Role of Self-Esteem, Perceived Social Support and Coping Strategies in the Escalation of Depressive Symptoms among Young Adults

Submitted by

Ilamathi. K. S

(21PCP007)

Under the Guidance of

Ms. M. Benadict Savitha

A Thesis submitted to

Avinashilingam Institute for Home Science and Higher Education for Women

In Partial Fulfillment of the Requirements for the Degree of

Master of Science in Clinical Psychology

(2021-2023)

May 2023

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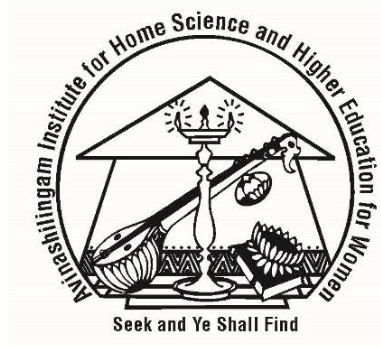

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Signature of the Head of the Department **Signature of the Guide**

CERTIFICATE

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This is to certify that the project work entitled "**Role of Self-Esteem, Perceived Social Support and Coping Strategies in the Escalation of Depressive Symptoms among Young Adults",** submitted to Department of Clinical Psychology, Avinashilingam Institute for Home Science and Higher Education for Women, Coimbatore, in the partial fulfilment of **Degree of Master of Science in Clinical Psychology**, is the record of the original project work done by **Ilamathi. K. S (21PCP007)** during the period of her study, under my supervision and guidance.

Signature of the Guide

Signature of the Head of the Department

Submitted for the viva voice examination held on ________________________________

Internal Examiner **External Examiner**

DECLARATION

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I hereby declare that this project work entitled "**Role of Self-Esteem, Perceived Social Support and Coping Strategies in the Escalation of Depressive Symptoms among Young Adults",** submitted to Department of Clinical Psychology, Avinashilingam Institute for Home Science and Higher Education for Women, Coimbatore, in partial fulfilment of **Degree of Master of Science in Clinical Psychology**, is the record of the original project work done by **Ilamathi. K. S (21PCP007)** during the period of her study, under the supervision and guidance of **Ms. M. Benadict Savitha, M.Sc., ADMP, CCGC, Assistant Professor,** Department of Clinical Psychology.

Place: Signature of the Candidate

Date:

Ilamathi. K. S

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ABSTRACT

Abstract

Early adulthood stage is a critical period for the development of mental health and well-being. During this stage, individuals face numerous challenges that can lead to stress, which in turn can escalate depressive symptoms. The present study explores the relationship between self-esteem, perceived social support, and coping strategies in the escalation of depressive symptoms among young adults. This research is a correlational quantitative research. The sample of this study was 200 with 100 females and 100 males. The study used simple random sampling technique. State Self-Esteem Scale by Heatherton and Polivy (1991), Multidimensional Scale of Perceived Social Support (MSPSS) by Zimet et al. (1990), Coping Scale by Hamby, Grych, and Banyard (2013), Center for Epidemiologic Studies Depression Scale Revised (CESD-R- 10) by Andresen et al. (1994) were used. The data was systematically analysed using Statistical Package for the Social Sciences (SPSS). The result shows that self-esteem, perceived social support, and coping strategies are negatively correlated to depressive symptoms. There is a significant gender difference in self-esteem and depressive symptoms. The findings suggest that low self-esteem, low perceived social support, and maladaptive coping strategies were significantly associated with higher levels of depressive symptoms.

Keywords: self-esteem, perceived social support, coping strategies, depressive symptoms

INTRODUCTION

Chapter – 1

Introduction

Early adulthood is the period in which individuals begin investigating and realizing the capabilities of their lives, which supports them characterize as adults now, not teenagers. Choices made during that period excessively shape a person's future life direction and mistakes made at that point have lifelong results (Mintz, 2015). The explorations of emerging adulthood too make it the age of uncertainty. For most youthful individuals in industrialized nations, the years from the late youngsters through the twenties are years of significant alter and significance. During this time, numerous youthful individuals get the level of instructions and training that will give the establishment their salaries and professional accomplishment for the update of their adult work lives (Chisholm & Hurrelmann, 1995).

Early adulthood is the age of conceivable outcomes, when numerous diverse prospects stay conceivable, and when little about a person‛s heading in life has been chosen for certain. Erikson (1950), who was the primary to create the thought of identity, proposed that it is primarily an issue in adolescence, but that was a long time prior i.e. more than 68 years ago, and nowadays it is basically in emerging adulthood that identity explorations take place (Cote, 2006). It tends to be an age of tall trusts and extraordinary desires, in portion because few of their dreams have been tried within the fires of genuine life.

Early adulthood is a very crucial period in a person‛s life. In the present scenario, emerging adults who are studying in colleges and universities lead stressful life. The environment overcharged with stress is affecting them. Emerging adulthood is the accomplishing stage where youthful grown-ups increment their issue-fathoming abilities, pick up life encounters, and get to investigate unused thoughts that are procured out of the home (Schaie & Willis, 2015). It can be a time of tall hazard for college and university students, where opportunities can result in choices that open upon close-off life openings.

Self-Esteem

Definition

Self-esteem refers to a person's overall sense of his or her value or worth. It can be considered a sort of measure of how much a person "values, approves of, appreciates, prizes, or likes him or herself" (Adler & Stewart, 2004).

Self-esteem is quite simply one's attitude toward oneself. He described it as a "favorable or unfavorable attitude toward the self" (Morris Rosenberg, 1965).

Types of Self-Esteem

- Low Self-esteem
- High Self-esteem
- Inflated Self-esteem

Low Self-Esteem. People who have low self-esteem, think of themselves as below average. They do not believe in themselves, they do not trust in their abilities and they do not place value on themselves. Low Self-esteem can affect a lot of things in one's life. Some of the effects of low Self-esteem are poor relationships, addiction, depression, and anxiety.

Poor relationships. Low Self-esteem causes poor relationships because of self-doubt and the belief that one is not good enough for anything of value and going to unbelievable lengths to please the wrong people.

Addiction. People with low self-esteem mostly tend to use hard drugs and substances to ease their negative feelings about themselves. They see the use of hard drugs or alcohol as an escape and thereby exposing themselves to detrimental effects.

Depression and Anxiety. Low Self-esteem also causes depression and anxiety which is the feeling of sadness and worry or fear. Low Self-esteem brings a lack of confidence, leading to anxiety and intense sadness.

High Self-Esteem. People who have high self-esteem tend to love and accept themselves. They believe in themselves and their abilities. They have the confidence that

whatever challenges might come, they will be able to surpass them. Some of the benefits of high Self-esteem include being able to be oneself without the fear of being judged, readiness to accept new challenges, not always searching for approval from other people, and readiness to learn new things as accepting that one does not know everything, and also take corrective criticism. People with high self-esteem have enhanced initiative and pleasant feelings and are more pleasant to be around.

Inflated Self-Esteem. People with inflated Self-esteem tend to think of themselves as better than other people and are always ready to underestimate others. This is a very negative type of Self-esteem because it prevents people who have it from forming meaningful and healthy relationships. They always want to be ahead and most times do not mind hurting people to achieve the success they desire, thinking that will bring them happiness. People with inflated Self-esteem cannot listen to others. Rather, they constantly blame others and undervalue them and also adopt a hostile attitude and behavior toward others. They are always ready to brag to hide their incompetence and they have a great fear of rejection and failure hence the reason they feel the need to camouflage. People like this can change but it has to start with them accepting it. They need to realize that they are humans who are prone to fail and make mistakes.

Maslow's Hierarchy of Needs

Self-esteem has long been considered a basic human need or motivation, according to previous studies. Two sorts of "esteem" were identified by American psychologist Abraham Maslow, including the need for others' respect (appreciation, achievement, and recognition) and a need for Self-esteem (self-love, self-confidence), among others. Because of this, individuals will be unable to develop and reach self-actualization if their need for Self-esteem is not addressed, as explained by Maslow. Maslow argues that "the one that shows in the respect we deserve and gets from others, more than praise, fame, and flattery, is the finest expression of Self-esteem."

Coopersmith's Theory of Self-Esteem

Coopersmith (1967) defined Self-esteem in terms of worthiness, that is, to what extent the individual believes himself to be capable, significant, successful, and worthy. He reported four major factors contributing to the development of Self-esteem. First, it is the amount of respectful, accepting, and concerned treatment that an individual receives from the significant others in his life. The second factor is the perspective history of success and the status and position he holds in the world. His successes generally bring him recognition and are thereby related to this status in the community. The third determinant of Self-esteem is aspirations. Experiences are interpreted and modified by the individuals' values and aspirations. The fourth factor is the individual's manner of responding to de-evaluation.

Based on two criteria, subjective and behavioral evaluations, Coopersmith (1967) has derived four types of Self-esteem, High-High, High-low, low-high and low-low. He found that by and large, there was a significant degree of congruence between the subjective evaluation of the self and the observer's rating of the subject's Self-esteem behavior on the behavior rating form. He found that the personality pattern of children in these four groups differ markedly. He reports: "The four groups were found to differ significantly in achievement, sociometric status, ideal self, and achievement motivation and represent distinct types of Self-esteem."

Coopersmith's theory reveals that one of his research goals was to explore and ascertain that certain family conditions help to promote high Self-esteem. For his research, he took over 1700 boys and their families as the sample and found that these boys' self- attitudes were formed either by how their parents or significant others saw them or by how they thought they were seen by parents and/or significant others (Borba, 1989). His study also revealed three critical elements common to the homes of subjects with high Self-esteem, namely- They come from a background where they experience the kind of love that expresses respect, concern, and acceptance. Their parents were significantly less permissive than were parents of children with lower self-esteem. There was evidence of a high degree of democracy in these families. The

children were encouraged to present their ideas and opinions for discussion, disregarding the deviation of these suggestions from parental thinking.

The constituents of Self-Esteem

Nathaniel Branden (1969) recognized three main constituents of Self-esteem. Firstly, Self-esteem plays a key role in survival and affects the overall development of an individual. Secondly, Self-esteem is an automatic outcome of an individual's belief and consciousness. Thirdly, it is closely related to an individual's thoughts, feelings, actions, and behavior.

Self-esteem develops at an early age in an individual. It consists of two types of feelings: One of the feelings is related to a sense of belonging that is deeply embedded in social experience. The other is the sense of mastery that is personal in nature and does not depend on social experience.

a) *Belonging* comes with the feeling that one is loved and valor one's true self and not for any particular reason. The feeling that comes from belonging is connected to a feeling of life security. This feeling brings a sense of security and the confidence that regardless of the situation around them they are always respected and valued.

b) The second feature of Self-esteem is a *sense that comes from mastery*. Mastery comprises one's belief that one is affecting his world positively – not essentially on a very big scale but in the daily activities of life. Mastery comes from the feeling that is derived when an individual is occupied with an activity or when there a person is struggling with an obstacle and his/her will or desire to overcome it (Gecas and Schwalle, 1993, Csikszentmihalyi, 1975).

Other components of Self-esteem include

1) Worthiness
2) Competence

They are important while growing up, and the relationship between Self-esteem and these components is studied.

Worthiness. It can simply be termed as what one thinks and feels about himself. It can also be said as 'self-respect'. Low Self-esteem caused by a low sense of competence can be enhanced by aiming at worthiness. Self-esteem can either be negative or positive deeds towards the self. An individual can think that he/she is a person of worth and respects himself/herself and simply feels for whom he/she is, and he/she does not expect any person to stand in awe of him/her nor does he/she stand in awe of himself/herself. He/she does not necessarily consider himself/herself superior to others (Rosenberg, 1979). Levels of Worthiness include:

a) Approval seeking. Approval seeking can be defined as gaining approval fromothers and having a sense of acceptance from one's social environment. This is dependent on the worth that comes with acceptance from others like a partner's idea of perfection, social or religious standards, meeting a pare,nt and living up to an external standard

b) Narcissistic. People with narcissistic personality disorder show a greatly overstated sense of their reputation, they are those people who want others to identify their special charisma or capabilities automatically, and they are those who respond harshly when someone queries their contributions or accomplishments. This level of worthiness can be termed as an overstated or over-inflated worthiness irrespective of reactivity to criticism and competence level.

Competence

William James (1890) defines Self-esteem as action, in specific, action that is competent or successful. It is an individual competence in some areas that matter. It determines whether failure (or success) in individuals has a direct correlation to one's self-esteem. Low Self-esteem relates to a perception of low self- worst self-worth an individual focus on his/her competence. Levels of competence include:

a) Success-seeking competence. It is based on achievement orientation. A collectivistic society pushes people toward the worthiness dimension. Similarly, an individualistic society pushes people towards competence. It starts when an individual focuses on his/her successes

and failures, and the anxiety and worthiness attached to them. Mostly the problem arises when things do not go as planned, as suggested by a study done by Crocker and Park (2004) on highly successful college students who find it difficult in securing highly ranked programs for graduation.

b) Anti-social competence. When one highly depends on his sense of competence, one's sense of worth becomes tightly tied to one's success. The exaggerated need for success or power leads to a sense of vulnerability to aggressively acting out. An example of such behavior includes businessmen who uncaringly destroy the career of others to move to the stand n top and individuals who deliberately, consistently, and consciously violate other people's rights to achieve their aim without considering the feeling of others.

Self-Esteem sources

According to Coopersmith (1967) who was one of the pioneers in the study of Self-esteem has covered that Self-esteem has four different sources:

a) *Virtue*: means obedience to moral standards

b) *Competence*: means completing the goal successfully

c) *Power*: The capability to control or influence others.

d) *Significance*: means being cherished by others as shown by their reception.

Also, Epstein (1979) pointed out four similar sources that are more dynamic which are
as follows:

Acceptance versus Rejection. All human beings desire a sense of acceptance from others in their social environment. It varies with age and affects our feelings and our relationship with our parents or caregivers, siblings, peers, spouse, etc. throughout our life. "Being valued" is the most significant feeling that is related to the sense of acceptance in a relationship. Acceptance can be regarded as a source of Self-esteem because it has a connection to worthiness which denotes others value an individual through various expressions such as

attention, respect, or even love. Similarly, the feeling of being rejected is a painful one. Rejection can have various modes such as being devalued, ignored, abandoned, used or mistreated, etc. Rejection can play a live role in the development and maintenance of Self-esteem.

