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Specific domains of self-esteem in adolescents : Differences between suicide ideated, depressed and non-depressed samples

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Running Head: ADOLESCENT SELF-ESTEEM & SUICIDAL IDEATION

Specific Domains of Self-esteem in Adolescents:

Differences Between Suicide Ideated, Depressed and

Non-depressed Samples

by

Wendy J. Nicholls

A Thesis Submitted in Partial Fulfilment of the

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USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

Abstract

A 1997 West Australian Child Health Survey (Zubrick et al., 1997) highlighted the need to explore issues regarding problems leading to emotional distress in adolescents. Adolescent self-esteem and suicidal ideation emerged as issues that required further research. The need to understand adolescent issues from a developmental perspective was also evident, due to the difficulties teenagers typically face during their adolescent years. This study builds on previous research by S. Harter and her colleagues, which identified different domains of self-esteem in young adolescents from a general population. Domains of self-esteem according to Harter's Self-perception Profile for Adolescents (1988) and Social Support Scale for Children (1985) are explored in this study, comparing three different groups of older adolescents. The purposive sample included 78 participants aged 16 to 18 years, including 53 from the general population, 33 non-depressed and 20 depressed and, 25 adolescents who are receiving therapy after being diagnosed with recent experiences of suicidal ideation. Four research questions are posed to explore comparisons between the three groups in different domains of self-esteem. Self-perception is explored in nine domains, scholastic competence, social acceptance, athletic competence, physical appearance, job competence, romantic appeal, behavioural conduct, close friendship and global self-worth. Discrepancy scores, where perceived importance is greater than perceived competence in different domains are also explored. The discrepancy scores identify

perceived inadequacies in different domains, indicating specific areas where self-esteem is threatened in the suicide-ideated group. Perceived parental and peer support are also compared between the three groups to ascertain how teenagers view themselves through the eyes of significant people in their lives. It was expected that perceived physical appearance, social acceptance, athletic competence, scholastic competence and behavioural conduct would be higher in the non-depressed teenagers than in the depressed and suicidal ideated samples. Larger discrepancy scores were expected in the suicidal ideated adolescents than those in the general population, indicating greater perceived inadequacies in domains of self-esteem. It was also expected that the clinical group would score lower perceived parental support and lower perceived peer support than the other groups. Results provided differences between the three groups, with global self-worth, physical appearance and scholastic competence emerging as being of most concern for suicide ideated adolescents. Implications for clinicians working with depressed and suicidal adolescents are discussed within the context of current literature. Suggestions for further research are proposed and practical implications regarding clinical assessment for suicidal adolescents are discussed.

Declaration

I certify that this thesis does not incorporate, without acknowledgment, any material previously submitted for a degree or diploma in any institution of higher education and that, to the best of my knowledge and belief, it does not contain any material previously published or written by another person except where due reference is made in the text. Nor does it contain any defamatory material.

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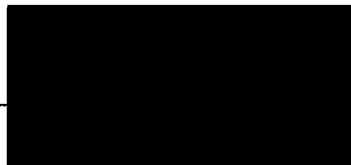
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CHAPTER ONE

Introduction

<u>Background</u>

Internationally, suicidal behaviour has been recognised as being a considerable problem in the past two decades, particularly among adolescents (Aro, Marttunen, & Lonnqvist, 1993; Diekstra, 1989, 1995; Harter, 1993; Harter, Marold, & Whitesell, 1992; Heaven, 1994; MacLean, 1990; Pfeffer, 1994; Steele, & McLennan, 1995). In Australia, the prevalence of adolescent suicide has recently gained the attention of the West Australian child health authorities. A recent Australian Bureau of Statistics (ABS) WA Child Health Survey highlighted the escalation of adolescent suicide and suicide ideation among young West Australians during the past decade (Zubrick et al., 1997).

The WA Child Health Survey highlighted some key considerations in addressing adolescent developmental issues. The need to explore and understand various types of problems that lead to emotional distress in adolescence was emphasised. The report reviewed adolescent issues such as self-esteem, self-efficacy, school socialisation, stress, sports and leisure. Considerable attention was also given to problems associated with violence, bullying, self-harm and suicidal behaviour (Zubrick et al., 1997). Thus, the need to explore adolescent issues from a

developmental perspective and to ascertain specific areas that are

causes for concern during adolescence emerged.

Psychological change is unavoidable for adolescents, as they work

toward gaining independence and increasing responsibilities. This is

often at a time when their direction in life requires them to make

considerable adjustments. They develop their own value system,

become more sexually mature, establish relationships at a more mature

level and, prepare for their chosen career paths or entry into the

workforce (Zubrick et al., 1997). Such adjustments could also be

explained in terms of changes in the physical, intellectual, emotional,

attitudinal and physical areas (Capes, 1975). Further, adolescents of the

nineties have to face considerably more challenges, demands and

expectations that carry larger risks, compared with adolescents of past

generations (Zubrick et al., 1997). Thus, it is evident that the changes

within adolescents' own physical, intellectual and social developmental

processes and the context of their social era all have an impact on their

psychological well being.

A major area covered in the Zubrick et al. (1997) survey was the

assessment of global self-esteem in adolescent students, particularly in

relation to academic competence. The association between academic

competence and self-esteem has received considerable attention in the

literature (Beer & Beer, 1992; Bekhuis, 1994; Cairns, McWhirter, Dufffy, &

Barry, 1990; Harter, 1990; Marsh, 1986; Trent, Russell, & Cooney, 1994),

indicating recognition of the association between the two variables. The

survey also identified an association between adolescent stress and parental expectations of academic performance (Zubrick et al., 1997). The results of the survey emphasise the need for research that identifies specific areas that may be contributing to low self-esteem among Australian adolescents. Further, due to the high prevalence of suicidal behaviour among older adolescents in Australia (Zubrick et al., 1997), the need to explore factors that contribute to suicide ideation becomes evident. Considering the many changes that occur during adolescence, the question of what causes teenagers to want to end their lives leads to quite a complex range of issues.

There are a number of factors that need to be considered when assessing causes of distress leading to suicide ideation and suicide. According to Baumeister (1990), suicide is a self-destructive behaviour, whereby the individual seeks to escape from feelings of inadequacy that have eventuated from falling short of various expectations and standards. Harter et al. (1992) found that adolescents who reported frequent thoughts of suicide also experienced feelings of inadequacy, low self-worth, a lack of social support, depression and a sense of hopelessness regarding the future. Although depression is commonly found in those who are suicide ideated, Baumeister (1990) suggests that suicide attempts can not always be explained by depression. He considers that depression does not always lead to suicide attempts, nor are suicidal people necessarily clinically depressed. Therefore, although depression is often a factor that is commonly associated with depression, it is

apparent that issues related to how a person feels about the self as a person are more likely causal factors of suicide ideation. Thus, Harter et al. (1992) suggest that various areas of low self-esteem, including different aspects of perceived inadequacy, which may or may not be related to depression, are more likely to lead to suicide ideation.

