and meeting stringent methodological and sample selection criteria, researcher reported that both the severity and the profile of cognitive deficiencies in depression are postulated to be similar to those seen in moderately severe traumatic brain injury. Paul et al.(1992) found that 28.6% of the depressed patients were classified as Huntington's Disease patients (DEP-HD subjects), 49.0% were classified as normals (DEP-N subjects), *none* were classified as Alzheimer's disease patients, and 22.4% were not well-classified. The DEP-HD group closely resembled the HD group on additional indices of verbal learning and memory, and differed from the DEP-N group, which strongly resembled the normal control group.

It is concluded from reviewed studies (cited above) that very few studies are carried out on Indian adolescents which is corroborated with reviews reported by Ravindra, Lazar and Lalitha(2014). The number of studies goes down to be meager when depression is studied in relation to parenting pattern among adolescents who take competitive examinations (at

preparatory stage for their career) in Indian context. Keeping this fact in the backdrop, the precision "Parenting pattern leads to Adolescents' depression through performance in competitive examinations" was formulated to bring more clarity and comprehensibility in existing knowledge on adolescents' depressive behavior in the presence of parenting pattern during their preparatory stage.

Objectives

Keeping the above cited precision in view, the present study was carried out in order to fulfill the following objectives.

1. To examine the level of depression among adolescents who take up competitive examinations along with regular course of studies.
2. To determine the extent of relationship between parenting pattern and level of depression among adolescents who take up competitive examinations along with regular course of studies.

Hypotheses

Based on the above cited objectives, following hypotheses were formulated.

1. Adolescents who take up competitive examinations along with regular course of studies demonstrate depressive disorder.
2. Parenting pattern exhibit negative relationship with depression among adolescents who prepare for competitive examinations along with regular course of studies

Method and Procedure

Keeping the appropriateness and suitability, descriptive survey method was employed to collect data from 300 adolescents being selected through purpose sampling based on certain inclusive and exclusive criteria. In order to record scores on

depressive behavior, Beck Depression Inventory (BDI-II) developed by Aaron T. Beck, Robert A. Steer, and Gregory K. Brown (1996) was employed. Each of the twenty-one items (i.e. 21 dimensions) of BDI-II that corresponds to a symptom of depressive behavior is scored on a four points scale (ranging from 0 to 3) and summed up to have a cumulative depression score(total scores of 0-13, 14-19, 20-28, 29-63 is considered as minimal, mild, moderate and severe respectively). The test-retest reliability coefficient is 0.93($p<.001$) and the BDI-II is found to be having higher validity (i.e. 2.96 points higher mean score) than BDI-I. Parenting pattern was recorded with the help of Parenting pattern Scale developed by R.L. Bharadwaj, Harish Sharma, and Amita Garg (1995). Each of the 40 items (distributed across eight major dimensions) of the parenting pattern scale is scored with a five points scale (ranging from 1 to 5) and summed up to have cumulative parenting pattern score (minimum of 40 and maximum of 200). The test-retest reliability coefficient is 0.72 and coefficient of validity (parallel form) is 0.75. Karl Pearson's coefficient of correlation was computed to determine the extent of relationship between adolescents' depressive behavior and their parenting pattern.

Results and Conclusions

In order to examine the level of depressive behaviour, 300 sampled adolescents were categorized into four groups – minimal, mild, moderate and severe. It was found that 10%, 30.66%, 29.67% of adolescents demonstrate severe, moderate, mild depression level respectively while rest 29.67% were reported to be having minimal level of depression. It is apparent that maximum number (N=181) of selected adolescents were within the bracket of mild and moderate levels of depression while rest of them fall within severe (N=30) and minimal levels (N=89). It is concluded that variation in depressive behavior may be attributed to lack of competencies;

academic stress, unevenly distributed academic load, teachers' attitude/mental set, and parenting pattern.

The extent of relationship that parenting pattern establishes with adolescents depressive behavior could corroborate the above result. The correlation coefficient between both variables was found to be –0.1667 which indicate a negligible negative relationship. It is concluded that better is the parenting pattern, lower is adolescents' depressive behavior; and bitter is the parenting pattern, higher may be adolescents' depressive behavior.

Therefore, the precision "parenting pattern leads to adolescents' depression through performance in competitive examinations' was scientifically and rationally proven to be valid and it may further be interpreted that parenting pattern leads to depression through academic stress and load during adolescents' preparatory stage(preparing for a vocation/job through entrance examinations)when regular course of studies become fuelling factor.

Lacunae in Existing Research

1. Anxiety disorders and mood disorders are often equated with depressive disorder that invites a number of unwanted interventions by school authorities, teachers and parents.
2. In the absence of sound knowledge in psychometric assessment techniques vis-à-vis developmental psychology (especially developments during adolescents), many of teachers and educated parents get involved in debating upon adolescents' depressive behavior that leads to more misunderstanding than clarity.
3. Distinction between children and adolescents' behavior is seldom possible, puberty is the major reference for scholars and puberty alone may not be deemed scientific for examining adolescents' depression.