Virtue versus Guilt. Virtue, according to Coopersmith (1967) implies adherence to moral and ethicalstandards, i.e., certain standards of behavior that determine how much respect an individual has for himself. Failure to meet up to the standards set personally or the standards of a particular group can be regarded as guilt.

Influence versus Powerlessness. Both Coopersmith (1967) and Epstein (1979) described influence as a person's abilityto direct one's environment or manage it. But influence is also described as a source of Self-esteem because the ability to relate with the immediate environment and with other people around us directly shapes our Self-esteem and the way people face challenges.

Achievement versus Failures. Both these terms are sources of an individual's self-esteem. Achievement is a source of Self-esteem because not just any success counts. For instance, successful people ina particular area generally have a problem with Self-esteem. For some individuals, the meaning of achievement can be different. For example, brushing their teeth for intellectually challenged or physically challenged people, or being recognized as a part of a group can be significant achievements. Failure can harm a person's self whenthey are not able to achieve their desired goal.

Factors influencing Self-Esteem

Age. Self-esteem grows during the period of transition and it continues to grow after this period, throughout different stages of development.

Gender. Compared with boys girls tend to be more susceptible to having Self-esteem. This is mainly because of the increased social pressure to emphasize appearance over intelligence or any other areas.

Socioeconomic status. Researchers state that during late adolescent years, adolescents in higher-income families have better self–esteem.

Body image. In the context of media images, the children are comparing themselves. The body weight. Height, complexion, and so on. Based on this they develop self–esteem (Patricia A.Van den Berg et al. 2010).

Hormonal changes experienced during teenage also affect Self-esteem. During puberty, they undergo major changes and their Self-esteem can often become fragile. It is said that teens who set goals in their life have a high level of self-esteem compared with those who don‘t. Social and family support is also directly related to Self-esteem, the support may increase the level of Self-esteem (Marmot, 2003).

Ways to Improve Self-Esteem

Some actions that can help self-esteem include:

- **Become more aware of negative thoughts.** Learn to identify the distorted thoughts that are impacting your self-worth.
- **Challenge negative thinking patterns.** When you find yourself engaging in negative thinking, try countering those thoughts with more realistic and positive ones.
- **Use positive self-talk.** Practice reciting positive affirmations to yourself.
- **Practice self-compassion.** Practice forgiving yourself for past mistakes and moving forward by accepting all parts of yourself.

Importance of Self-Esteem

Self-esteem impacts the decision-making process, relationships, emotional health, and overall well-being. It also influences motivation, as people with a healthy, positive view of themselves understand their potential and may feel inspired to take on new challenges. People with healthy Self-esteem have a firm understanding of their skills. They can maintain healthy relationships with others because they have a healthy relationship with themselves. They have realistic and appropriate expectations of themselves and their abilities. They understand their

needs and can express them. People with low self-esteem tend to feel less sure of their abilities and may doubt their decision-making process. They may not feel motivated to try novel things because they don't believe they're capable of reaching their goals. Those with low self-esteem may have issues with relationships and expressing their needs. They may also experience low levels of confidence and feel unlovable and unworthy. People with overly high Self-esteem may overestimate their skills and may feel entitled to succeed, even without the ability to back up their belief in themselves.

Coping Strategies

"Coping" has been defined by theorists as a "Measure taken to enhance the balance between an individual and his environment" (French & Rodgers, 1974) or as "Attempts to meet environment demand to prevent negative consequences" (Mechanic, 1968). The clearest definition among many is the one offered by Lazarus and Folkman (1984) who wrote that "Coping refers to constantly changing cognitive and behavioral efforts to manage specific external and or internal demands that are appraised as taxing or exceeding the resources of the person." This definition implies that coping may consist of several adjustments made either simultaneously or sequentially. It is restricted to instances of perceived stress. Based on his assessment, he will have to adopt appropriate coping behavior to get rid of the stressful situation. Thus stress reduction depends on the appropriateness of the choice of coping mechanisms adopted by the individual.

Coping is defined as the efforts that people make to manage situations that were appraised as potentially harmful or stressful (Caltabiano et.al.2002).

Coping Strategies are a conscious effort to solve a personal or interpersonal problem that will help in overcoming, minimizing, or tolerating stress or conflict (Giblin, 2015).

Coping strategies are defined as "conscious, rational ways for dealing with the anxieties of life" and are often categorized into active (or approach) and passive (or avoidance) strategies (Merry, 2015).

The coping mechanism in general, have been classified into set patterns for the use of research and clinical purpose. There are many patterns of classification of coping responses (Moos, 1982). Most approaches distinguish between the two:

1. Strategies are active in nature and oriented towards confronting the problem.

2. Strategies that entail an effort to reduce tension by avoiding direct dealing with the problems. Many authors in general have adopted similar classifications in various dimensions. (Pearlin et.al, 1978; Moos & Billings et.al, 1982).

Coping is expending conscious effort to solve personal and interpersonal problems, and seeking to master, minimize or tolerate stress or conflict. The effectiveness of the coping efforts depends on the type of stress and/or conflict, the particular individual, and the circumstances. The term coping generally refers to adaptive or constructive coping strategies, i.e. the strategies reduce stress levels. However, some coping strategies can be considered maladaptive, i.e. stress levels increase.

Coping refers to 'cognitive and behavioral efforts made to master, tolerate, or reduce external and internal demands and conflicts' (Folkman & Lazarus, 1980). There are many ways to categorize coping strategies. One of the most commonly used categories is active coping versus passive/avoidant coping (Carrico et al., 2006). Active coping efforts are aimed at facing a problem directly and determining possible viable solutions to reduce the effect of a given stressor. Meanwhile, passive/avoidant coping refers to behaviors that seek to escape the source of distress without confronting it (Folkman & Lazarus, 1984). Setting aside the nature of individual patients or specific external conditions, there have been consistent findings that the use of active coping strategies produces more favorable outcomes compared to passive coping strategies, such as less pain as well as depression, and better quality of life (Holmes & Stevenson, 1990). On the other hand, relying on passive/avoidant coping strategies is associated with increased depression and anxiety (Clement & Schonnesson, 1998).

Coping has two main functions: altering the troubled person-environment relationship (problem-focused coping) and regulating emotional distress (emotion-focused or cognitive coping). Both functions of coping are used by individuals in stressful situations. Coping refers to ‘cognitive and behavioral efforts made to master, tolerate, or reduce external and internal demands and conflicts’ (Folkman & Lazarus, 1980). There are many ways to categorize coping strategies. One of the most commonly used categories is active coping versus passive/avoidant coping (Carrico et al., 2006). Active coping efforts are aimed at facing a problem directly and determining possible viable solutions to reduce the effect of a given stressor. Meanwhile, passive/avoidant coping refers to behaviors that seek to escape the source of distress without confronting it (Folkman & Lazarus, 1984).

Theoretical Model of the Coping Process

Coping strategies refer to the specific efforts, both behavioral and psychological, that people employ to master, tolerate, reduce, or minimize stressful events. Two general coping strategies have been distinguished: problem-solving strategies are efforts to do something active to alleviate stressful circumstances, whereas emotion-focused coping strategies involve efforts to regulate the emotional consequences of stressful or potentially stressful events. Research indicates that people use both types of strategies to combat most stressful events (Folkman & Lazarus, 1984). The predominance of one type of strategy over another is determined, in part, by personal style (e.g., some people cope more actively than others) and also by the type of stressful event; for example, people typically employ problem-focused coping to deal with potential controllable problems such as work-related problems and family-related problems, whereas stressors perceived as less controllable, such as certain kinds of physical health problems, prompt more emotion-focused coping.

This model identifies stress as a transaction between individuals and their environment, where the individuals’ perception of the stressful situation is the mediating variable of how they can cope with it. Transactions that are perceived as stressful (i.e. harmful, threatening, or

challenging) require coping that will manage their level of distress (emotion-focused coping) or manage the problem that is causing their distress (problem-focused coping) (Lazarus & Folkman, 1984). Regardless of the chosen coping mechanism, there is an event outcome that is either favorable, unfavorable or there is no resolution. Event outcomes lead to positive or negative emotional responses. The Lazarus and Folkman (1984) model predicts that problem-focused coping will reduce the level of problems that could create stress and that emotion-focused coping will reduce the level of internal emotional distress.

Classification of Coping Strategies

The two main categories of coping strategies are emotion-focused coping and Problem-focused coping.

a) Problem-focused strategy

This strategy relies on using active ways to directly tackle the situation that caused the stress: that must concentrate on the problem. Here are some examples:

- Analyze the situation, e.g. Pay attention, avoid taking on more responsibility than manageable.
- Work harder, e.g. Stay up all night to study for an exam
- Apply what is already learned to daily life, e.g. losing the job for the second time - now know the steps to apply for a new job
- Talk to a person that has a direct impact on the situation,e.g. Talk directly to the boss to ask for an extension to the project that is due in one week.

b) Emotion-focused strategy

Emotion-focused coping strategies are used to handle feelings of distress, rather than the actual problem situation. They focus on the emotions:

- Brood, e.g. accepting new tasks instead of saying –no, but keep complaining and saying it is unfair.
- Imagine/Magic thinking, e.g. dreaming about a better financial situation.

- Avoid/Deny, e.g. avoid everything related to this situation or take drugs and/or alcohol to escape from this situation.
- Blame, e.g. blame oneself or others for the situation.
- Social support, e.g. talk to a best friend about the concerns.

Weiten (1998), identifies three broad types of coping strategies.

1. Appraisal Focused (Directed towards challenging one‘s assumptions, adapting cognitive).
2. Problem Focused (Directed towards reducing a stressor, adaptive behavioral).
3. Emotion Focused (Directed towards changing one‘s emotional reactions).

Appraisal-Focused Coping Strategy. Appraisal Focused Strategy occurs when the person modifies the way they think. For example:- Employing denial or distancing oneself from the problem. People may alter the way they think about a problem by altering their goals and values, such as by seeing the humor in a situation. ―Some have suggested that humor may play a greater role as a stress moderator among women than men‖. On the other hand, appraisal-focused strategies are appropriate when there is no straightforward solution to a problem.

Problem-Focused Coping Strategy. People using problem-focused strategies try to deal with the cause of their problems. They do this by finding out information on the problem and learning new skills to manage the problem. On the other hand, problem-focused coping strategies are simply solution-oriented approaches to dealing with a situation that causes stress. Problem-focused coping is aimed at changing or eliminating the source of stress. The three problem-focused coping strategies identified by Folkman and Lazarus are:

- Taking control
- Information seeking
- Evaluating the pros and cons

Emotions-Focused Coping Strategy. Emotion-focused coping strategies involve releasing pent-up emotions, distracting oneself, managing hostile feelings, meditating, or using

systematic relaxation procedures. Emotion-focused coping –Is oriented toward managing the emotions that accompany the perception of stress. The five Emotion-focused coping strategies identified by Folkman & Lazarus (1984) are:

- Escape
- Accepting responsibility or blame
- Self-control
- Avoidance
- Positive reappraisal

Other forms of coping strategies

1. Positive Techniques (Adaptive or Constructive Coping)
2. Negative Technique (Maladaptive Coping or non-coping)

Positive Techniques. One positive coping strategy, anticipating a problem is known as proactive coping. Anticipation is when one reduces the stress of some difficult challenge by anticipating what it will be like and preparing for how one is going to cope with it. Two others are social coping, such as seeking social support from others, and meaning-focused coping, in which the person concentrates on deriving meaning from the stressful experience. Yet another way of coping is avoiding thoughts or circumstances that cause stress. One of the most positive methods people use to cope with painful situations is humor. They feel things to the full but master them by turning them all into pleasure and fun.

Negative Techniques. While adaptive coping methods improve functioning, maladaptive, coping techniques will just reduce symptoms while maintaining strategies including dissociation, safety behavior, etc. These coping strategies interfere with the person‘s ability to unlearn or break apart, the paired association between the situation and the associated anxiety symptoms. These are maladaptive strategies as they serve to maintain the disorder.

Perceived Social Support

Perceived social support refers to how individuals perceive friends, family members, and others as sources available to provide material, psychological, and overall support during times of need. Perceived social support has been consistently related to well-being, as the perceived levels of support, love, and care can provide positive experiences (e.g., Siedlecki et al., 2014). A review suggested that high perceived social support is related to better physical and mental health outcomes as well (Uchino et al., 2013).

Perceived social support states the understanding of which people from one's social circle are accessible to provide social support (Demaray & Malecki, 2002). For this study, three dimensions of perceived social support are explored such as support from family, support from friends, and support from special persons (Significant others). Social support is the physical and emotional comfort given to all by family, friends, co-workers, and others. Maintaining a healthy social support network is hard work and something that requires ongoing effort over time. Social support is the belief and reality that one is cared for, has help to be had from different persons, and is part of a supportive social group.

Two foremost models were proposed to describe the link between social support and health the buffering assumption and the direct outcomes assumption (Wills 1991). Gender and cultural differences in social support have additionally been observed. Social support systems are a vital part of our life. Those systems consist of all people consider and can go to for help, recommendation, or some other sort of emotional help. Social support systems may be made from friends and family contributors people they support each have their social support systems which can include, their direct assistance professional, family members, friends, healthcare providers, co-workers, Social workers, teachers, regional center staff, all of whom they trust.

Types of Social Support

Companionship Support. Companionship support is the type of support that gives someone a sense of social belonging. This can be seen as the presence of companions to engage in shared social activities (Uchino, 2004).

Emotional Support. Emotional support is the offering of empathy, concern affection, love, trust, acceptance, intimacy, encouragement, or caring. It is the warmth and nurturance provided by sources of social support. Providing emotional support can let the individual know that he or she is valued. It is also referred to as "esteem support" (Wills, T.A., 1991, Taylor, S. E., 2011, & Slevin, 1996).

Perceived and Received Support. Perceived support refers to a recipient's subjective judgment that providers will offer (or have offered) effective help during times of need. Received support refers to specific supportive actions (e.g., advice or reassurance) offered by providers during times of need (Gurung, 2006).

Structural Support. Structural support refers to the extent to which a recipient is connected within a social network, like the number of social ties or how integrated a person is within his or her social network. Family relationships, friends, and membership in clubs and organizations contribute to social integration. Functional support looks at the specific functions that members of this social network can provide, such as tangible, emotional, and informational support (Barrera, 1986).