The purpose of this thesis is to explore different components of self-esteem that may contribute to suicidal ideation in adolescence. This will be framed within a developmental context and will also consider various components of depression that may be contributing to suicidal ideation. While the main focus of this thesis is on various aspects of self-esteem and depression in suicide ideated adolescents, it is acknowledged that these variables alone are not assumed to be causal factors of suicide ideation. It is evident that other factors exist that potentially contribute to suicide ideation during adolescence. Therefore, this study is considered to address only a small part of a potentially complex range of other issues that may also contribute to youth suicide. This research proposes to provide some understanding of how adolescents who are experiencing suicide ideation differ in specific domains of self-esteem, when compared with adolescents in the general population who are not suicide ideated.

As it is necessary to address three major areas in this study, the literature review is considerably comprehensive. The following three chapters will review the literature in each area. Chapter Two will discuss diverse views on self-esteem in general and then will focus on adolescent

self-esteem, with consideration given to developmental issues. Chapter

Three will review adolescent depression, linking the various issues

associated with self-esteem and suicide ideation. Chapter Four will

address the area of suicide ideation in adolescence and will review

epidemiological reports and potential factors contributing to suicidal

behaviour. These three areas will form the basis and give the reader

some understanding behind the research questions and hypotheses

addressed in this thesis.

CHAPTER TWO

Self-esteem

Self-esteem is an important consideration when addressing suicidal behaviour. This is due to the general understanding that the initiative to end one's life is a direct assault on the self as a person. Therefore, to understand suicidal thinking, it is necessary to be aware of different concepts about the self. Defining self-esteem is difficult due to the number of diverse theoretical viewpoints that have existed over the past century. Dusek (1996) states that the number of definitions of the self equals the number of people who have studied it. Of major concern regarding the existing research on self-esteem is the vague understanding of what constitutes self-esteem. According to Demo (1985), definitions of self-esteem vary among theorists and researchers, leading to very little consensus. This is possibly reflected in the diversity of terms used to describe self-esteem, such as self-concept, self-evaluation, self-perception, self-worth and so on. Bogan (1988) suggests that various theorists may assign different meanings to different terms. Therefore, definitions may vary according to the terminology used, which is also influenced according to the meaning assigned to the terms used. For the purpose of this thesis, the term self-esteem refers to the overall concept of self that encompasses all expressions of one's own perceived value. Self-perception refers to the part of self-esteem that refers to the concept or perception one has of self, according to one's own ability and self-attributes.

In general, there is an understanding that self-esteem is derived from a personal concept of self, including self-image, self–worth and a sense of self in general. This is also reflected in the Zubrick et al. (1997) survey. However, two major perspectives on self-esteem appear to emerge from the literature. One is that self-esteem is based on the social interactions with significant others in one's life, while the other is more directed toward an individual's view of the self in relation to competence. For example, some theorists argue that concepts of self-esteem are at least partially, social in nature and that people develop a view of self through the perceived opinions and positive regard of significant other people in their lives (Harter, 1989; Rosenberg, 1965). Similarly, others consider that self-esteem is developed through the social experiences of growing up, with an emphasis on the support and influences of the parents and significant adults (Killeen & Forehand, 1998). Other theories suggest that self-esteem is predominantly determined by various areas of competency in one's life (Chan, 1997; Harter, 1989; Marsh, 1986; Nottelmann, 1987).

Harter (1986) suggests that both perspectives together provide a complete appraisal of self-esteem. Her approach to the study of self-esteem is based on the pioneering works of early psychological theorists, James and Cooley (cited in Harter, 1986). James considered self-esteem to be attributed to the perceived level of importance on specific domains of competency, in association with one's own performance. That is, when issues are deemed to be important to an individual and that individual's

competence regarding those issues is high, self-esteem is more likely to be high. Conversely, should an individual have high aspirations in an area deemed important to that person and perceived competence is low, that person will experience low self-esteem generated from that area (Harter, 1989). Alternatively, Cooley viewed self-esteem as a social construct, whereby the perceived reflection of self is based on the social interactions with other people. In other words, people assess their own value according to the perceived regard or support they receive from other people. Therefore, the opinions and judgements of people who are considered important to an individual determine the level of self-esteem accorded to that individual (Harter, 1989).

Further differences among theorists have existed in the past century regarding the overall conceptual understanding of self-esteem. While some have maintained that self-esteem is a global concept, often described as a uni-dimensional construct, others suggest that it is multi-dimensional in nature and can be viewed in terms of having specific domains that can be identified and evaluated separately (Eiser, Eiser, & Havermans, 1995; Marsh & Gouvernet, 1989). More recent views propose a multi-dimensional perspective, suggesting that self-esteem is influenced by various aspects of academic, physical, personal and social domains (Dusek, 1996; Marsh & Gouvernet, 1989; Trent et al., 1994). Harter (1982) suggests that self-esteem is multi-dimensional, comprising of a combination of domains of perceived competence and perceived social support or regard. She suggests that competence domains include

scholastic competence, social acceptance, athletic competence, physical appearance, job competence, romantic appeal, behavioural conduct, close friendship and global self-worth. Social support domains include parent support, teacher support, classmate support and friend support. This view contrasts to the uni-dimensional approach, which is indicated by some theorists, to mask important distinctions in domains across peoples' lives (Harter, 1988; Trent et al., 1994). Recent research on specific domains of perceived competence in adolescence and their association with global self-worth, led Chan (1997) to suggest that making evaluative distinctions across various domains of life provides valuable information that would not be identified with uni-dimensional measures. This reflects the current view generally accepted among theorists and researchers, that self-esteem is multifaceted and is best considered in separate components, including a global concept.

Another difference occurs in the theoretical perspectives approaching the study of self-esteem. Harter (1989) draws attention to the difference between the individual difference approach and the developmental approach. In her work, she integrates these two perspectives to form a more comprehensive perspective of the role of global self-worth. While individual differences among gender and personality are evident, Harter (1989) claims that developmental issues have an effect on self-esteem throughout the life span (Harter, 1989). This is also substantiated by Damon and Hart (1985) and by Smollar and Youniss (1985), who further suggest that changes occur so rapidly in the

development of self-concept, that a distinction is also evident from early to late adolescence. Adolescent issues such as identity, status, independence and competence (Beer & Beer, 1992), perception of self and the environment (Brage & Meredith, 1994) and the pressures associated with competence and academic performance (Harter & Marold, 1994; Zubrick et al., 1997) are clearly developmental in nature and need to be considered when studying adolescent self esteem.