4. Studies are carried out on adolescents' behaviour having either one/two/three independent variable(s), and therefore not necessarily be explaining absolute relationship or dependency of depression with other independent variables.
5. A number of studies (in Indian context) have not employed any screening test prior to the administration of depression scale/inventory thus it could hardly be interpreted within the ambit of scientific communications that could serve the purpose of research.
6. Reviewed studies demonstrate similar trends and thus relying heavily on statistical measures that are deemed sufficient for testing corresponding hypotheses. Correlation coefficient results based (studies) are noticed as most frequently used statistical techniques followed with differential measurement based statistical techniques (that are either t-test, ANOVA or post hoc techniques). These statistical techniques are in practice in Indian context for decades; and researchers employ such statistical measures in all disciplines. Interestingly, India shines with city like Bengaluru and entire world is overwhelmed with mesmerized effects of ICT in every walk of life, Indian researchers fail to draw benefits from virtual world in terms of not employing higher (advanced) order statistics with the help of sophisticated soft wares.
7. Since depression disorder is psycho-somatic, adequacy in knowledge on psychometric assessment techniques are pre-requisites for making extensive research in this area. Physiological variables relating to depressive behavior is at the core in medical science research (pediatrics to geriatric) while medical scientists assess magnitude of physiological changes (illness) as resultant of psychological variables that are cognitive and related to mental health (psyche) of individuals. Interdisciplinary approaches are hardly noticed, i.e., these studies are carried out based on what physiological changes are clinically reported on the cases (patients) that are identified with support of standardized tools on depressive behavior (in

other words, medical [clinical] scientists carry out research based on physical changes and prone to corroborate physiological variables to depressive behavior dealing depression and physical changes separately). On the other hand, psychiatric (or pediatrics psychiatry) scientists rely heavily on clinical approaches in examining cognitive (mental/psyche) and behavioural change and corroborate such psychological variables with physiological problems (illness/disorder). In such cases, integration of assessment techniques of physiology and psychology are hardly found, thus create a cognitive level dissonance among academe, not only in India, rather across boundaries of nations across globe.

Keeping the above cited seven potent issues as the backdrop, it may be concluded that lacunae in assessing depressive disorders especially in children, adolescents and young adults (in the light of discrepant views within medical science) have led whole world understanding depressive behavior less and fuelling misunderstanding more on it.

Corrective Measures

It is true that every piece of research bears novelty in some way or the other, and the current research draws attention of budding researchers in medical, health, and social sciences. The present study is extended its usefulness in terms of helping parents, school psychologists, teachers, and teacher educators at large, and to be published in an issue of EAR in 2015.

1. Level of anxiety during adolescence (post puberty stage) is significantly higher and can hardly be explained as single most psychological cause of depressive behavior.
2. Mood change is not primarily a deviated behavior rather mood changes are frequent and autonomous (and generic in nature) during adolescence and thus cannot be equated with factors responsible for depressive behavior, if not through all

stages, especially during childhood, adolescence and young adulthood stage.

3. Parent (father/mother/both) child interactions, nuclear (single) v/s joint family environment, home environment, school/institutional environment, socio-economic status and literacy (and educational) level of parents and near family members, caste and religion based myths v/s egalitarianism, neighbour v/s community ecology are factors that may be tested(for their accountability for exerting joint influences on adolescents' depressive disorder) through higher order statistical measures (such as interactional analysis or factor analysis). Keeping all such social and psychological factors under one category, studies could be easily extended by including a number of physiological symptoms (that are chronic/continuous not essentially discrete) such as rapid abdominal pain (RAP), insomnia, so on and so forth.

4. Another sisterly branch of medical science, i.e., pharmacy/pharmaceutical insights and innovations have propagated magic effects of drugs/pharmaceutics either serotonin or any drugs that are highly catalytic in nature, and by and large, severely depressive disorder cases are benefitted to the highest level than moderate or mild level of depression during adolescence. Therefore, doctors succeed in healing patients and positively encourage them to track back to normal state through adequate self-evaluation/assessment techniques/strategies. Despite of their salutary effects (and instant noticeable effects), application of drugs in the cases ranging from border line through moderate depressed (adolescents) have always been discarded due to many possible reasons by many psychotherapeutic experts. One of such reasons may be attributed to the ADR (adverse drug reactions/ side effects) which is highly debatable among medical scientists and pharmacologists.

5. Many of the psychological tools don't satisfy all norms that are fundamental/essential from psychometric perspective to

understand/examine adolescents' depressive behaviour. Therefore, budding researchers should be guided to choose right kind of psychological tools that should qualify all norms of standardized tool.

6. Studies on depressive disorder remain widely inconclusive, because of scarcity of adequate knowledge on genetics, environment and their interactions. Discrepant views on depression exist across geneticists and social scientists, and these views critical for examining adolescents' depressive disorders.

Conclusion

Parenting pattern apparently is proven to be push factor for depression in adolescents and young adults, and velocity/magnitude of such push factor (i.e. parenting pattern) are doubled when adolescents take competitive along with regular course based examinations. Parents (in general), irrespective socio-economic-educational status, are to be educated towards understanding adolescents and critical aspects of this stage (in life) from human development perspective. Since all causative factors of depression is yet to be known to world academe, studying depression all the more has become a serious concern and especially for adolescents, but early identification/detection/diagnose could prevent physiological and neurological disorders (that occur at later stage and could be fatal), since a proverb that could convey messages to parents, teachers and counselors—"A stitch in time saves nine."

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Acknowledgement: Authors of this article hereby thank American Psychological Association (APA) and affirm that conceptual and theoretical framework of this article, by and large, is supported by insights of psychologists world over to understand global trends in psychological research. *The American Psychologist* (Vol. 69, No.2 & No.3); and *Monitor ON PSYCHOLOGY* (Vol 45, No 4) are key resources that raised confidence of present researchers.