Tangible Support. Tangible support is the support of material support, such as financial assistance, goods, and services like the gift of food that often arrives after the death of a family. Also called instrumental support, this form of social support encompasses the concrete, direct ways people assist others (Langford, Bowsher, Maloney, and Lillis, 1997).

Informational Support. Informational support is the provision of advice, guidance, suggestions, or useful information to someone. This type of information has the potential to help others for solving the problem (Krause, 1986 & Tildenand Weinert, 1987).

Social support has been shown to improve mental health and act as a shield against stressful life events (Dollete and Phillips, 2004). Social support is provided through the association of people from Social family, friends, and the community (Awang, Kutty, and Ahmad, 2014, Zimet, Dahlem, Zimet, and Farley, 1988). A study of 115 university students showed that students had less stress with higher social support and were well-adapted to the university (Friedlander, Reid, Shupak, and Cribbie, 2007). Similarly, the impact of academic stress, defined as frustration, conflict, pressure, change, and Self-esteem on mental well-being, was found to depend on the level of social support perceived by friends (Glozah, 2013). The study by (Awang et al., 2014) showed that social support from family and friends has a significant impact on the emotional, social, and academic performance of university students. In this phase of youth development, however, friends become more and more important as a source of social support compared to the family (Kugbey, 2015), as the focus shifts from parents to peers when the child wants to leave the family.

Lack of social support is a determinant of mental health problems, including depressive symptoms in students the university (Bukhari and Afzal, 2017, Safree and Dzulkifli, 2010) and harms the quality of life of students (Dafaalla et al., 2016). Research data indicate a significant negative relationship between social support and mental health, including depression and stress (Alimoradi, Asadi, Asadbeigy, and Asadniya, 2014, Bukhari and Afzal, 2017, Kugbey, 2015). The consistent results of these cross-sectional studies have highlighted the important role of social support for student wellbeing.

Theories of Social Support

Relational regulation theory (RRT). RRT elucidates the important relationship between mental health and feelings of support. Perceived support, as previously stated, functions as a buffer and has a direct influence on psychological wellness. RRT was proposed to account for the immediate effects of perceived support on mental wellness that cannot be explained by the stress and coping hypothesis. According to RRT, individuals control their

emotions via everyday interactions and shared activities rather than through stress-management sessions, which explains the association between felt support and psychological wellness. This regulation is relational in nature, since the support providers, discussion subjects, and activities that assist in emotion control are mostly subjective. Earlier research has shown that the majority of perceived assistance is relational.

Life-span theory. The life-span theory delves into the connection between social support and health, emphasizing the contrast between perceived and actual support. According to this theory, social support develops throughout life, most notably during childhood as a consequence of parental attachment. Social support develops along with the development of adaptive personality characteristics such as low aggressiveness, low neuroticism, high optimism, and social coping ability. Support and other personality qualities ("psychological theories") have a substantial influence on health, particularly through promoting healthy behaviors (e.g., exercise and weight management) and mitigating health-related stress. The fact that a part of perceived support is trait-like and that perceived support is connected with adaptive personality characteristics and attachment experiences provides evidence for the life-span theory.

Social Support and Relationship with Depressive Symptoms

Perceived social support and connectedness are stronger predictors of decreased depression in young adults than gender, Self-esteem, and sleep quality (Armstrong and Oomen-Early, 2009). Numerous studies have been concerned with the role of perceived social support from parents, peers, and the school in the reduction of depressive symptomatology in children and adolescents (e.g., Rawana, 2013).

Additionally, theoretical efforts have been made as well to understand the relationship between social support and depression. Based on the stress-mobilizing hypothesis, stress encourages individuals to seek social support (Singh and Dubey, 2015). However, one should note the high correlation between stress and psychological distress and especially the high

comorbidity between stress and depression. This high comorbidity may explain a spurious positive relationship between depression and perceived social support (Starr et al., 2014).

The psychological pathways that mediate the association between perceived social support and mental health outcomes need to be further investigated (Uchino et al., 2013). This evidence is necessary for the effort to theoretically understand the functions of perceived social support and to inform appropriate areas for interventions that could limit the negative effects of low social support on mental health. One important parameter involved in the relationship between social support and mental health is Self-esteem.

Perceived Social Support and Self-Esteem

According to the social-cognitive perspective, perceived social support promotes Self-esteem, which subsequently leads to positive mental health outcomes (Lakey and Cohen, 2000). Perceived social support is suggested to be associated with positive thoughts about self; hence the direct and indirect impact on mental health outcomes through Self-esteem. However, the way young adults think about social ties and support may activate different self-evaluations. For example, some may interpret social support as an indicator of their social acceptance and may activate positive self-schemas (e.g., a lovable person). On the other hand, others may interpret social support as an indicator of negative qualities (e.g., a weak person). Social support may trigger conflict and comparison with others, in cases where negative self-evaluations are produced after receiving social support. For instance, evidence suggests that perceived social support may carry a Self-esteem-threatening message at times, as receiving high social support may be interpreted as a sign of low coping ability, which in turn might increase distress (Choenarom et al., 2005). A more recent theoretical perspective suggests that providers of social support help the recipient through the regulation of affect, thought, and action and that people who produce favorable effects and higher Self-esteem to the recipients of their support are more likely to be perceived as supportive (Lakey and Rhodes, 2015).

Depression

Meaning and Definitions of Depression

Depression is a psychological problem that affects the feelings, thoughts, and actions of an individual. Depression is marked by sadness and a lack of interest in all day-to-day activities. It can lead to a variety of emotional and physical problems, as well as decrease the ability to work.

Depression is also called Major depressive disorder, it's a mood disorder, the common symptoms of depression are feeling sad, low mood, lack of interest, decreased appetite, sleep disturbances, and so on. Almost everyone will experience depression to an extent at some point of time in their lives. It's a common response to loss in life, in the long run, it will harm one's life, if the sadness lasts for many days or weeks, hampering one's life.

"Depression" is more than just sadness. People with depression may experience a lack of interest and pleasure in daily activities, significant weight loss or gain, insomnia or excessive sleeping, lack of energy, inability to concentrate, feelings of worthlessness or excessive guilt, and recurrent thoughts of death or suicide. (APA, 2016).

Depression is a common mental disorder, characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness, and poor concentration. Depression can be long-lasting or recurrent, substantially impairing an individual‘s ability to function at work or school or cope with daily life. At its most severe, depression can lead to suicide. When mild, people can be treated without medicines but when depression is moderate or severe they may need medication and professional talking treatments. (WHO, 2015).

Types of Depression

Mild depression. Mild depression usually causes detectable symptoms and impacts our daily activities. They are less interested in doing things they previously enjoyed, unusual

irritability, and reduced motivation in work, home or social activities are common however they continue to function – just perhaps not as well as they normally would do when healthy.

Mild depression often goes undiagnosed because the symptoms are not considered to be ‘bad enough’ for people to think they may have depression and discuss it with their doctors or other people. However accurately diagnosing depression when it is mild, and treating it effectively at this stage can prevent the condition from worsening to become moderate or severe.

There are also more treatment options available for mild depression. Lifestyle changes such as regular exercise, relaxation, ensuring sufficient and regular sleep, etc. are often sufficient. Natural therapies such as St John’s Wart may also be effective treatments for depression if it is diagnosed early – when ‘mild’.

Moderate depression. Moderate depression can cause real difficulties with social, work, and domestic activities. Reduced interest in normally pleasurable activities becomes no interest – a real lack of interest and motivation. Simple things start to require real effort or just get neglected.

With moderate depression, there is usually a detectable reduction in self-confidence and/or self-esteem which can have a ‘snowball’ effect as they become less motivated and hence less productive. Often they start to worry about things unnecessarily such as performance at work, even if they are managing to maintain our previous standards, or more sensitive to feeling hurt or offended within personal relationships, sometimes they feel suicidal thoughts.

Again, there are more treatment options available and the time it will take to recover from moderate depression will be less than if it is left untreated and develops into major depression. Cognitive Behavioral Therapy (CBT) along with Progressive Muscular Relaxation Technique (PMRT) can be very effective and Self - Management Training may still be helpful. This only allows the illness to worsen as it is not being effectively treated. Lifestyle

improvements always have a positive impact, however, can take more effort to do as the depression becomes more severe.

Severe depression. Severe or Major depression causes considerable distress or agitation, loss of self-esteem, or feelings of uselessness and guilt. Severe (or Major) depression usually causes severe enough symptoms for a change to be noticeable by those around us even if they try to mask how they are feeling. People with severe depressive episodes may also suffer from delusions, hallucinations, or depressive stupor although these are less common. Suicidal ideation with suicidal attempts is also present in Severe depression. While they may be managing one moment, they can plummet very quickly into feelings of hopelessness and despair. It is common for people to feel that they are somehow responsible and 'to blame' for the way they are feeling and believe that others are better off without them. It is vital that professional help and treatment are sought as soon as possible and that treatment is adhered to.
APA Dictionary (2013) stated that a negative affective state interferes with daily life and ranges from unhappiness and dissatisfaction to intense sadness, pessimism, and despondency. Changes in eating and sleeping habits, a lack of energy or drive, difficulty concentrating or making decisions, and withdrawal from social activities are all common co-occurring symptoms. It might be a sign of a variety of mental health issues.

National Institute of Mental Health, (2011), reported that depression is characterized by a sense of sadness or melancholy. These feelings, however, usually only endure a short time. Depression has an impact on a person's day-to-day activities. It's a common yet serious illness.

Major Depressive Disorder (MDD), is a mental disorder defined by insistently low mood lasting for at least two weeks that affects one's thoughts, feelings, and behaviors. Low Self-esteem, a loss of interest in ordinarily pleasurable activities, a lack of energy, and pain with no obvious reason are all prevalent symptoms. Anxiety symptoms are frequently associated with depression. These issues can become chronic or recurrent, causing significant limitations in a person's capacity to manage his or her daily tasks.

Depression is one of several psychological issues that have plagued humanity since the dawn of time. It has long been regarded as the most serious mental health issue. It has been linked to the majority of suicides as a contributing factor. Depression became so frequent in the twentieth century that it was called "a common cold of mental illness" (Miller & Seligman 1973). Now during this 21st century also depression is observed to be increasing day by day due to the competitive world.

Depressive symptoms, according to Beck, can be explained in cognitive terms as a result of distorted interpretations of events caused by the activation of the negative self, personal world, and future representations (the negative cognitive triad). These disturbed cognitive patterns gradually gain dominance, resulting in the affective symptoms associated with depression. According to Beck’s, (1967, 1983) cognitive diathesis-stress depression theory defined depression is a combination of cognitive, genetic predisposition, stress, and negative thoughts.

Theoretical Background of Depression

Psychodynamic Theories. The psychodynamic method is exemplified by Sigmund Freud's (1917) psychoanalytic theory. Repressed anger over a loss (such as the symbolic or actual loss of a loved one as a kid) is directed inwards, reducing Self-esteem and increasing vulnerability to future events, allowing the individual to re-experience the loss when faced with similar triggering stimuli in adulthood.

According to psychodynamic theory, people vulnerable to depression may have very high levels of dependency, they mostly look for approval and support from other people, they will have low self-esteem, and many people will have unrealistic expectations and goals for themselves and people around them, which lead to sadness if they are unfulfilled. According to congruency models, depression is marked by a high dependence on social sources of acceptance as well as a high dependency on achievement outcomes. The psychodynamic approach’s fundamental flaws stem from the difficulty of empirically verifying hypotheses using

operational definitions that allow empirical (clinical and experimental) examination. Further, complaints include a lack of emphasis on stressful life situations, as well as conscious negative rumination and "self-verbalization."

Cognitive Theories of Major Depression. The cognitive triad version of despair proposed by Beck, (1967) defines 3 types of negative (helpless and/or critical) self-referent thinking that rise spontaneously in depressed people: negative perspectives about the self, the world, and the future. The 3 essential beliefs which consist of feelings of hopelessness and worthlessness engage with cognitive processes, causing problems in perception, memory, and problem solving, in addition to reinforcing a negative questioning ‘obsession.’ According to the concept, traumatic occasions as early as adolescence can cause poor attitudes and expectations, which include the loss of life of parents or siblings, parental rejection, criticisms, overprotective parenting, negligence or abuse, bullying, or separation from a peer group. These matters could make someone depressed.

Behavioral Theories of Depression. Behaviorist theory emphasizes the relevance of the surroundings in shaping behavior and makes a specialty of observable behavior. According to operant conditioning (Lewinsohn, 1974), the elimination of positive reinforcement from the surroundings or conditions that might serve to reinforce `maladaptive behavior, results in increased social isolation. Further, an individual will be unable to find out other available positive reinforcements. However, at the same time as those theories offer evidence while the motive of depression is known (or observable), they offer a quandary while the underlying purpose is unknown (‘endogenous’ depression), and they fail to take into account the effect of thought (cognitive) on mood.

Symptoms of Depression

Psychological Symptoms. These symptoms vary from negative mood to hallucinations/delusions, loss of energy or fatigue, suicidal thoughts, guilt, worthless, feelings,

pessimism, loss of concentration, loss of interest or pleasure, and perceptual abnormalities are the common symptoms of depression.

Somatic Symptoms. These symptoms are expressed through disturbances in bodily functions such as sleep disturbances, muscle fatigue, psychomotor retardation, loss of appetite, menstrual problems, loss of sex drive, restlessness, constipation, headache, backache, etc.

Emotional symptoms. The most common symptoms of depression are feelings of sadness, lack of interest, low appetite, and disturbed sleep patterns. A depressed mood can be excruciatingly uncomfortable and overwhelming.

Cognitive symptoms. A depressed person has slow thinking, troubling concentrating, and is distracted easily. Thought processes have been slowed to a near-halt. Guilt and a sense of meaninglessness are common. Depressed people blame themselves for what has gone wrong; even though the fault is not due to them. They place a great deal of emphasis on the negative aspects of themselves, their surroundings, and the future.

Causes of Depression

Biochemical Factors. An imbalance in some neurotransmitters may cause depressive symptoms. For example, the bio chemical's like serotonin, dopamine, and nor-epinephrine. Although a low level of dopamine may not cause depression directly, it may cause depression-related symptoms.