Adolescent Self-esteem

Adolescent self-esteem is a complex area of study involving many underlying issues associated with cognitive development, social development and identity issues related to self-understanding. Specific domains of self-perception pertinent to the adolescent developmental period have been identified by scholastic competence, athletic competence, job competence, behavioural conduct, physical appearance, social acceptance, close friendship, romantic appeal and a sense of global self-worth. The discrepancy between perceived competence and perceived importance on each domain determines the level of self-esteem experienced in that area. That is, when the perceived level of importance exceeds the perceived level of competence on any domain, low self-esteem results (Harter, 1988).

From a developmental perspective, adolescence is perhaps one of the most critical developmental periods influencing self-esteem. This is largely due to the many changes that take place in an adolescent's life, as stated in Chapter One. Much of the knowledge about developmental

changes in adolescence stems from the works of Erikson (1963). Erikson's fifth stage of psychosocial development depicts the adolescent period, which is described as being a time of crisis when generally, adolescents either develop a sense of *identity* or *role confusion*. This time of life marks the end of childhood and the beginning of youth, as the adolescent questions much that was learned as a child following a period of rapid physiological change. Previously accepted moral, ethical, ideological and societal values that were formed in the earlier years of development are revisited and questioned (Erikson, 1963). Further, the uncertainty of future adult roles will often cause adolescents to be preoccupied with their view of themselves according to who they are and how they appear through the eyes of others (Erikson, 1968).

Adolescent Identity, Self-understanding and Self-esteem

        The concept of identity development and formation is closely linked to the concepts of self-understanding and self-esteem (Heaven, 1994). According to Damon and Hart (1982) assessment of self-esteem cannot be done without consideration of self-understanding, as an understanding of self is instrumental in obtaining an understanding of one's social world. This interplay of association between identity, self-understanding and self-esteem further demonstrates the importance and significance of a developmental focus when investigating adolescent self-esteem. As adolescents develop new and diverse roles and skills while striving for continuity and sameness (Erikson, 1968), it is necessary to be mindful that it is a transitory period of life, wrought with many developmental

changes. Such changes can have significant effects on adolescent self-views. While adolescents with high self-esteem are considered to be better adjusted psychologically and are more successful in life, those who have low self-esteem have been found to experience more negative outcomes in general (Dusek, 1996; DuBois, Bull, Sherman, & Roberts, 1998).

A comprehensive review by Damon and Hart (1982) outlines a distinct developmental difference in various aspects of self-understanding occurring from infancy through to adulthood. This includes significant changes between early and late adolescence. According to the review, existing literature provides substantial evidence that researchers recognise an increase in the use of psychological and social relational concepts throughout the adolescent period. Self-awareness increases as adolescents become aware of their own thoughts and emotions and, that their mental experiences have limitations that are sometimes beyond their control (Damon & Hart, 1982). Heaven (1994) suggests that adolescent self-understanding is developed through a process, with a realisation of the development of one's own personality, resulting in a more thoroughly developed psychological self by late adolescence.

Cognitive and Psychological Changes in Self-esteem

Harter (1990) suggests that changes taking place from childhood to adolescence are closely linked to cognitive development, but are more likely to be related to more personal changes such as those occurring within the self. Psychological changes in emotions, beliefs, attitudes,

motives and wishes emerge throughout adolescence. Therefore, changes in self-concept throughout adolescence are to be expected. Damon and Hart (1982) propose that four developmental levels exist regarding self-descriptions, progressing from childhood to adolescence. The first two relate to early and middle childhood and are characterised by categorical and comparative self-definitions respectively. The third level occurs in early adolescence and is more socially oriented, while the fourth level, occurring in late adolescence is more internalised, describing the self in terms of beliefs, morals, values and personal views. Thus, the existing evidence suggests that changes occur within the content of self-concept in adolescence, from behavioural and socially external self-descriptions to more internal psychological self-descriptions (Damon & Hart, 1982; Harter, 1990).

Considering the range of substantial developmental changes during adolescence in relation to identity, self-understanding and the development of a self-concept, challenges and difficulties during this period can be viewed as imminent. However, self-esteem is also affected by other factors occurring during adolescence that are more externally oriented, such as success in achieving the desired outcomes of scholastic competencies, personal life goals and social interactions (Harter, 1990).

The bulk of the adolescent period marks the years of academic achievement, leading to the pursuit of career goals such as university entrance or full time employment. During this time, the pressure of striving to achieve a variety of goals and challenges occurs within the

context of broadening experiences with social interactions. Therefore, it is not surprising that the period of adolescence brings with it many challenges that have considerable impact on self-esteem.

The Role of Perceived Competence in Self-esteem

Harter (1990) acknowledges a fundamental process of children making comparisons between themselves and other children, which affects them throughout their development. This is evident in the education system, as children are graded and ranked according to their ability. Harter (1990) suggests that this will cause children to place increasing value on performance as they develop. She further states that domains such as scholastic competence, peer popularity and physical appearance become more important, with an increased investment in their value with development. This highlights the implications surrounding adolescent self-esteem in the secondary school years, and the likelihood of adolescents investing more of themselves in these areas as high school progresses.

Academic performance is perhaps one of the most difficult challenges to adolescents as they approach the final years of their formal schooling. According to Rosenberg, Schooler and Schoenbach (1989), academic achievement represents an aspect of major importance to adolescent self-worth that has societal value. Nottleman (1987) found that self-esteem in early adolescence was associated with perceived competence in social, academic and physical domains. However, while domains of perceived competence remained stable over a one-year

period, self-esteem did not remain stable, but declined. In particular, self-esteem changed considerably from late child hood to early adolescence, becoming quite unstable. Nottelman (1987) concluded that transition from elementary to high school could in part be responsible for adolescents developing a lower self-esteem, due to the adjustments that need to take place. However, a drop in grade point average indicated that there are different standards for competence between elementary and high schools, which could also make a difference. These findings suggest that the experience and progress throughout high school could influence self-esteem considerably over the five years of attendance.

Self-esteem also seems to be considerably affected by daily experiences of adolescents. Chan (1997) found that scholastic competence, behavioural conduct and physical appearance all significantly predicted global self-worth. Harter (1990) states that physical appearance constantly appears as correlating most highly with global self-worth, closely followed by social acceptance, which was further supported by Trent et al. (1994). Cairns et al. (1990) found that perceived cognitive and social competence were the best predictors of overall self-esteem scores. While variations are evident in domains of self-perception and their effects on global self-worth, it appears that in general, scholastic competence, behavioural conduct, social acceptance and physical appearance are most important to adolescents.