Genetic Factors. Genetic factors also play a role in depression. According to previous research, if one identical twin suffers from depression, it is likely that the other twin will also develop depression later in their life. History of depression in the family will have a higher risk of suffering from depression later in their lives.

Personality Traits. Depression is highly correlated with low Self-esteem and self-confidence as well as high negative thinking.

Environmental Factors. People who are constantly exposed to violence, negligence, disadvantage, abuse, poverty, pollution, and strenuous work are more susceptible to depression.

Prevalence of depression

According to a report, in the year 2022, the prevalence rate of depression in India is 4.50% and the cases stand at 56,675,969. Moreover, according to UNICEF reports which warned that the pandemic can impact the mental health and well-being of children and youth for years, one out of seven children in the age group of 15- to 24-year-olds feels depressed or has little interest in doing things. In India, states such as Tamil Nadu, Kerala, Goa, Telangana, Andhra Pradesh, and Odisha seem to have the highest prevalence of depressive disorders.

More than 264 million people suffer from depression worldwide. (World Health Organization, 2020). Depression is the leading cause of disability in the world. (World Health Organization, 2020). Neuropsychiatric disorders are the leading cause of disability in the U.S. with major depressive disorder being the most common. (National Institute of Mental Health, 2013).

Depression statistics by age

- Adolescents aged 12 to 17 years old had the highest rate of major depressive episodes (14.4%) followed by young adults 18 to 25 years old (13.8%). (Substance Abuse and Mental Health Services Association, 2018)
- Older adults aged 50 and older had the lowest rate of major depressive episodes (4.5%). (Substance Abuse and Mental Health Services Association, 2018)
- 11.5 million adults had a major depressive episode with severe impairment in the past year as of 2018. (Substance Abuse and Mental Health Services Association, 2018)
- Severe depression among college students rose from 9.4% to 21.1% from 2013 to 2018. (Journal of Adolescent Health, 2019)
- The rate of moderate to severe depression rose from 23.2% to 41.1% from 2007 to 2018. (Journal of Adolescent Health, 2019)

Need for the study

Early adulthood is a significant life transition, which is often characterized by stress and may contribute to the development or exacerbation of depressive symptoms. Due to the considerable negative outcomes that are associated with depressive symptoms across the lifespan, it is important to understand the mechanisms and pathways through which depressive symptoms arise. Self-esteem is reported to have a significant impact on important life outcomes including health and social outcomes during adulthood. Perceived social support has been consistently related to well-being, as the perceived levels of support, love, and care can provide positive experiences. Different individuals use different strategies for coping with negative affective states and associated life problems. Such coping mechanisms are important in periods of anxiety and depression.

REVIEW OF LITERATURE

Chapter – 2

Review of Literature

Yeong, Woorim, and Young (2023) investigated the association between perceived social support and depressive symptoms in Korea. Depressive symptoms were measured using the Patient Health Questionnaire-9 (PHQ-9) and perceived social support was assessed based on the number of contacts that participants had identified as being available in case participants needed isolation due to COVID-19 exposure. This study included the general adult population aged 19 years and older involving 2,25,453 participants. The study concluded that individuals with no perceived social support had the poorest depression scores, followed by those with low, middle, and high support. The results of the study suggest that strategies to manage the mental health of vulnerable individuals are required to reduce the potential mental health consequences of COVID-19.

Rathakrishnan, Singh, and Yahaya (2022) examined the relationship between perceived social support and coping strategies and the psychological distress of depression, anxiety, and stress among the students of the Public University in Sabah during the COVID-19 pandemic. The total respondents were 385 students from the university who ranged from 20 to 23 years of age. Tools were used: Depression, Anxiety, and Stress Scale (DASS-21), Brief COPE Scale (Brief COPE), and Multidimensional Scale of Perceived Social Support (MSPSS). Based on the findings of the study it was clear how vulnerable university students are to psychological distress during the COVID-19 pandemic, but it can be overcome with social support and suitable types of coping strategy. Besides, a negative link between depression and problem-focused coping was reported.

Alenezi et al. (2022) conducted a study to investigate burnout, depression, and anxiety levels among healthcare workers serving children with Autism Spectrum Disorder. This quantitative cross-section survey was done with (N = 381) participants. Arabic version

of the Maslach Burnout Inventory (MBI), Area of working surgery (AWS), Patient Health Questionnaire for Generalized Anxiety Disorder (GAD - 1), and Patient Health Questionnaire for Depression (PHQ - 9) were used for data collection. The result shows that 52.4% of Health care workers reported moderate to high levels of anxiety, and 47.8% moderate to very high levels of depression. ASW shows that healthcare worker has higher emotional fatigue and low job satisfaction.

Sharma and Subedi (2022) identified stress and different coping styles among caregivers of differently able children. The cross-sectional study was carried out in three organizations, by using the Parents Stress Scale and Brief Cope Inventory. A face-to-face interview was used to collect data, from 102 caregivers of differently-abled children. The result of the study showed that more than half of the caregivers had high levels of stress. The coping style used frequently is self-distraction acceptance and positive reinforcement.

Huang et al. (2021) discussed the impacts of coping styles and perceived social support on the mental health of undergraduate students during the early phases of the COVID-19 pandemic in China. It aimed to explore the effects of coping style and perceived social support on the psychological well-being of college students and relevant risk factors. The questionnaire included the 21-item Depression, Anxiety, and Stress Scale (DASS-21); the Perceived Social Support Scale (PSSS); and the Simplified Coping Style Questionnaire (SCSQ). Among 3113 college students, the rates of anxiety, depression, and stress symptoms were 13.3, 15.4 and 6.8%, respectively. Multiple linear regression analysis showed that active coping style and family support were protective factors while passive coping style could aggravate psychological problems among participants.

Wahab et al. (2021) conducted a study on the Risk of Depression Among MMT Patients: Does Coping Strategies and Perceived Social Support Play a Role? The study included: One hundred and ninety-six patients attending a methadone maintenance therapy

program. The Patient Health Questionnaire-9 (PHQ-9) was used to screen for depression, the Multidimensional Scale of Perceived Social Support (MSPSS) was used to assess participants' perceived social support, and the Brief COPE questionnaire was used to assess coping strategies. The diagnosis of depression was made using Mini International Neuropsychiatric Interview (MINI). About 13.8% of our sample were diagnosed with depression. From our analysis, it was found that having higher levels of perceived social support, the use of active and emotion-focused coping mechanisms, support-seeking, and self-distraction coping mechanisms were associated with a lower likelihood of depression. On the contrary, the use of dysfunctional coping strategies such as denial, behavioral disengagement, and self-blame was associated with an increased likelihood of depression (OR=9.384, 95% CI 3.081-28.581, $P < .001$). It was found that active and emotion-focused along with support and self-distraction coping strategies, and higher levels of perceived social support may serve as a buffer against depression in patients receiving therapy.

Bellos et al. (2020) analyzed depression and its Relationship with Coping strategies and illness perceptions during the COVID-19 lockdown in Greece. A total of 3379 individuals took part. Depressive symptoms were assessed with the Patient Health Questionnaire (PHQ-9) and Anxiety symptoms were assessed with the first 2 core items of the Generalized Anxiety Disorder scale (GAD-2). To assess the coping strategies Brief COPE questionnaire was used. Illness perceptions related to the COVID-19 epidemic were assessed using the revised "Illness Perception Questionnaire" (IPQ-R) Participants showed high levels of personal control and used more often positive strategies to cope with the stress of the epidemic. Depressive symptoms were higher in the younger, students, in those with a stronger emotional impact, in those isolated due to symptoms, and in those overexposed to media for COVID-19-related news. Lower levels of depression were seen in those using positive coping strategies and showing high levels of personal and treatment control.

Alsubaiea, Staind, Websterdand, and Wadman (2019) examined the differential impact of sources of social support on student wellbeing. University students completed an online survey measuring depressive symptoms (Patient Health Questionnaire (PHQ-9)), social support (Multidimensional Perceived Social Support (MPSS)), and quality of life (WHOQOL-BREF). The sample was 461 students (82% female, mean age 20.62 years). The prevalence of depressive symptoms was 33%. Social support from family and friends was a significant predictor of depressive symptoms ($p = 0.000$*). Quality of life (psychological) was significantly predicted by social support from family and friends. Quality of life (social relationships) was predicted by social support from significant others and friends. Sources of social support represent a valuable resource for universities in protecting the mental health of students.

Lee et al. (2019) investigated the association of positive and negative social support with the risk of depressive symptoms. This is a large-scale cohort study conducted in Korea using a random sampling technique involving 21,208 adult men and women. The tools used in the study were the Center for Epidemiologic Studies Depression Scale (CES-D) and the self-constructed social support scale. The study concluded that negative social support provoked the depressive symptoms and positive social support reduced the depressive symptoms. An inverse relationship was found between both social support and depressive symptoms.

Li et al. (2019) examined the indirect role of self-esteem in the relationship between job stress and depressive symptoms among migrant workers in Macau and whether this indirect effect is modified by social support. A sample of 900 mainland Chinese migrant workers was recruited into the study. Job stress, social support, self-esteem, and depressive symptoms were measured. Conditional process analysis was used to examine the proposed moderated mediation model. Job stress was associated with depressive symptoms through lower self-esteem. The indirect effect of job stress on depressive symptoms via decreased self-esteem was

significant among migrant workers with higher levels of social support, but not among migrant workers with lower levels of social support. Our findings suggest that when migrant workers perceive a high level of social support, job stress is more likely to threaten their self-esteem and in turn increase their risk for depression.

Nguyen et al. (2019) conducted a study to determine the prevalence of low self-esteem and sociodemographic features related to anxiety, depression, educational stress, and suicidal ideation in secondary school students in Vietnam. A cross-sectional design was employed for this study with the participation of 1,149 students in Cantho City in Vietnam. A structured questionnaire Rosenberg Self-esteem Scale, Center for Epidemiology Studies Depression (CES-D) and to address the issue of suicidal ideation, additional questions on whether the student had ever seriously considered suicide or made a suicide plan used a 3-point scale along with an anxiety scale and the Educational Stress Scale for Adolescents. These results, therefore, suggested the need for a school-based or web-based provision aimed at proactively increasing students' self-esteem and skills for dealing with academic stress.

Crutcher, Moran, and Covassin (2018) examined the relationship between social support from athletes, family, and other athletic trainers and depressive symptoms. A cross-sectional carried out on 204 Athletic training students in the US using a random sampling method. The tools used for the study were the Perceived Social Support Scale and the Center for Epidemiologic Studies Depression Scale (CES-D) Questionnaire. The study concluded that in athletic training students, increased satisfaction with social support may reduce stress perceptions and depression.

Ioannou, Kassianos, and Symeou (2018) tested the mediating role of self-esteem in the relationship between social support and depressive symptoms. This cross-sectional observational study was conducted in Cyprus involving 334 young adults in the age range of 17–26 (78% female) using a random sampling method. The tools used were the Center for

Epidemiologic Studies Depression Scale (CES-D) (Radloff, 1977), Multidimensional social support scale. The results showed that the perception of social support from family and friends was linked to lower depressive symptoms. It was discovered that social support is more effective against depressive symptoms.

Ren, Qin, Zhang, and Zhang (2018) aimed to understand the debate over the relationship between social support and depression. A longitudinal study was carried out on 2834 students of adolescence aged range 13-17 years in China using a simple random sampling technique. The tools involved in the study were Children Depression Inventory (CDI) (Kovacs, 2003) and the Perceived School Climate scale for teacher social support and peer social support. The results indicated that depressive symptoms led to a reduction in expected social support, but not from teachers. Teacher and peer encouragement are integrally related and mutually influential.

Ahn, Kim, and Zhang (2017) examined how varying forms of social support moderate depressive symptomatology among older adults with multiple chronic conditions (MCC). Data were analyzed using a sample of 11,400 adults, aged 65 years or older, from the 2006–2012 Health and Retirement Study. The current study investigated the moderating effects of positive or negative social support from spouses, children, another family, and friends on the association between MCC and depression. A linear mixed model with repeated measures was used to estimate the effect of MCC on depression and its interactions with positive and negative social support in explaining depression among older adults. Varying forms of social support played different moderating roles in depressive symptomatology among older adults with MCC. Positive spousal support significantly weakened the deleterious effect of MCC on depression. Conversely, all negative social support from spouses, children, another family, and friends significantly strengthened the deleterious effect of MCC on depression. Minimizing negative

social support and maximizing positive spousal support can reduce depression caused by MCC and lead to successful aging among older adults.

Bukhari and Afzal (2017) aimed to study the impact of perceived social support on psychological problems (depression, anxiety, and stress). A cross-sectional study used Purposive sampling involving 200 university students in Karachi, Pakistan. The tools used in the study are the Depression, Anxiety, and Stress Scale -21 (Lovibond and Lovibond, 1995), and the Multidimensional social support scale (Zimet et al. 1988). The results disclosed that perceived social support was a significant negative predictor of depression and anxiety. Perceived social supports predicted 6% depression and 2% anxiety including 58%, 69%, and 40% mild to severe levels of depression.

Kannan et al. (2017) studied on Self –esteem among 11-15 Years Old Orphanage Children in Kanchipuram District, Tamil Nadu‖, among 11-15 years old 221children from orphanages and 221 school going children from families in Tamil Nadu, India, states that comparing with school children who were under parental care the orphan children had low self-esteem due to the effect of various factors like their environment they were raised, the risk of abuse join the institution they stay, health issues, lack of socialization and parental care. The authors have included the risk factors like environment, risk of abuse in the institution, health issues, and lack of parental care and socialization to compare the self-esteem of children from orphanages and families. Thus the study covers most of the factors that need to be analyzed about self-esteem.

Shanmugam and Karthyayini (2017), in their study Assertiveness and Self–Esteem in Indian Adolescents‘‘ among 60 adolescents from Bangalore, India, stated that the majority of the respondents were moderately assertive, and half of them had high self-esteem. There was a significant positive correlation between adolescents' assertive behavior and self-esteem. Also, assertive scores with age and education level had a significant association. The variable

educational level was significantly associated between self-esteem and assertive score. Here the study is about the correlation between one of the major life skills which have to be developed during adolescent years. Even though there are many studies based on different life skills, studies on assertiveness are very few. Hence the study helps the researcher to know that there is a significant association between assertiveness, educational level, and self-esteem.

Zamani, Dehkordi, and Shahry (2017) conducted a study to determine the status of perceived social support and related personal and family characteristics of 763 university students in Iran. This cross-sectional study was done using a cluster random sampling technique. The tool used for the study was Vaux's social support questionnaire. The results revealed that depression and stress are expected to significantly reduce by ensuring social support and reducing sources of stress in the educational environment.

Dafaalla et al. (2016) examined how common depression is, and what role social support and quality of life can play in the development of depression, anxiety, and stress. The cross-sectional study was carried out in Sudan on 487 medical Students using a clustered random sampling technique. The tools used in the study were Medical Outcomes Study (MOS) social support survey and Depression, Anxiety, and Stress Scale -21. The results showed that only the positive social interaction domain and depression were found to have a significant relationship. 21% of students were depressed to a moderate degree.

Jayanti and Thirunavukarasu (2016) investigated the relationship between perceived social support and depression among adolescents. This is a case-control study conducted on 1120 Adolescents in India using a random sampling technique. The tools used for the study were the Multidimensional social support scale and Beck Depression Inventory. The results revealed that adolescents with insufficient perceived social support have a 1.9 times higher risk of experiencing depression than those with appropriate perceived social support. According to

the results, 45.7 percent of the youths had moderate depression, 25.4 percent had mild depression, 19.6 percent had major depression, and 9.3 percent had minor depression.

Rueger et al. (2016) assessed the relationship between social support and depression in youth and compared the cumulative evidence for 2 theories that have been proposed to explain this association: the general benefits (GB; also known as main effects) and stress-buffering (SB) models. Using a random effects model, the overall effect size based on k = 341 studies and N = 273,149 participants was r = .26, with robust support for the GB model and support for the SB model among medically ill youth. Stress-buffering analyses suggest that different stressful contexts may not allow youth to fully draw on the benefits of social support, and we propose value in seeking to better understand both stress-buffering (effects of social support are enhanced) and reverse stress-buffering (effects of social support are dampened) processes. Key findings regarding other moderators include a different pattern of effect sizes across various sources of support. In addition, gender differences were largely absent in this study.

Dolenc (2015) examine self-esteem, anxiety level, and coping strategies among secondary school students about their involvement in organized sports. The sample included 280 Slovenian male and female secondary school students aged between 15 and 19 years. The participants completed The Adolescent Coping Scale, the Spielberger State-Trait Anxiety Inventory, and the PSDQ Self-esteem Scale. The results revealed that participants engaged in organized sports exhibited higher self-esteem scores and lower anxiety scores in comparison to non-sport participants. Sport participants reported more productive coping than non-sport participants, which represents an active and problem-focused approach to dealing with everyday problems.

Du, King, and Chu (2015) analyzed the connections between hope, social support, and depression. It is a Correlation study involving 384 Adolescents aged ranging 12-18 years in Hong Kong. The tools used for the study were Children’s Hope Scale (Snyder et al., 1997),

Social Support Scale (Zimet, Dahlem, Zimet and Farley, 1988), the Rosenberg self-esteem scale (Rosenberg, 1965), the Center for Epidemiologic Studies Depression Scale (CES-D) (Andresen, Malmgren, Carter and Patrick, 1994; Radloff, 1977). The results indicated that hope and social support were associated with higher levels of personal and relational self-esteem, which were in turn related to decreased levels of depression.

Kugbey, Boadi, and Atefoe (2015) examined the impact of social support from family, friends, and significant others on the levels of depression. The cross-sectional study was conducted on 165 university students in Ghana using a random sampling method. The tools used for the study were the Multidimensional social support scale (Zimet, Dahlem, Zimet, and Farley, 1988) and Depression, Anxiety, and Stress Scale -21. The results showed the level of depression was significantly predicted by support from friends and others which is 13.9% mild, 20.6% moderate,7.3% severe, and 15.3% extremely severe level of depression.

Singh and Singh (2015) investigated the effect of parental bonding and social support on depression among adolescents. This is a cross-sectional study conducted in India on 160 Adolescents in the Age range of 14-19 years using a random sampling technique. The tools used in the study were Reynolds adolescent depression scale (William Reynolds, 2002) and the Speech, Spatial, and Qualities of Hearing Scale (SSQ) (Sarason, Levine, Basham, and Sarason, 1983). It was found that social support, father care, and mother care were negatively contributing to adolescent depression.

Sharma and Agarwala (2015) conducted a study on Self-esteem and Collective Self – Esteem Among Adolescents: An Interventional Approach‘‘ among 17-23 years old 74 adolescents in Uttar Pradesh, India the result of the mean score of self-esteem during pre– measure and post measure was 11.31 and 17.42 also pre-test and the post-test mean collective score was 34.73 which increased to 53.47. This indicates the effectiveness of the interventional program in enhancing self-esteem and collective self-esteem. The interventional study about

self-esteem would help the researcher to get the knowledge that, even among children staying in a family, interventional programs can make a difference in self-esteem.

Barger et al. (2014) examined the quality and quantity of social relationships associated with depression. It is a cross-sectional study conducted in Switzerland on 12,286 Adults using a simple random sampling method. A telephone systemic interview (CIDI) was used to measure severe depression, while a postal survey was used to evaluate depressive symptoms and social support dimensions. The results indicated that there is a significant depression and depressive symptoms were linked to the perceived consistency and duration of social support. Psychological well-being was related to a wide variety of social support dimensions.

Bartha, Hofmann, and Schoria (2014) evaluated the frequency of various forms of depression and their ties to education, material and social capital, and job/school satisfaction. The cross-sectional study used the random sampling of 9066 males in Switzerland aged between 18-25 years. The tool used was Patient Health Questionnaire (PHQ-9). The result showed that the prevalence of depression was 3.60% and 3.62% for sub-threshold. It was reported that low social support and low satisfaction with social relations increased depressive symptoms.

Colman’s (2014) aim was to find variables that protect against the development or incidence of depression in early adulthood, as well as their experiences with stressors during this period. A longitudinal study was conducted on samples of 1137 with ages ranging from 16-17 years in Canada using a simple random sampling method. The tool used to measure the depression level was a composite international diagnostic interview (CIDI-SF: 9 items). The results revealed that high levels of competence in adolescents were related to a lower risk of depression in early adulthood. When compared to those with low social support in adolescence, those with high social support were slightly less likely to become depressed. Physical exercise in adolescence was related to a lower risk of depression.

Cooley et al. (2014) examined whether peer social support, alone or in conjunction with peer delinquency, moderated the relations between overt and relational victimization, depressive symptoms, and rule-breaking behavior. The samples included 152 adolescents (55% male; 95% Latino) between the ages of 14–19 and their second-hour teachers. Findings indicated that peer social support buffered the association between relational victimization and depressive symptoms. Overt victimization was uniquely related to increased rule-breaking behavior but unrelated to depressive symptoms. Peer social support and peer delinquency interacted to influence the association between relational victimization and rule-breaking behavior. When levels of both social support and peer delinquency were high, relational victimization marginally significantly predicted increased rule-breaking behavior. Relational victimization was unrelated to rule-breaking behavior when levels of peer delinquency were high and social support was low. The moderating effects of peer social support did not differ according to gender.

Shan Qiaoa et al. (2014) studied the perceived social support, loneliness, and self-esteem among children affected by HIV/AIDS. Children with higher perceived social support were more likely to report higher self-esteem scores at baseline. However, the self-esteem scores remained stable over time controlling for baseline perceived social support and all the other variables. Conclusions of the positive effect of perceived social support on psychological adjustment may imply a promising approach for future intervention among children affected by HIV/AIDS, in which efforts to promote psychosocial well-being might center on children and families with lower levels of social support.

Wang, Cai, Qian, and Peng (2014) conducted a study to see that social support has a moderating impact on the relationship between stress and depression in university students. A cross-sectional study was carried out on 632 undergraduate students 315 female and 317 male, the age range of 18-22 years in Chongqing City China. The tools used for the study were PSS

Scale, Self- rating depression Scale. The results showed that the prevalence of depression was 18.7%. Social support moderated the correlation between stress and depression, according to hierarchical regression analysis. Undergraduate students who were under a lot of stress and had a poor degree of social support had higher depression levels than students who were under a lot of stress and had a lot of social support.

Zhang, Yan, Zhao, and Youan (2014) investigated the association between perceived stress and depression was moderated by social support. This cross-sectional study involved 1674 people in East Asian Countries using a random sampling technique. The tools used for the study were the Center for Epidemiologic Studies Depression Scale (CES-D) and the perceived social support scale. The results found that there is a moderating effect of friend support between perceived stress and depression.

Budge, Adelson, and Howard (2013) studied facilitative and avoidant coping as mediators between distress and transition status, social support, and loss. Method: A total of 351 transgender individuals (n = 226 transgender women and n = 125 transgender men) participated in this study. Participants completed measures on transgender identity, family history of mental health concerns, perceptions of loss, coping, depression, and anxiety. The rates of depressive symptoms (51.4% for transgender women; 48.3% for transgender men) and anxiety (40.4% for transgender women; 47.5% for transgender men) within the current study far surpass the rates of those for the general population. Structural equation modeling (SEM) was used to analyze the data - 2 separate models were hypothesized, based on reports of anxiety or depression. The SEM results suggest that the processes for transgender women and transgender men are primarily similar for depression and anxiety; avoidant coping served as a mediator between transition status and both distress variables. Social support was directly related to distress variables, as well as indirectly related through avoidant coping.

Mendieta et al. (2013) investigated the association between social support, loneliness, and well-being. This is a cross-sectional study carried out on 2042 participants in Spain using the random sampling method. The questionnaire on the frequency of loneliness and satisfaction with social support was used. The results revealed that emotional support was significantly more effective in reducing loneliness and increasing well-being; partner support, family support, and support from friends, respectively, significantly decreased romantic loneliness, family loneliness, and social loneliness.

Ramezankhani et al. (2013) analyzed the relationship between perceived social support, depression, and perceived stress in university students. A cross-sectional study was conducted using random sampling techniques on 390 university students in Iran. The questionnaires used for the study are the Multidimensional social support scale and Beck Depression Inventory**.** The present study revealed a significant relationship between perceived social support and depression, that is individuals receiving less social support, reported higher depression. 22.1% suffered from mild depression 23.3% moderate depression, 4.4% severe depression.

Rawana (2013) studied the relative importance of body change strategies, weight perception, perceived social support, and self-esteem on adolescent depressive symptoms. The Participants ($N = 4587$, 49% female) were selected from the National Longitudinal Study of Adolescent Health. Regression analyses were conducted on the association between well-known depression risk factors (lack of perceived support from parents, peers, and schools), body change strategies, weight perception, and adolescent depressive symptoms one year later. Each well-known risk factor significantly predicted depressive symptoms. Body change strategies related to losing weight and overweight perceptions predicted depressive symptoms above and beyond established risk factors. Self-esteem moderated the relationship between trying to lose weight and depressive symptoms. Maladaptive weight loss strategies and overweight perceptions should be addressed in the early identification of depression programs.

METHOD

Chapter - 3

Method

The methodology is the overall strategy or approach used by researchers to conduct research. It encompasses the theoretical and philosophical underpinnings of the research, the research design, data collection methods, data analysis techniques, and the overall framework within which the research is conducted. Research methods refer to the specific techniques, procedures, or tools that researchers use to collect, analyze and interpret data. It can be quantitative, involving numerical data, or qualitative, involving non-numerical data.

The procedure of the present study namely, the role of self-esteem, perceived social support, and coping strategies in the escalation of depressive symptoms was carried out involving the following steps:

- Objectives
- Hypothesis
- Sampling Technique
- Sample
- Variables
- Data Collection
- Research design
- Tools
- Procedure
- Analysis of data

Objectives

- To assess the level of self-esteem among young adults
- To assess the level of perceived social support among young adults
- To understand the level of coping among young adults

- To explore the relationship between self-esteem, perceived social support, and coping strategies in an escalation of depressive symptoms among young adults
- To find the gender difference in self-esteem, perceived social support, and coping strategies in an escalation of depressive symptoms among young adults
- To find the effects of self-esteem, perceived social support, and coping strategies in depressive symptoms among young adults

Hypothesis

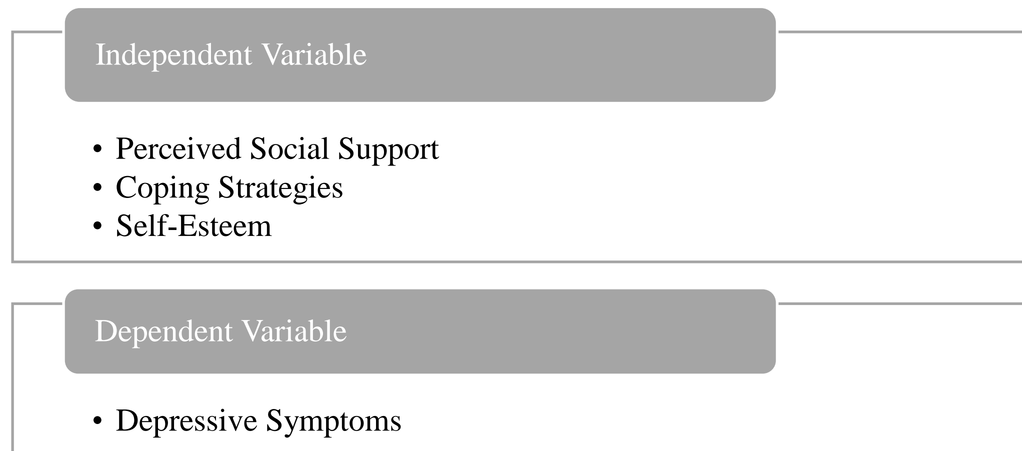
The hypotheses are stated as Alternative Hypotheses, so that they can be either accepted or rejected, based on the results.

- **H1:** There will be a significant relationship between self-esteem and perceived social support among young adults
- **H2:** There will be a significant relationship between perceived social support and coping strategies among young adults
- **H3:** There will be a significant relationship between self-esteem and coping strategies among young adults
- **H4:** There will be a significant relationship between self-esteem, perceived social support, coping strategies, and depressive symptoms among young adults
- **H5:** There will be a significant gender difference in self-esteem, perceived social support, coping strategies, and depressive symptoms among young adults
- **H6:** There will be a significant influence on depressive symptoms by self-esteem, coping strategies and perceived social support among young adults

Sample

The sample for the present study included students from Namakkal district. A total of two hundred participants (N= 200) 50% of male students and 50% of female students aged 18 to 25 years were selected.