Employment provides another area for adolescents to express their own perceived level of competence, as employment prospects

emerge during the adolescent period. Many high school students take the opportunity to earn a small personal income through the means of part time work. Mortimer, Finch, Ryu, Shanahan and Call (1996) consider that in the context of adolescent development, employment has become of increasing importance in recent years. They questioned whether increased work activity would influence academic achievement, behaviour or the mental health of students. Academic achievement was found to be higher in students who worked at a moderate pace than those who worked at a high pace and those who did not work at all. They found no evidence to suggest that self-esteem or depressive symptoms were related to work intensity. Also, according to Bachman and Schulenberg (1993) self-esteem is not necessarily related to the amount of paid work in which high school students are engaged, when low grades and career motives are taken into account. A further finding from the Mortimer et al. (1996) study is, that apart from engaging in more alcohol use, employed students showed no increase in problem behaviour. Thus, there appears to be no evidence to suggest that moderate part-time employment is detrimental to adolescent mental health, behaviour or academic achievement.

Social and Cognitive Development

The increase in social roles from childhood to adolescence is substantial and adolescent perception of various roles will have different effects on self-view. However, other developmental processes are occurring simultaneously to accommodate the ability to cope with the

variety of roles now in place. The cognitive development of formal operational thinking (Piaget & Inhelder, 1969) coincides with increased socialisation pressures (Harter, 1990), increasing the complexity of the adolescent developmental process. According to Harter (1990), while the cognitive developmental process appears to equip adolescents for further social demands, neo-Piagetian views consider that adolescent cognitive development occurs in stages. Therefore, adaptation to social pressures may be problematic as the adolescent progresses through various sub-stages of cognitive development until a time when full abstract reasoning can be achieved. Harter and Monsour (1992) found that considerable changes occurred in role-related attributes of the self throughout adolescence. This provides evidence to suggest that as various social roles are adopted, adolescents are able to develop greater differentiation of themselves due to increased cognitive ability.

The social roles of adolescents and their impact on self-esteem have gained considerable attention in the literature (Harter, 1990; Hoffman, Ushpiz, & Levy-Shiff, 1988; Killeen & Forehand, 1998; Rosenberg, 1965; Rosenberg et al., 1989; Schonert-Reichl & Muller, 1996). Research suggests that specific social roles occur simultaneously with conflicting opposite attributes in adolescence (Harter, 1990; Harter & Monsour, 1992). For example, feelings about friends may be quite contrary to feelings about teachers or peers. Harter (1990) found that distinct developmental differences were revealed between the ages of eleven and eighteen. She found that mid-adolescence (14-16) was a

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troublesome time, as opposing conflicts peaked during this period. At this time, adolescents experience conflicts within their personalities, due to opposing feelings attributed to various people within their lives. As a result, conflict occurs within the adolescent and with the ability to accommodate differentiation between the social roles. However, Harter and Monsour (1992) found a systematic decrease in conflict, opposing attributes and confusion in adolescents from year nine to year eleven. Harter (1990) and her colleagues (Harter & Monsour, 1992) suggest that Fischer's (1980) neo-Piagetian theory provide some reasonable explanation for these changes throughout adolescence.

According to Fischer (1980), formal operational thinking is presented as having sub-stages. That is, early adolescents can only operate with "single abstractions" about the self, being able to construct basic abstractions without cognitively relating them to the self or others. Therefore, they do not concern themselves with opposite attributes such as, for example, *cheerful* and *depressed* (Harter, 1990). Middle adolescence allows comparisons of abstractions, a term Fischer (1980) called "abstract mapping", which enables them to detect inconsistencies within the personality. This is a problematic time for adolescents as they are not yet able to integrate such inconsistencies (Harter, 1990). Older adolescents develop an "abstract system", enabling abstract reasoning to occur in relation to the self and to the self within various social roles. Fully developed abstract reasoning enables the adolescent to integrate single attributes, such as *cheerful* and *depressed* and combine them to

describe themselves or others as being *moody*. Thus, a higher order of abstract reasoning can take place enabling the older adolescent to resolve attributes that seem contradictory, by describing themselves or others in more complex terms such as for example, being *flexible*, *sensitive* or *adaptive* (Harter, 1990).

The Real and Ideal Self

Another developmental variation occurring during the adolescent period is the ability to differentiate between the real and the ideal self. According to Harter (1990), this process is also congruent with cognitive development and is another aspect of the self-concept formation. During childhood and adolescence, discrepancies exist between the real and ideal self, as self-perceptions vary according to how things really are or how the person would like them to be or perceive them to be in the future. Consistent with Fischer's (1980) theory of sub-stages in adolescent cognitive development, Strachen and Jones (1982) found that larger discrepancies between real and ideal selves were more evident during middle adolescence than earlier or later. Harter (1990) suggests that the middle adolescent period is distressing because of the lack of cognitive ability to integrate discrepancies between the real and ideal self. These identified vulnerabilities in the self-concept formation during the middle adolescent period, provide evidence to suggest that fourteen to sixteen year-olds may experience added stress that is not present either earlier or later.

Individual Differences

Further patterns have been identified with gender differences in adolescent self-esteem. Research findings indicate that adolescent females consistently report lower rates of global self-worth or general self-esteem than their male counterparts (Bekhuis, 1994; Cairns et al., 1990; Chan, 1997; Chubb, Fertman, & Ross, 1997; Harter, 1990; Trent et al., 1994). Trent et al. (1994) found that a similar pattern applied in domains of athletic competence and physical appearance, with a general theme of females reporting lower scores. Chan (1997) found that while boys felt more competent than girls in the athletic and physical appearance domains, girls were more confident in their ability to behave more positively than boys. Other gender differences were found by Cairns et al. (1990), with males showing perceived social competence to be a more important determinant of self-esteem than girls. Chubb et al. (1997) suggest that gender differences in adolescent self-esteem need to be explored. Their findings indicated that gender differences peaked in the ninth grade. Further, following an observation that gender differences were absent in self-esteem for primary aged children, they concluded that puberty and the impact of the female gender role, as determined by society may have negative consequences for female adolescent self-esteem.

Other individual differences associated with environmental conditions, age and social situations have also been found to be influential on adolescent self-esteem. Cairns et al. (1990) found that a

stable environment was associated with the stability of self-concept

throughout adolescence, with those remaining in stable environments

showing consistently higher self-esteem. In a similar vein, Bekhuis

(1994) found more variability of self-esteem in problem schools, while a

more positive social environment was related to a considerable reduction

in individual differences. Chan (1997) found that older adolescents felt

more competent in the employment domain than younger adolescents.

While some of these results seem self-evident and are to be expected,

others may provide information to increase the understanding of the many

variables that may influence self-esteem in the adolescent period.