Variables



Sampling Technique

Simple Random Sampling Technique was used.

Data Collection

Inclusion Criteria

- Age ranges from 18 - 25 years
- Both male and female participants
- Samples willing to participate in the study

Exclusion Criteria

- The participants other than those aged 18-25 years
- The participants who are unwilling to participate
- Samples outside Namakkal

Research Design

This study utilizes the correlational research design.

Tools

Center for Epidemiologic Studies Depression Scale Revised (CESD-R- 10)

The CES-D-10 by Andresen et al. (1994) is a 10-item Likert scale questionnaire assessing depressive symptoms in the past week. It includes three items on depressed affect, five items

on somatic symptoms, and two on positive affect. Options for each item range from “rarely or none of the time” (score of 0) to “all of the time” (score of 3). Scoring is reversed for items 5 and 8, which are positive affect statements. Total scores can range from 0 to 30. Higher scores suggest a greater severity of symptoms. This scale is a self-report measure of depression. The internal consistency for the CES-D-10 is (Cronbach’s α=0.86) and the Test-retest reliability for the CES-D-10 is (ICC=0.85). Test-retest reliability for individual items is (ICC=0.68-0.73). The convergent validity is .91 and the divergent validity is .89 (Miller et al. 2008).

Coping Scale

The coping strategies were measured using the Coping scale by Hamby, Grych, and Banyard (2013). This scale was partially adapted from Holahan and Moos (1987) and Pitzberg and Copach (2008). This is a 13-item scale and is a 4-point Likert scale. (1= not true about me, 2= a little truth about me, 3= somewhat true about me, 4= mostly true about me). Total scale scores can be a sum of all the items, and it has 3 sub-scales. Cognitive coping, behavior coping, and emotional coping. The validity of the scale is .81 and the reliability is .88.

Multidimensional Scale of Perceived Social Support

The Multidimensional Scale of Perceived Social Support (MSPSS) by Zimet et al. (1990) is a self-report 12-item instrument capturing the multidimensionality of perceived social support, through items that measure social support from family, friends, and a special person (significant other). The three subscales of family, friend, and significant other perceived social support consist of four items, rated on a seven-point Likert scale ranging from “very strongly disagree” to “very strongly agree.” The subscales’ discriminant validity is satisfactory and the instrument has good psychometric properties in terms of validity and reliability index for all three subscales ranging from 0.85 to -0.92 and 0.87 to 0.93 for the whole scale (Budge et al., 2013). The total score of the three subscales is summed to create the total score of perceived social support with higher scores indicative of higher perceived social support.

State Self-Esteem Scale

Heatherton and Polivy (1991) developed the State Self–Esteem Scale modified from the widely used Janis-Field Feelings of Inadequacy Scale consisting of a 20-item scale that measures a participant's self-esteem at a given point in time. The 20 items are subdivided into 3 components of self-esteem: performance self-esteem, social self-esteem, and appearance self-esteem. All items are answered using a 5-point scale (1= not at all, 2= a little bit, 3= somewhat, 4= very much, 5= extremely). Cronbach alphas for the State Self-Esteem Scale subscales ranged from 0.73– 0.81.

Procedure

The research topic was proposed and the hypotheses and objectives were framed. Young adults were contacted and sought consent for collecting data. They were debriefed about the research – coping skills, depressive symptoms, perceived social support, and self-esteem scale were given to the participants and they were instructed to read each item very carefully and choose from options that suit them the best. Copies of the questionnaires were made and then given to the participants directly. They were informed that the data collected will be confidential. The scoring was done according to the scoring key and interpreted using the norms provided by the authors. The results were analyzed and the hypotheses were verified.

Analysis of Data

- The data were analyzed using Statistical Package for the Social Sciences (SPSS - 29).
- Product Moment Correlation and independent sample T-test were used to find the role of self-esteem, perceived social support, and coping strategy in the escalation of depressive symptoms.

Ethical Consideration

The subjects' cooperation and willingness are essential for any study to be successful. If the participant is unwilling or uninterested in actively participating in the study, they may end up giving inaccurate information, which could skew the results. The measures listed below should be taken to check the validity of the data and for ethical reasons.

• All study subjects need to be made aware of the study's objectives.

• It should be done with the participant's consent.

• The participants' privacy and anonymity will be protected.

Institutional Human Ethics Committee

As the study involves human subjects, all procedures described in the study were reviewed and approved by the Institutional Human Ethics Committee, Avinashilingam Institute for Home Science and Higher Education for Women, Coimbatore. The approval number for the research purpose is **AUW/IHEC/CP-22-23/XMT-07.**

RESULTS AND DISCUSSION

Chapter - 4

Results and Discussion

Early adulthood is a significant life transition that can be a particularly stressful experience, which may lead to the development or exacerbation of depressive symptoms. Due to the considerable negative outcomes that are associated with depressive symptoms across the lifespan, it is important to understand the mechanisms and pathways through which such symptoms arise. This study explores how self-esteem, perceived social support and coping strategies are associated with the development of depressive symptoms during early adulthood.

The results of the study titled " Role of Self-Esteem, Perceived Social Support, and Coping Strategies in the Escalation of Depressive Symptoms in Young Adults " was conducted. Two hundred responses including 100 female responses and 100 male responses were selected by simple random sampling method. All the participants were assessed using the State self-esteem scale, Multidimensional Scale for Perceived social support, Coping Scale, and Center for Epidemiologic Studies Depression Scale Revised (CESD-R- 10). The age of the sample ranged from 18-21 years and 22-25 years. The data was analyzed using,

1) Independent sample *t*-test was used to find gender differences in self-esteem, perceived social support, coping strategies, and depressive symptoms in young adults.
2) Product Moment Correlation was used
    - To find the significant relationship between self-esteem and perceived social support among young adults
    - To find the significant relationship between perceived social support and coping among young adults

- To find the significant relationship between self-esteem and coping among young adults
- To find the significant relationship between self-esteem, perceived social support, coping strategy, and depressive symptoms among young adults

3) Linear Regression was done
   - To examine how self-esteem, perceived social support and coping strategies would predict depressive symptoms among young adults
4) The distribution analysis was done for self-esteem, perceived social support, coping strategies, and depressive symptoms.

Table 1

Demographic Data of samples (N=200)

S.No	Demographic Data		N	Percentage*
1.	Age	18-21	114	57 %
		22-25	86	43 %
2.	Gender	Male	100	50 %
		Female	100	50 %
3.	Family	Nuclear	137	68 %
		Joint	63	32 %
4.	Locality	Urban	106	53 %
		Rural	94	47 %
5.	Marital Status	Married	12	06 %
		Unmarried	188	94 %

Note. *Percentages are rounded-off

Table I shows the percentage for the demographic data of the study, the samples are between 18 to 21 years and 22 to 25 years of age. The percentage of the age group from 18 to 21 years and 22 to 25 years is 57% and 43%. In gender, the percentage of age for a male is 50% and for a female is 50%. In family type, the percentage value for the Nuclear family is 68% and for the joint family is 32%.In the locality, the percentage value for urban is 53% and for Rural is 47%. In the marital status, the percentage value for the married is 6% and for the unmarried is 94%. The above data gives a comprehensive outline of the general information of those participants included in this study.

Table 2

Distribution of Self-Esteem

Levels	Gender	N	Percentage
Low	Male	2	1 %
	Female	1	0.5 %
Moderate	Male	46	23 %
	Female	35	17.5 %
High	Male	52	26 %
	Female	64	32 %

Table 2 shows the distribution of self-esteem at different levels among young adults based on gender. The distribution analysis shows that 1% of male and .5% of female participants seem to have a low level of self-esteem, 23% of male and 17.5% of female participants seem to have a moderate level of self-esteem, 26% of male and 32% of female participants seem to have a high level of self-esteem.

Figure 1

Distribution of Self – esteem

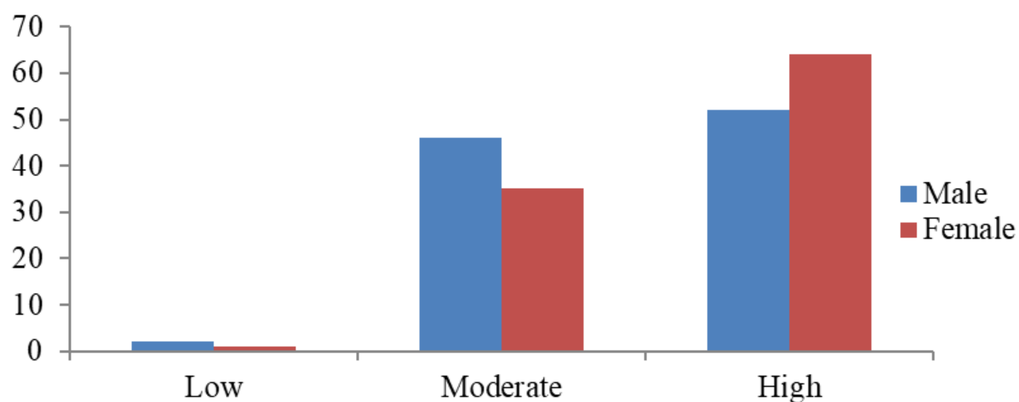


Table 3

Distribution of Perceived Social Support

Levels	Gender	N	Percentage
Low	Male	6	3 %
	Female	5	2.5 %
Moderate	Male	24	12 %
	Female	24	12 %
High	Male	70	35 %
	Female	71	35.5 %

Table 3 shows the distribution of perceived social support at different levels among young adults based on gender. The distribution analysis shows that 3% of male and 2.5% of female participants seem to have a low level of perceived social support, 12% of male and 12% of female participants seem to have a moderate level of perceived social support, 35% of male and 35.5% of female participants seem to have a high level of perceived social support.

Figure 2

Distribution of Perceived Social Support

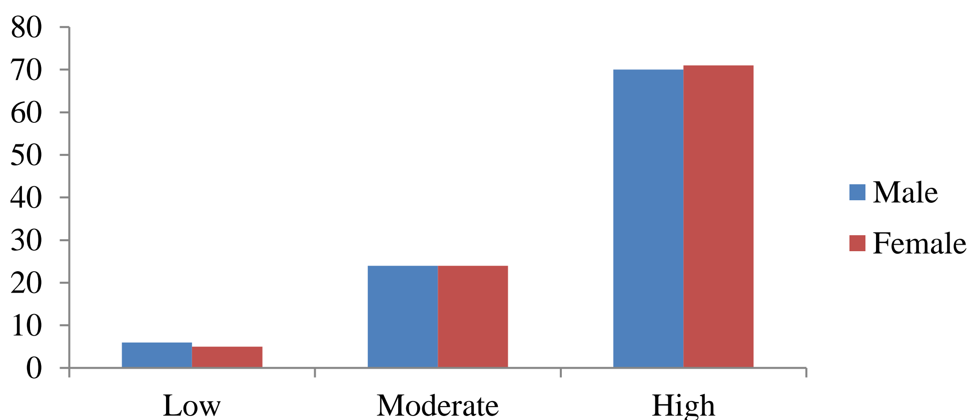


Table 4

Distribution of coping strategies

Levels	Gender	N	Percentage
Low	Male	3	1.5 %
	Female	6	3 %
Moderate	Male	56	28 %
	Female	67	33.5 %
High	Male	41	20.5 %
	Female	27	13.5 %

Table 4 shows the distribution of coping strategies at different levels among young adults based on gender. The distribution analysis shows that 1.5% of male and 3% of female participants seem to have a low level of coping strategies, 28% of male and 33.5% of female participants seem to have a moderate level of coping strategies, 20.5% of male and 13.5% of female participants seem to have a high level of coping strategies.

Figure 3

Distribution of coping strategies

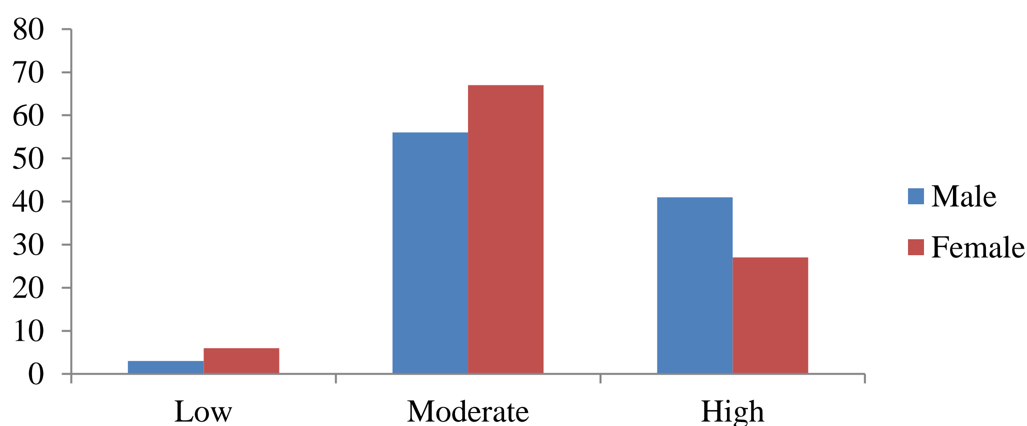


Table 5

Distribution of Depressive symptoms

Levels	Gender	N	Percentage
Mild	Male	33	16.5 %
	Female	47	23.5 %
Moderate	Male	51	25.5 %
	Female	44	22 %
Severe	Male	16	8 %
	Female	9	4.5 %

Table 5 shows the distribution of depressive symptoms at different levels among young adults based on gender. The distribution analysis shows that 16.5% of male and 23.5% of female participants seem to have a mild level of depressive symptoms, 25.5% of male and 22% of female participants seem to have a moderate level of depressive symptoms, 8% of male and 4.5% of female participants seem to have a severe level of depressive symptoms.