Self-perception and Social Support

It is clear that a range of varying factors exist that can have a

considerable impact on adolescent self-esteem. However, specific

domains of self-esteem that include views of self in terms of perceived

competency, and the way in which the self is perceived through the eyes

of significant others, indicated by social support, provide a clear indication

of which areas of self-esteem are more affected than other areas. The

link between self-perception through various areas of competency and

the role that social support plays in contributing to self-esteem in

adolescence has been studied extensively by Harter (1988, 1989,

1990,1993) and her colleages (Harter & Marold, 1994; Harter et al.,

1992). They concluded that an overall sense of self-esteem is derived

from perceived competence in specific domains of importance, combined

with the perception of the extent to which significant others hold one in high esteem, a process termed *positive regard* or *social support*.

The work of Harter and her colleagues has revealed that the role of social support in relation to achievement, behaviour and attitude is largely dependent upon the perceived positive regard held by significant persons in the adolescent's life. Four significant groups of people whose opinions are important throughout childhood and adolescence were identified as being parents, peers, teachers and close friends (Harter, 1985). Further analysis based on the information obtained from a group of children and adolescents led Harter (1993) and her colleagues to identify two significant sources of support that were better predictors of self-esteem in younger adolescents. These were classmates and parents. Their analysis showed that peers rated physical appearance, athletic competence and social acceptance to be the most important attributes to have and, parents rated academic competence and behavioural conduct as being most important. These findings indicated that approval from parents was more likely to result from excellence in school work and good behaviour, while approval from peers was more likely to come from being good looking, likable and more athletically skillful (Harter, 1993).

CHAPTER THREE

Adolescent Depression

While self-esteem plays a role in understanding suicidal thinking, depression is also a significant contributor, often presenting in people who experience suicidal behaviour. This chapter will provide a background for understanding adolescent depression and will address the different presentations of depression. However, it mainly focuses on causes, antecedents, individual differences and developmental factors associated with adolescent depression.

According to the National Health and Medical Research Council of Australia (NHMRC) (1997), adolescent depression is a serious problem for the community and to adolescent mental health services. It is estimated that approximately 20% to 40% of the adolescent population experience some form of depression lasting for at least six months at any given time (NHMRC, 1997; Peterson et al., 1993).

According to the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994), depression is not a simple condition, but has several variations and is influenced by other factors. For instance, specific types of depression have different characteristics and are best considered within the context of severity (NHMRC, 1997; Peterson et al., 1993). It is further necessary to consider causes and antecedents (Harter, 1993; Peterson et al., 1993) and individual differences within a developmental context (Compas et al., 1997; Peterson et al., 1997). Another consideration is understanding that

there is a reciprocal effect between depression and self-esteem (Harter, 1990; Rosenberg et al., 1989). The potential link between self-esteem, depression and suicide also needs consideration (Harter et al., 1992). Heredity and environmental factors can also affect these variations, indicating that when evaluating depression, other influential factors need to be considered.

Types of Depression

The NHMRC (1997) suggest that depression in adolescence can be categorised into three different types. These are *Depressed Mood*, *Depressive Syndrome* and *Depressive Disorder*, also known as Clinical Depression (Diekstra, 1995; Peterson et al., 1993). *Depressed Mood* can be evident when demonstrated by a sense of sadness or unhappiness that can exist for either a brief or a longer period of time (Peterson et al., 1993). Although not a classified clinical disorder, *Depressed Mood* is important as it is more prevalent in adolescents needing clinical assistance and, it is considered a potential risk factor for developing *Depressive Syndrome* and *Depressive Disorder* (NHMRC, 1997). *Depressed Mood*, along with the more severe types of depression can be detected through self-report measures of depression that identify negative emotions, mood and depressive symptoms (Peterson et al., 1993).

Depressive Syndrome is considered to be a clinically significant condition that includes a range of emotional symptoms of depression and anxiety (NHMRC, 1997). Depressive and anxious complaints commonly

found in adolescents are feeling lonely, crying, fearing negative behaviour, feeling unloved, needing to be perfect, feeling worthless, guilty, suspicious, self-conscious, sad and worried (Peterson et al., 1993). Considering the adolescent identity crisis issues as proposed by Erikson (1968), it is evident that the prevalence of such symptoms in teenagers can be considered to be quite understandable. However, when the symptoms are intense and prolonged, they cause considerable distress and often need clinical attention.

Depressive Disorder is a classified mood disorder according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994). Of the three types of depression presented, *depressive disorder* is considered to be the most severe (NHMRC, 1997). Due to the common presentation in clinical practice, the American Psychiatric Association (1994) has provided a categorical system to identify different types. There are two main types that present more prevalently in adolescence, *Major Depressive Disorder* and *Dysthymia* (NHMRC, 1997). Both have a range of possible features and symptoms (American Psychiatric Association, 1994).

Harrison, Geddes and Sharpe (1998) state that depressive disorders can be further categorised according to the severity of the disorders, whether they are mild, moderate, severe or psychotic. Mild depression is very common, often going undiagnosed and characterised by consistent low mood, often mixed with anxiety features. This contrasts to moderate depression, which usually occurs prior to seeking

professional help and includes somatic symptoms such as agitation, anhedonia, poor concentration and a decrease in motivation. Pessimistic and negative thoughts and feelings of hopelessness and helplessness that often lead to suicidal thoughts are also present at this stage. Severe and psychotic depressive conditions are characterised by magnified symptoms of moderate depression, causing the person to experience no pleasure in life and increasing the likelihood of suicidal thoughts and intentions (Harrison et al., 1998).

Causes and Antecedents

The causes of depression in adolescence vary and can be attributed to a number of factors. Many risk factors are associated with adolescent depression, and do not generally stand alone, but are interactive with one another (Harrison et al., 1998). These include a number of genetic and environmental conditions (Harrison et al., 1998), otherwise stated as biological and psychosocial factors (Heaven, 1994). According to Peterson et al. (1993), biological processes, psychological, cognitive and family factors, peer influence, school factors and the stresses of every day life events can contribute to depression in adolescence. First, the influence of hormonal changes during puberty can have a considerable effect on the biological processes occurring during adolescence. Apart from the obvious changes affecting the body, sleeping and eating patterns can also be affected considerably (Peterson et al., 1993). A genetic disposition through having a depressed parent or family member is also a significant risk factor that can increase the

chances of adolescents experiencing depression (Harrison et al., 1998; NHMRC, 1997; Peterson et al., 1993). This also produces an environmental condition that provides a model of depressive behaviour to the adolescent.