Figure 4

Distribution of Depressive symptoms

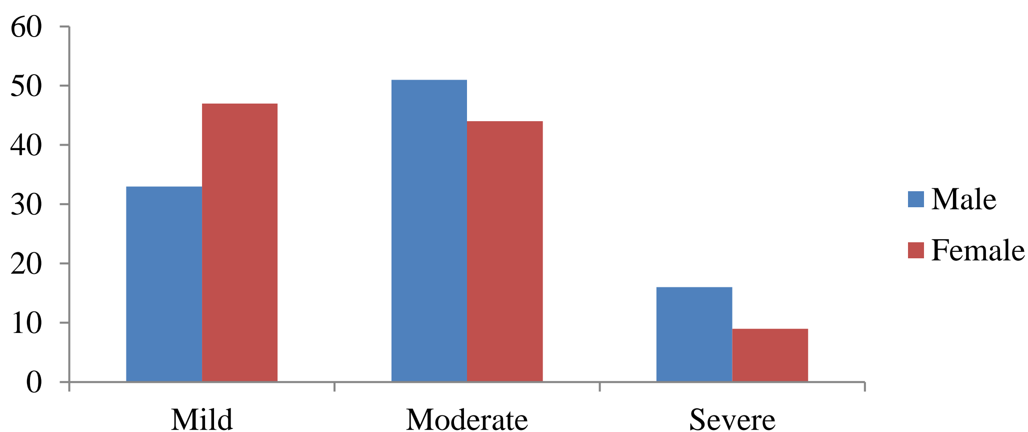


Table 6

Correlation between Self-esteem and Perceived Social Support

Variables	N	Self-esteem	Perceived social support
Self-esteem	200	-	.478**
Perceived social support	200	.478**	-

Note. **Correlation is significant at the 0.01 level (2-tailed).

A Pearson product-moment correlation was run to determine the relationship between self-esteem and perceived social support among individuals. There was a significant correlation between self-esteem and perceived social support among individuals, which was statistically significant (r = .478, n = 200, $p < 0.01$).

Table 6 shows the correlation between the variables self-esteem and perceived social support among young adults. The statistical value indicates that the correlation is significant and there exists a positive correlation which means, when there is more social support there is an increased level of self-esteem. Social support can provide individuals with the resources and encouragement needed to develop and maintain a healthy sense of self-esteem. Social support can provide individuals with positive feedback, recognition, and validation. This can help boost an individual's self-esteem, making them feel valued and appreciated. Moreover, having a support system in place can also provide individuals with a sense of belonging and connectedness, which can further enhance their self-esteem. Social support can also help individuals cope with stressful or challenging situations. This can help prevent feelings of inadequacy or helplessness, which can negatively impact an individual’s self-esteem. Having someone to turn to for advice or guidance during tough times can help individuals feel more capable and confident, which can strengthen

their self-esteem. Research on social support by Gecas (1972) found that adolescents were high on self-esteem when in a social environment. It is important here to say that if the social support environment is improved it would lead to an increase in the level of self-esteem. Nolen et al., (1999) found through research that individuals with high self-esteem are having a probability to have more social support. Hence, the hypothesis 1 *"there will be a significant relationship between self-esteem and perceived social support among young adults"* **is accepted**.

Table 7

Correlation between Perceived Social Support and coping strategies

Variables	N	Perceived social support	Coping Strategies
Perceived social support	200	-	.376**
Coping Strategies	200	.376**	-

Note. **Correlation is significant at the 0.01 level (2-tailed).

A Pearson product-moment correlation was run to determine the relationship between coping strategies and perceived social support among individuals. There was a significant correlation between coping strategies and perceived social support among individuals, which was statistically significant ($r = .376$, n = 200, $p < 0.01$).

Table 7 shows that there is a significant relationship between self-esteem and coping strategies. The statistical value indicates that the correlation is significant and there exists a positive correlation between perceived social support and coping strategies among participants. That is, when there is a high level of coping strategies it results in a high level of perceived social support. Social support provides individuals with practical, emotional, and informational assistance to help individuals cope and improve their mental health. The finding of a previous study (Tindle, Hemi & Moustafa, 2022) suggests that seeking social support from others can improve psychological flexibility, allow individuals to utilize adaptive coping strategies and reduce avoidant coping strategies. It also suggests that social support increases psychological flexibility and indirectly contributes to reducing avoidant coping strategies, and increasing approach coping strategies. Social support can help individuals better regulate their emotions, making emotion-focused coping strategies more effective. Social support can also help individuals to identify their strengths and

provide motivation to continue to use effective coping strategies. Furthermore, social support can help individuals to perceive stressors as less threatening, and therefore, decrease the need for coping strategies. Hence, the hypothesis 2 *"there will be a significant relationship between the perceived social support and coping strategies among young adults"* **is accepted.**

Table 8

Correlation between coping strategies and Self-esteem

Variables	N	Coping Strategies	Self-esteem
Coping Strategies	200	-	.284**
Self-esteem	200	.284**	-

Note. **Correlation is significant at the 0.01 level (2-tailed).

A Pearson product-moment correlation was run to determine the relationship between coping strategies and self-esteem among individuals. There was a significant correlation between coping strategies and self-esteem among individuals, which was statistically significant (r = .284, n = 200, $p < 0.01$).

Table 8 shows that there is a significant relationship between self-esteem and coping strategies. The statistical value indicates that the correlation is significant and there exists a positive correlation between coping strategies and self-esteem among the participants. When there is a high level of self-esteem, it results in a high level of coping strategies. Individuals with high self-esteem are more likely to employ adaptive coping strategies when faced with stressful situations. Adaptive coping strategies are those that are more likely to lead to positive outcomes, such as problem-solving, seeking social support, and engaging in positive self-talk. Conversely, individuals with low self-esteem are more likely to use maladaptive coping strategies, such as avoidance, denial, and substance use, which are less likely to lead to positive outcomes. A Positive self-view can lead to a greater sense of control and confidence in managing challenging situations, which in turn can lead to the use of more adaptive coping strategies. The finding obtained from the study (Celenk & Peker, 2020) supports that self-esteem has a full mediating effect between coping styles with stress

and psychological well-being. One of the past researches suggested that high self-esteem individuals exhibit a more challenging attitude towards the problem, and are able to identify and use more individual and contextual coping resources. Individuals with low self-esteem may make more negative evaluations about themselves and their sources of coping. They may have difficulties in researching and using coping resources to cope with the problematic situation (Moksnes, 2019). Hence, the hypothesis 3 *"there will be a significant relationship between coping strategies and self-esteem among young adults"* **is accepted.**

Table 9

Correlation between coping strategies, self-esteem, perceived social support, and depressive symptoms

Variables	N	Self-esteem	Perceived Social Support	Coping strategies	Depressive symptoms
Self-esteem	200	-	.478**	.284**	-.438**
Perceived Social Support	200		-	.376**	-.491**
Coping strategies	200			-	-.642**
Depressive symptoms	200				-

Note. **Correlation is significant at the 0.01 level (2-tailed).

A Pearson product-moment correlation was run to determine the relationship between coping strategies, self-esteem, perceived social support, and depressive symptoms among individuals. There was a significant correlation between coping strategies, self-esteem, perceived social support, and depressive symptoms among individuals, which was statistically significant (n = 200, $p < 0.01$).

Table 9 shows that there is a significant relationship between coping strategies, self-esteem, perceived social support, and depressive symptoms. The statistical value indicates that self-esteem, coping strategies, and perceived social support are positively correlated with one another. The result also indicates that self-esteem, coping strategies, and perceived social support are negatively correlated to depressive symptoms. It shows that low self-esteem, coping strategies, and perceived social support lead to an increase in depressive symptoms. Low self-esteem has been consistently found to be a risk factor for depression. People with low self-esteem tend to have negative views of themselves, which can lead to feelings of worthlessness, hopelessness, and helplessness - all of

which are common symptoms of depression. Social support has been found to be a protective factor against depression. People who have supportive relationships with family, friends, or other social networks are less likely to experience depressive symptoms. This may be because social support provides emotional and practical assistance, as well as a sense of belonging and connectedness, which can buffer against the negative effects of stress and adversity. It is found that effective coping strategies, such as problem-solving, positive reappraisal, and seeking social support, are associated with lower levels of depression. In contrast, ineffective coping strategies, such as avoidance, rumination, and substance use, are associated with higher levels of depression. By promoting self-esteem, fostering supportive relationships, and encouraging effective coping strategies, it may be possible to prevent or reduce the risk of depression. The findings of the longitudinal study (Lee, 2013) indicate that self-esteem may affect both perceived social support and disengagement coping to subsequently predict depressive symptomatology. Hence, the hypothesis 4 *"there will be a significant relationship between coping strategies, self-esteem, perceived social support, and depression among young adults"* **is accepted.**

Table 10

Group Statistics based on gender

Variable	Gender	N	Mean	SD	*t*	*p*
Self – Esteem	Male	100	70.50	11.706	-1.973*	.041
	Female	100	73.53	9.940		
Perceived social support	Male	100	66.69	13.966	-1.113	.267
	Female	100	68.90	14.110		
Coping Strategies	Male	100	36.40	6.267	-1.801	.073
	Female	100	38.03	6.528		
Depressive symptoms	Male	100	13.45	6.225	2.566**	.010
	Female	100	11.18	6.287		

Note. * Correlation is significant at .05 level (1-tailed)

** Correlation is significant at .01 level (2-tailed)

A *t* test is a statistical test that is used to compare the means of two groups. It is often used in hypothesis testing to determine whether two groups are different from one another.

Table 10 shows the gender difference in self-esteem, coping strategies, perceived social support, and depressive symptoms among young adults calculated by independent sample t-test. The statistical value indicates that there is a significant gender difference in depressive symptoms and self-esteem. The mean score of self-esteem was lower for males (70.50) than for females (73.53), and the difference was statistically significant (t = -1.973, $p < .05$). This suggests that

females have higher self-esteem than males in this sample. It also shows that females seem to have higher self-esteem than males. It is during this period of development, females mainly build their self-esteem and self-concept. During late adolescence and early adulthood, girls tend to develop a sense of self. In accordance with the culture, it might be possible that girls to have a higher level of self-esteem. This result might be also due to the high maturity level of females (Ansu & Vidhya, 2016). The mean score of perceived social support was slightly lower for males (66.69) than for females (68.90), but the difference was not statistically significant (t = -1.113, p = .26). This suggests that there may not be a significant gender difference in perceived social support in this sample. The mean score of coping strategies was lower for males (36.40) than for females (38.03), but the difference was not statistically significant (t = -1.801, p = .07). This suggests that there may not be a significant gender difference in coping strategies in this sample, although the p-value is close to the conventional threshold for statistical significance ($p < .05$). The mean score of depressive symptoms was higher for males (13.45) than for females (11.18), and the difference was statistically significant (t = 2.566, p = .01). This suggests that males may have higher levels of depressive symptoms than females in this sample. The majority of surveys conducted previously found the significant difference among the different gender, such as American male college students are more easily depressed than females (Grant et al., 2002). Overall, the results suggest that there may be some gender differences in self-esteem and depressive symptoms, but not in perceived social support or coping strategies, in this particular sample. However, it is based on a single study and may not generalize to other populations or contexts. Further research is needed to confirm and extend these findings. Hence, the hypothesis 5 *"there will be a significant gender difference between coping strategies, self-esteem, perceived social support, and depression among young adults"* **is partially accepted.**

Table 11.1

Regression model to examine the relationship between depressive symptoms on self-esteem, coping strategies and perceived social support

Model	R	R Square	Adjusted R Square	Std. Error of Estimate
1	.716[a]	.513	.506	4.460

a. Predictors: (Constant), self-esteem, coping strategies, perceived social support

Table 11.1 shows the regression model to examine the relationship between depressive symptoms on self-esteem, coping strategies and perceived social support. The statistical values of R and R^2 show that there is a simple correlation and is .716 (the "**R**" Column), which indicates a high degree of correlation. The R^2 value (the "**R Square**" column) indicates how much of the total variation in the dependent variable can be explained by the independent variable. The statistical value shows that, 51.3% of the total variation in the depressive symptoms can be explained by self-esteem, coping strategies and perceived social support, which is moderate. This indicates that self-esteem, coping strategies and perceived social support are important, but there are likely other factors that also contribute to the development and experience of depressive symptoms.

Table 11.2

Analysis of Variance of the regression model predicting depressive symptoms by the predictors self-esteem, coping strategies and perceived social support

Model	Sum of Square	df	Mean Square	F	*p*
Regression	4109.200	3	1369.733	68.874	<.001[b]
Residual	3897.955	196	19.888		
Total	8007.155	199			

a. Dependent Variable: Depressive symptoms
b. Predictors: (Constant), self-esteem, coping strategies, perceived social support

Table 11.2 shows the Analysis of Variance of the regression model predicting depressive symptoms by the predictors self-esteem, coping strategies and perceived social support. The result indicates that the regression model predicts the dependent variable significantly well. This indicates the statistical significance of the regression model that was run. Here, $p < .001$, which is less than .001, and shows that, the regression model statistically significantly predicts the outcome variable.

Table 11.3

Unstandardized and standardized coefficients of the regression model predicting depressive symptoms by the predictors self-esteem, coping strategies and perceived social support

Model		Unstandardized Coefficients		Standardized Coefficients	*t*	*p*
		B	Std. Error	Beta		
1	(Constant)	45.420	2.481		18.307	<.001
		-.094	.027	-.207	-3.500	<.001
		-.502	.053	-.509	-9.385	<.001
		-.112	.033	-.194	-3.385	<.001

a. Dependent Variable: Depressive Symptoms

Table 11.3 shows the unstandardized and standardized coefficients of the regression model predicting depressive symptoms by the predictors self-esteem, coping strategies and perceived social support. The statistical value indicates that the regression model predicts the dependent variable significantly well. It may be inferred that coping strategies are found to be moderately significant ($\beta = -.502$, $p < 0.001$) negative predictors of depressive symptoms. It may also be further noted that self-esteem and perceived social support has a weak negative prediction towards Depressive Symptoms. Hence it may be inferred that whenever there is a change in self-esteem, coping strategies and perceived social support there will also be a change in the individual's level of depressive symptoms. From this, it is understood that coping strategies play an important role in the influence of depressive symptoms among young adults. Overall, this model suggests that social support, coping, and self-esteem are important predictors of depressive symptoms, and that

increasing these factors may help to reduce symptoms of depression. However, it is important to keep in mind that this is only one model and additional research would be needed to confirm these findings. Hence, the Hypothesis 6 stating*, "there will be a significant influence on depressive symptoms by self-esteem, coping strategies and perceived social support among young adults"* **is accepted**.