A previous history of depression during childhood or earlier adolescence is another significant risk factor for adolescent depression (Harter et al., 1992; NHMRC, 1997). According to Peterson et al. (1993), personal psychological problems such as low self-esteem, anxiety, the presence of an eating disorder or stresses in family life, including marital conflict, parental divorce, emotional unavailability of parents and economic hardship, can all be influential. Personal difficulties and negative family life conditions such as these can be common experiences in adolescence, often extending over a considerable length of time and having quite detrimental effects (Peterson et al., 1993). Twin studies with young teenagers have shown that environmental influences have little effect on adolescent depression (Eley, 1997). However, other research sampled with a wider age range suggests environmental factors, especially those in the family, have a significant impact on depression in adolescence (Peterson et al., 1993). Also, stresses associated with normal developmental processes and personal psychological problems, combined with stressful family living conditions are more likely to cause considerable distress. Thus, adolescents are vulnerable to depression when their life experiences have been difficult both personally and within the family context.

Adolescent experiences of school life, with academic performance and socialisation with peers are also considered possible risk factors for depression (NHMRC, 1997). These two areas encompass a broad range of potential difficulties that can lead to depression. For instance, having a learning difficulty or being unable to achieve expected academic standards, can cause considerable distress to students who have high aspirations. Also, being unable to relate to peers socially or being rejected by peers can lower the self-worth of adolescents, causing them to become depressed (Harter, 1993). Peterson et al. (1993) suggest that low popularity with peers and lack of close friendships contribute to depression, while conversely, depression contributes to poor peer relations. Thus, poor peer relations and depression in adolescence affect each other in a reciprocal manner.

The impact of cognitive development in adolescence is also found to be associated with adolescent depression (Peterson et al., 1993). As cognitive processes become more complex from childhood to adolescence (Piaget & Inhelder, 1969), the increased demands on the need for self-reflection and planning for the future has been found to play a role in depressed mood (Peterson et al., 1993). Marcotte (1996) found that depressed adolescents had distorted cognitions, thinking in a certain way that resulted in their own suffering. Also, they were more vulnerable in general to depression due to irrational beliefs, resulting from a tendency to be egocentric, self-focused and self-critical. However, Carey, Carey and Kelley (1997) suggest that the interplay existing between

cognition, emotion and behaviour is responsible for depression in adolescents. Although they did not find that dysfunctional automatic processes predicted depression conclusively, they suggested that a vulnerability to depression existed. These findings provide evidence to suggest that cognitive processes play an active role in adolescent depression, with the co-occurrence of emotional and behavioural factors.

Individual and Developmental Differences

Consistent with the adolescent self-esteem literature, research consistently reports that girls are more prone to depression than boys (Compas et al., 1997; Harter, 1993; Marcotte, 1996; NHMRC, 1997; Peterson et al., 1993). Peterson et al. (1993) suggest that there are several reasons for gender differences. First, they propose that varied coping styles and individual differences in experiences are different in girls and boys. They suggest that response styles differ, with males being able to distract themselves more effectively than females. They consider that girls have more challenging experiences during early adolescence, as they generally experience puberty earlier than boys do. They also report that parental divorce is more prevalent with families where girls are present (Peterson et al., 1993).

Patterns in the progress of adolescent depression, particularly during middle adolescence, have also been identified. According to Peterson et al. (1993), gender differences in depression have been found to emerge by about fourteen to fifteen, becoming stable throughout adulthood. Marcott (1996) found that depressive symptoms sharply

increased at fifteen to sixteen years in general and that the course of development of those symptoms significantly differed in girls and boys. While depressive symptoms steadily increased throughout adolescence for girls, they decreased during middle adolescence for boys and increased later in adolescence. Therefore, differences in depressive symptoms throughout the adolescent period, both developmentally and between genders may be a normal process of adolescent development.

Adolescent Depression and Self-esteem

The inverse relationship between self-esteem and depression has been well established in the literature (Beer & Beer, 1992; Brage & Meredith, 1994; Harter, 1993; Harter et al., 1992; Lasko et al., 1996; Rosenberg et al., 1989). According to Brage and Meredith (1994), the association between self-esteem and depression in adolescence is due to the pressure of developmental tasks that are influential during the adolescent developmental process. The same developmental tasks outlined previously for self-esteem also apply to the interplay between self-esteem and depression. For instance, adolescent developmental issues such as identity, status, competence and independence all have an impact on the mental health and well being of adolescents.

According to Rosenberg et al. (1989), strong theoretical arguments exist to suggest that low self-esteem is responsible for personal and social problems, while there are also strong theoretical grounds to argue that personal and social problems are responsible for causing and being caused by low self-esteem. Thus, Rosenberg et al. (1989) found the

relationship between self-esteem and depression to be bidirectional, with the effect of each on the other being substantial. However, their data showed that depression had more of an effect on self-esteem than self-esteem had on depression. One possible explanation for these findings could be that the results depend on the effects of the different components of self-esteem and the different types and levels of depression. As self-esteem is multifaceted, depression is also a complex area of mental health with different types and levels of severity. Further, while some depressed states are considered to be normal in the average life experience, the length, intensity and disruptiveness, distinguish normal experiences from pathological states of depression (Diekstra, 1995).

Social Support, Depression and Suicide Ideation

Relationships with parents and peers have had considerable attention in the adolescent depression literature (Harter, 1993; Lasko et al., 1996; Peterson et al., 1993). Research by Lasko et al. (1996) found that adolescent depressed mood was more likely to be associated with low self-esteem and parent variables such as lack of intimacy and social support, than with friend variables of the same nature. Harter et al. (1992) found a distinction between parent support and peer support and that they were each associated with other specific domains of self-perception. The researchers proposed direct paths from a specific combination of self-esteem variables to depression, which also led to suicide ideation. Although low self-esteem and depression can be

included within the range of normal adolescent developmental

experiences, there is a potential for more serious problems to emerge,

such as suicide ideation and more tragically, adolescent suicide.

CHAPTER FOUR

Adolescent Suicide Ideation

According to the WA Child Health Survey (Zubrick et al., 1997), the prevalence of suicidal behaviour such as suicidal ideation and self-harm is becoming increasingly evident in schools. More than 15% of adolescents attending school reported having had thoughts of suicide over the previous six-month period. The major proportion of these were older adolescents (22%), being almost double the number of younger adolescents (12%). The survey indicated the need to understand various problems and stresses that lead to the consideration of suicide, which is reported in New Zealand (Drummond, 1997) and Australia (Zubrick et al., 1997) to be the second major cause of death in young people following car accidents. The recent establishment of the Youth Suicide Prevention Strategy, an Australia wide government initiative, further exemplifies considerable concern for the problem of youth suicide in Australia. The strategy aims to prevent youth suicide, to reduce the prevalence of self-harm, suicide ideation and suicidal behaviour, and to increase opportunities for youth, their families and their communities. It also assumes that complex sociological and individual factors are involved in youth problems associated with suicide (Mitchell, 1998), a view also accepted by others (Drummond, 1997; Heaven, 1994).

Diekstra (1989; 1995) reviewed youth suicide, including trends in the past century and reported an increase in the rates of suicidal behaviour over certain periods of time. World trends over the past

century indicate that around 1910 and the 1970s to 1980s suicide rates in

young people soared. Although no analytical research evidence is

available for the 1910 period, Diekstra (1989) suggests that dramatic

societal changes that preceded World War I may have been influential.

The second major rise in youth suicide rates from 1970 to 1986 indicates

that social characteristics, such as a decrease in social and moral

standards and high divorce rates predicted subsequent increases in

suicide rates (Diekstra, 1989). According to Diekstra (1989), a low

population of people under fifteen also existed at that time, which was

suggested could be indicative of a decline in the existence of traditional

family groups. Familial variables have also been identified by others as

being associated with suicide ideation in adolescents (Adams & Adams,

1996; Garnefski & Diekstra, 1997; Harter et al., 1992; Levy, Jurkovic, &

Spirito, 1995).

Many countries have experienced an increase in suicidal

behaviour since 1970 (Diekstra, 1989, 1995). According to a 1994 United

Nations report, New Zealand was ranked as having a higher rate of

teenage suicide rates than most other industrialised countries

(Drummond, 1997). Societal changes in New Zealand and features of

adolescent development such as those associated with the adolescent

identity crisis (Erikson, 1968) are considered to be largely responsible for

such high suicide rates (Drummond, 1997). Thus, the literature suggests

that though other factors exist, societal changes and environmental

conditions considerably influence the overall occurrence of suicidal

behaviour. A relatively recent review of world trends in youth suicide suggests that the rate of disadvantaged adolescents has increased in many industrialised countries amidst a general increase in living standards (Diekstra, 1995). Drummond (1997) suggests that perhaps adolescents in Australia, New Zealand and other western countries are unable to find their place in society due to the impact of the social, societal and economic changes in recent years. According to Diekstra (1995), modern industrialisation may have disadvantaged some adolescents, resulting in a poorer quality of social and mental life than adolescents from former generations.

Causes and Antecedents

The literature suggests that reasons for adolescent suicidal behaviour were associated with biological, psychological or sociological factors (Heaven, 1994). These can be due to family problems, abuse, the loss of someone close, depression, hopelessness, peer problems, unemployment, poverty, substance abuse or psychiatric disorders (Garland & Zigler, 1993; Heaven, 1994; NHMRC, 1997). Heaven (1994) suggests that physical disability and the impact of suicide coverage presented by the media can also lead to suicidal behaviour. Other personal life experiences may precede suicidal behaviour such as an encounter with the law, interpersonal difficulties, confusion about sexual orientation or the perception that one is a failure (Garland & Zigler, 1993). The National Action Plan for Suicide Prevention (1999) reports that suicidal behaviour can be linked to almost any adverse life event.

According to the WA Child Heath Survey, the characteristics more prevalent in those who were suicide ideated included taking drugs or alcohol, having a pessimistic outlook on the future and having low self-esteem. In fact, almost half the suicide-ideated students had self-esteem scores falling into the lowest 20% (Zubrick et al., 1997). Heaven (1994) suggests that the cumulative effects of life events are more likely to cause suicidal behaviour than one stressful event alone. Adolescent suicidal ideation can be as the result of psychological factors, psychosocial factors, individual differences and developmental factors.

Psychological Factors

Psychological perspectives on suicidal behaviour present a range of views from different theorists (Heaven, 1994). Five different psychological perspectives have been identified as providing explanations for suicidal thinking. The *psychoanalytical* approach suggests that suicidal people are unable to adequately organise their internal processes, resulting in various forms of distress. The *cognitive behavioural* approach considers a negative 'cognitive set' to be responsible. The *social learning* approach indicates that childhood experiences shape the behaviour, causing aggression to be turned inward and expressed through self-harm. The *multidimensional* approach considers various forms of distress such as psychological pain, an overwhelming desire to end life, experiencing heightened distress, being overcome with emotions or experiencing incongruent feelings and attitudes. Finally, the *neuroscience* approach suggests that suicidal

behaviour is a result of the presence of biological disorders (Heaven, 1994).

A major consideration of suicidal behaviour in the literature has been the presence of hopelessness (Harter et al., 1992; Hewitt, Newton, Flett, & Callander, 1997; Levy et al., 1995; Priester & Clum 1993; Steer, Kumar, & Beck, 1993). As a result, the body of current literature on adolescent suicide suggests that hopelessness is a common variable in suicide ideated populations. Steer et al. (1993) found that hopelessness effectively predicted suicidal behaviour. Various theorists have included measures of hopelessness in suicide ideated populations in relation to a range of different variables. For example, Priester and Clum (1993) incorporated problem solving with hopelessness and suicide ideation and found that problem solving is affected by psychological factors, which are also predictive of hopelessness and suicide ideation. Levy et al. (1995) investigated hopelessness with family dysfunction variables and socioeconomic status in adolescents who attended a hospital emergency room after having attempted suicide and found that hopelessness had the strongest relation to suicidal behaviour.

Hewitt et al. (1997) found that hopelessness, combined with socially prescribed perfectionism uniquely predicted suicide ideation in a psychiatric sample. Socially prescribed perfectionism was described as being the inability to meet expectations and standards that are imposed by others when one has a need to achieve. This is also similar to the view of self-perception as proposed by Harter (1990) who suggests that

low self-esteem can result when one's perceived importance of achieving

a task in a specific area exceeds the ability to perform. Further,

Baumeister (1990) proposes that the failure to meet unrealistic standards

that have been set by the self or others is a major factor in suicide

ideation. Hewitt et al. (1997) suggest that socially prescribed

perfectionism is associated with suicide ideation and entails a social form

of hopelessness.

Sense of hopelessness is a key factor in the suicide ideation

process. However, hopelessness is a term used to express the outcome

of other underlying psychological processes. Baumeister (1990) provides

some answers to this unexplained phenomenon related to suicide

ideation. He proposes a theory, which involves a psychological process

involving six stages. He suggests that suicide "emerges as an escalation

of the person's wish to escape from meaningful awareness of current life

problems and their implications about the self " (p. 91). The first stage

involves the occurrence of a severe life event that results from the

inability to meet unrealistic expectations. Then, negative attributions

occur, involving self-blame. Consequently, the self is compared to

standards, creating aversive high self-awareness of inadequacy,

incompetence, guilt or unattractiveness. Such comparisons then cause

negative affect. This results in a state of numb cognitive deconstruction,

as an attempt to escape from any meaningful thought processes. Finally,

the deconstructed mental state results in reduced inhibitions, which

creates a willingness to engage in suicidal behaviour. Baumeister (1990)

suggests that an increase or decrease in severity of any stage can influence suicidal behaviour. This theory provides some explanation for processes involved that potentially lead to suicidal behaviour.