SUMMARY AND CONCLUSIONS

Chapter – 5

Summary and Conclusions

A study on " Role of Self-Esteem, Perceived Social Support, and Coping Strategies in the Escalation of Depressive Symptoms" was conducted to understand the psychological aspects of self-esteem, perceived social support, and coping strategies in the escalation of depressive symptoms Young adulthood is a major life shift that can be extremely stressful, which may cause the onset or escalation of depression symptoms. Understanding the processes and routes through which such symptoms develop is crucial because of the significant poor effects that are linked to depressive symptoms over the lifespan. This current research investigates the relationship between depressive symptoms, self-esteem, perceived social support, and coping Strategies. The study was initiated with the following objectives:

- To assess the level of self-esteem among young adults
- To assess the level of perceived social support among young adults
- To understand the level of coping among young adults
- To explore the relationship between self-esteem, perceived social support, and coping strategies in an escalation of depressive symptoms among young adults
- To find the gender difference in self-esteem, perceived social support, and coping strategies in an escalation of depressive symptoms among young adults
- To find the effects of self-esteem, perceived social support, and coping strategies in depressive symptoms among young adults

The hypotheses formulated for the research were:

- There will be a significant relationship between self-esteem and perceived social support among young adults
- There will be a significant relationship between perceived social support and coping among young adults

- There will be a significant relationship between self-esteem and coping among young adults
- There will be a significant relationship between self-esteem, perceived social support, coping strategies, and depressive symptoms among young adults
- There will be a significant gender difference in self-esteem, perceived social support, coping strategies, and depressive symptoms among young adults
- There will be a significant influence of self-esteem, perceived social support, coping strategies on depressive symptoms among young adults

The sample for the study consisted of 200 young adults of age 18 to 25 years who live in Namakkal. The data was collected in person using a simple random sampling technique. Socio-demographic status profile, Confidentiality Statement, Center for Epidemiologic Studies Depression Scale Revised (CESD-R- 10), Coping Scale, Multidimensional Scale of Perceived Social Support and Self-esteem were given to the participants and they were instructed to read each item very carefully and choose the options that suit them the best. They were informed that the data collected will be confidential. The scoring was done according to the scoring key and interpreted using the norms provided by the authors. The results were analysed using the SPSS software version 29.0.0.0. Pearson Correlation and Independent Sample *t*-test were used to verify the hypotheses. The findings of the study were:

- There is a significant relationship between self-esteem and perceived social support among young adults. Hence formulated hypothesis 1 has been accepted.
- There is a significant relationship between perceived social support and coping among young adults. Hence formulated hypothesis 2 has been accepted.
- There is a significant relationship between self-esteem and coping among young adults. Hence formulated hypothesis 3 has been accepted.

- There is a significant relationship between self-esteem, perceived social support, coping strategy, and depressive symptoms among young adults. Hence formulated hypothesis 4 has been accepted.
- There is a significant gender difference in self-esteem, perceived social support, coping strategy, and depressive symptoms among young adults. Hence formulated hypothesis 5 has been partially accepted.
- There is a significant influence of self-esteem, perceived social support, coping strategies on depressive symptoms among young adults. Hence formulated hypothesis 6 has been accepted.

Conclusions

The beginning of adulthood is the time when people start looking into and realizing the potential of their lives, supporting the idea that they are now considered adults rather than teenagers. Choices made then heavily influence a person's future course in life, and mistakes made then have a lasting impact. The ambiguities of entering adulthood also contribute to the age of uncertainty. Overall, findings from the present study suggest that self-esteem, perceived social support, and coping strategies have a significant negative correlation with depressive symptoms. The study suggests that individuals with stronger self-esteem, social support networks, and effective coping strategies are less likely to experience depression than those who lack these protective factors. The followings are some of the conclusions of the study perceived social support and self-esteem are positively related, coping strategies and self-esteem are positively related, perceived social support and coping strategies are positively related. Self-esteem, and there is a significant gender difference in depressive symptoms and self-esteem. It also seems that self-esteem, perceived social support, and coping strategies are significant predictors of depressive symptoms. It is also suggested that by promoting self-

esteem, fostering supportive relationships, and encouraging effective coping strategies, it may be possible to prevent or reduce the risk of depression.

Limitations

- The area of the present research was restricted to a limited geographical location and hence generalizing the results would be done with care
- The sample size of the study was small
- The study was confined to young adults (18-25 years). Hence, the generalization of results is limited
- All the measures were self -report based measures which might have led to socially desired responses and bias as well as affected the results of this study

Recommendations

- The research can be expanded to diversified and cross-cultural samples
- Further research can be carried out on a larger sample size
- More in-depth analysis can be carried out on self-esteem, academic anxiety and life orientation of different age groups
- An interventional study could be conducted to reduce depressive symptoms and enhance self-esteem
- Future studies would benefit from the inclusion of multiple informants (e.g., friends, parents) and multiple measurement modalities (e.g., self-report, interview, behavioral) to assess coping, self-esteem, social support, and depressive symptoms.

Implications

This study provides additional empirical support for the positive association between disengagement coping and depressive symptoms. More generally, and extending existing models of self-esteem and depression, the findings of this prospective study emphasize the

importance of perceived social support as a mechanism through which self-esteem affects depressive symptoms, as well as the notable harm of disengagement coping strategies. Understanding the aspects of self-esteem, coping strategies and perceived social support can help in the development of specific interventions to cope with the negative effects of depressive symptoms. From the study, it is inferred that coping strategies are moderate predictors of depressive symptoms which can help in the development of interventions in the future. The result of the study also shows that adaptive coping strategies can help in the reduction of depressive symptoms. This study would serve as a background data for further research.

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APPENDICES

Appendices

Annexure 1

Student Consent Form

I (Ilamathi. K. S) am pursuing my Master’s degree in Clinical Psychology and I would like to have your participation in this academic research. I assure confidentiality with the details provided by you and it will be used only for the academic purpose. Thank you for the same.

Study Procedure

You will be given four tests in form type along with a socio-demographic profile. You need to respond to all items in the tests. There is no risk in undertaking the study. There will be no direct benefits to you for your participation in this study. Your response to the question will be anonymous and kept confidential. Your participation in this study is voluntary. It is up to you to decide whether to take part or not in this study. If you decide to take part in this study, you will be asked to sign this form. You are free to withdraw at any time and without giving any reason. There is no cost would be provided to you for your participation in this study.

Consent Form

“By signing this consent form, I confirm that I have understood the information and have the opportunity to ask questions. I understand that my participation is voluntary and I am free to withdraw at any time, without giving a reason and without cost. I voluntarily agree to take part in this study.”

Name of the participant:

Signature:

Place:

Date:

Annexure 2

Demographic Profile

- Name :
- Gender :
- Age :
- Occupation or Qualification :
- Family : Nuclear/Joint
- Are you from an Urban or Rural :

Annexure 3

Avinashilingam Institute for Home Science and Higher Education for Women,

Coimbatore – 641043

Confidentiality Statement

I **Ilamathi, K. S.,** pursuing my II M.Sc., Clinical Psychology from the department of Clinical Psychology in Avinashilingam Institute for Home Science and Higher Education For Women, Coimbatore-43, is assigned to do a thesis as a part of the curriculum to complete my course. In this connection, I'm going to collect information from young adults (18-25 years) as my topic is **Role of Self-Esteem, Perceived Social Support and Coping Strategies in the Escalation of Depressive Symptoms among Young Adults**. I assure confidentiality with the details provided by you and it will be used only for the academic purpose. Thank you for the same.

Place: Signature of the Researcher

Date:

Annexure 4

State Self-Esteem Scale

Instructions: The best answer is what you feel is true of yourself at the moment. Do not skip any items. There is no right or wrong answer. All items are answered using 5-alternatives: (1= not at all, 2= a little bit, 3= somewhat, 4= very much,5= extremely)

1. I feel confident about my abilities	1	2	3	4	5
2. I am worried about whether I am regarded as a success or a failure	1	2	3	4	5
3. I keep worrying that people are noticing my shortcomings	1	2	3	4	5
4. I feel frustrated or rattled about my performance	1	2	3	4	5
5. I feel that I am having trouble understanding things that I read	1	2	3	4	5
6. I feel that others respect and admire me.	1	2	3	4	5
7. I am dissatisfied with my weight	1	2	3	4	5
8. I feel self-conscious	1	2	3	4	5
9. I feel as smart as others.	1	2	3	4	5
10. I feel displeased with myself	1	2	3	4	5
11. I feel good about myself	1	2	3	4	5
12. I am pleased with my appearance right now.	1	2	3	4	5
13. I am worried about what other people think of me.	1	2	3	4	5
14. I feel confident that I understand things	1	2	3	4	5
15. I feel inferior to others at this moment.	1	2	3	4	5
16. I feel unattractive.	1	2	3	4	5
17. I feel concerned about the impression I am making.	1	2	3	4	5
18. I feel that I have less scholastic ability right now than others	1	2	3	4	5
19. I feel like I'm not doing well	1	2	3	4	5
20. I am worried about looking foolish.	1	2	3	4	5

Annexure 5

Multidimensional Scale of Perceived Social Support

Instructions: Read each statement carefully. Indicate how you feel about each statement.

Circle the "1" if you **Very Strongly Disagree**

Circle the "2" if you **Strongly Disagree**

Circle the "3" if you **Mildly Disagree**

Circle the "4" if you are **Neutral**

Circle the "5" if you **Mildly Agree**

Circle the "6" if you **Strongly Agree**

Circle the "7" if you **Very Strongly Agree**

1	There is a special person who is around when I am in need.	1	2	3	4	5	6	7
2	There is a special person with whom I can share joys and sorrows.	1	2	3	4	5	6	7
3	My family really tries to help me.	1	2	3	4	5	6	7
4	I get the emotional help & support I need from my family.	1	2	3	4	5	6	7
5	I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
6	My friends really try to help me.	1	2	3	4	5	6	7
7	I can count on my friends when things go wrong.	1	2	3	4	5	6	7
8	I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
9	I can talk about my problems with my family.	1	2	3	4	5	6	7
10	There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7
11	My family is willing to help me make decisions.	1	2	3	4	5	6	7
12	I can talk about my problems with my friends.	1	2	3	4	5	6	7

Annexure 6

Coping Scale

Instructions: Read the statements carefully and choose the option that suits you the best. There is no right or wrong answer. Do not skip any statements and do it as quickly as possible.

S.No	Statements	Mostly true about me	Somewhat true about me	A little true about me	Not true about me
1.	When dealing with a problem, I spend time trying to understand what happened.	1	2	3	4
2.	When dealing with a problem, I try to see the positive side of the situation.	1	2	3	4
3.	When dealing with a problem, I try to step back from the problem and think about it from a different point of view.	1	2	3	4
4.	When dealing with a problem, I consider several alternatives for handling the problem.	1	2	3	4
5.	When dealing with a problem, I try to see the humor in it.	1	2	3	4
6.	When dealing with a problem, I think about what it might say about bigger lifestyle changes I need to make.	1	2	3	4
7.	When dealing with a problem, I often wait it out and see if it doesn't take care of itself.	1	2	3	4
8.	When dealing with a problem, I often try to remember that the problem is not as serious as it seems.	1	2	3	4
9.	When dealing with a problem, I often use exercise, hobbies, or meditation to help me get through a tough time.	1	2	3	4
10.	When dealing with a problem, I make jokes about it or try to make light of it.	1	2	3	4
11.	When dealing with a problem, I make compromises.	1	2	3	4
12.	When dealing with a problem, I take steps to take better care of myself and my family for the future.	1	2	3	4
13.	When dealing with a problem, I work on making things better for the future by changing my habits, such as diet, exercise, budgeting, or staying in closer touch with people I care about.	1	2	3	4

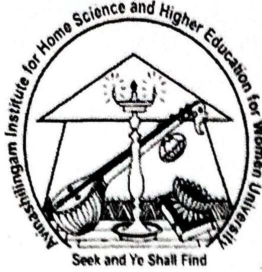
Annexure 7

Center for Epidemiologic Studies Short Depression Scale (CES-D-R 10)

Below is a list of some of the ways you may have felt or behaved. Please indicate how often you have felt this way during the past week by checking the appropriate box for each question.

		Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	All of the time (5-7 days)
1	I was bothered by things that usually don't bother me.				
2	I had trouble keeping my mind on what I was doing.				
3	I felt depressed.				
4	I felt that everything I did was an effort.				
5	I felt hopeful about the future.				
6	I felt fearful.				
7	My sleep was restless.				
8	I was happy.				
9	I felt lonely.				
10	I could not "get going."				

INSTITUTIONAL HUMAN ETHICS COMMITTEE



Avinashilingam

Institute for Home Science and Higher Education for Women (Deemed to be university under Category 'A' by MHRD, Estd. u/s 3 of UGC Act 1956) Re-accredited with 'A++' Grade by NAAC. Recognised by UGC Under Section 12 B Coimbatore- 641043, Tamil Nadu, India

06.01.2023

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Dr. Anitha Subash
Dr. K. Sampath Rani

To
Ms. Ilamathi, K. S.
Department of Clinical Psychology
Avinashilingam Institute for Home Science and
Higher Education for Women
Coimbatore- 641043

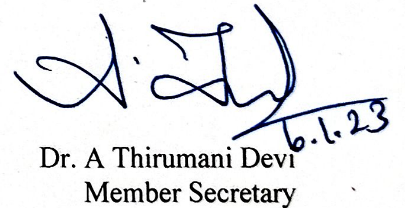
Dear Ilamathi,

Ref: Your proposal No. IHEC/22-23/CP-07 entitled "Role of Self-Esteem, Perceived Social Support and Coping Strategies in the Escalation of Depressive Symptoms among Young Adults"submitted for approval of IHEC on 19.11.2022.

The Institutional Human Ethics Committee of our University hereby grants approval to your research proposal No.IHEC/22-23/CP-07 entitled "Role of Self-Esteem, Perceived Social Support and Coping Strategies in the Escalation of Depressive Symptoms among Young Adults" submitted by you. The Approval number for the same is AUW/IHEC/CP-22-23/XMT-07.

We wish you all the best in your research endeavours.

Regards



Dr. A Thirumani Devi
Member Secretary