Psychosocial Factors

Societal demands tend to play a significant role in the occurrence of suicidal thoughts and behaviour in adolescents. From an ecological perspective, a range of social systems can be influential on adolescent adjustment, such as family, school, community and political (Bronfenbrenner, 1986). Both family structure variables and family distress have been found to be associated with adolescent suicidal behaviour. For instance, Garnefski and Diekstra (1997) found that family structure was associated with self-esteem, depression and suicide attempts in adolescents. Those from single-parent and stepfamily homes scored higher than intact families in all three areas. Garland and Zigler (1993) reported adolescents with previous suicide attempts, lived with more stressful family conditions and experienced less stable social relationships the previous year, when compared with just depressed and other normal healthy teenagers. This is further supported by the National Action Plan for Suicide Prevention (1999) which reports family problems to be associated with adolescent self-harm and suicidal behaviour.

According to Zubrick et al. (1997), the school also influences the health and development of social competence in adolescents. Modern teenagers are expected to achieve more than the adolescents of previous generations, thereby increasing the pressure to perform. Garland and

Zigler (1993) suggest that due to the increased pressure to perform at school, adolescents can perceive a sense of public disapproval, leading to feelings of failure and consequent suicidal ideation. Although this infers that low grades are associated with sense of failure, Baumeister (1990) states that college students who are suicidal often have higher grades than other students. However, these students also experience a greater level of parental expectation than their peers do. Therefore, the sense of failure that often accompanies suicidal thoughts is not necessarily associated with achievement, yet may pertain to acceptance of achieving certain standards. This view is also consistent with the model proposed by Harter et al. (1992), which proposes a link between scholastic competence and parental support. Academic performance and perceived parental approval was associated with sense of hopelessness and suicidal ideation.

Garland and Zigler (1993) also suggest that several other psychosocial factors influence suicidal behaviour in adolescence, such as parental absence, drug and alcohol abuse, an increase in ability to obtain weapons, effects of the media and exposure to fictional or real suicide stories. They considered family stress to result from societal pressures on mothers to be employed, which reduces supervision, thereby increasing the risk of alcohol and drug abuse in adolescents. A further consideration related to the effects of the media, suggesting that teenage suicidal behaviour increased following media coverage involving suicide. Similar effects were noted with the incidence of "copycat suicide"

following exposure to fictional stories involving suicide (Garland & Zigler, 1993).

Other common psychosocial factors that influence adolescent suicidal ideation are a family history of suicide, having peers who have committed suicide and a previous history of suicide attempts or self-harm (Garland & Zigler, 1993; Harrison et al., 1998). Living conditions that are beyond the control of the adolescent, such as socioeconomic status and social contact, also have a profound effect on adolescent suicidal behaviour. It is evident that the psychosocial factors influencing adolescent suicide ideation are numerous and present a complex range of factors that are interrelated. As Diekstra (1989) suggests, suicidal behaviour does not occur as a result of one single cause, but has many causes that incorporate both individual and societal factors. However, the aversive experiences in themselves do not cause suicidal behaviour, but rather the interpretation of those experiences according to the perception of an individual, happening within the context of both personal and social conditions.

Individual Differences

Amongst the diverse range of experiences that lead to suicidal thoughts and behaviour in adolescents, individual differences are also noted. Most studies have found differences associated with gender and age variables (Garnefski & Diekstra, 1997; Harter, 1993; Heaven, 1994; Zubrick et al., 1997). However, other differences affecting youth suicide refer to cultural differences, differences between rural and city youth and

differences in sexual orientation (National Action Plan for Suicide

Prevention, 1999).

Gender differences in adolescent suicide are similar to the trend in

adolescent depression, with girls generally reporting more emotional

disturbances leading to suicidal ideation (Garnefski & Diekstra, 1997;

Harter, 1993; Heaven, 1994). More specifically, Diekstra (1995) reports

depressive disorders, suicide ideation and para-suicidal behaviour to be

more prevalent in girls than in boys. However, actual suicide rates in

Australia (Zubrick et al., 1997) and New Zealand (Drummond, 1997) are

reported to be higher in boys than girls. Drummond (1997) reports the

male suicide rate in New Zealand to be 26.9 in 100,000, while the rate for

girls is only 3.6. Females are reported to have more suicide attempts in

contrast to males, who have more completed suicides (Drummond, 1997;

Heaven, 1994; Jackson, Mc Cartt Hess, & van Dalen, 1995). According

to Jackson et al. (1995) there is general acceptance of the belief that

males succeed in suicide more often due to access to more lethal means

to complete the act.

Age differences do not appear to be as profound as gender

differences in suicidal thought and behaviour. However, the general

trend in the literature indicates that older adolescents are more likely to

engage in suicidal behaviour than younger adolescents (Jackson et al.,

1995; McLean, 1990). According to McLean (1990), older males who

committed suicide were more likely to have an affective disorder or a drug

or alcohol abuse problem. A combination of age and gender differences

were reported by Zubrick et al. (1997) who suggest that while previous

suicide rates have been higher for males than for females, there has

more recently been an increase in older female adolescent suicides

(29%), when compared with younger female adolescents (13%). The

difference in older and younger male adolescents was negligble (Zubrick

et al., 1997). This indicates that age variables are more likely to be

associated with other variables that impact on adolescent mental health.

Older adolescents may be at higher risk because their lives are generally

more complex. However, as the literature suggests, increased cognitive

capacities occur as adolescents mature (Fischer, 1980; Harter &

Monsour, 1992; Piaget & Inhelder, 1969). Therefore, age variables are

less likely to impact on suicidal thoughts and behaviour than a multitude

of other factors.

Developmental Factors

        According to the National Action Plan for Suicide Prevention

(1999), recent surveys of young people have indicated that the period of

transition experienced by adolescents causes much inner conflict and

turmoil. Due to the transition from childhood, teenagers can find

themselves quite vulnerable in terms of trying to understand their place in

society. Further, when sexuality or racial issues, family problems,

parental imprisonment or parental suicide complicate adolescents' lives,

vital supports to enable healthy functioning may be lacking (National

Action Plan for Suicide Prevention, 1999). The adolescent period is

wrought with many different changes that can cause considerable

personal distress. When problems with negative and stressful life events are entered into the equation, adolescents are more likely to engage in suicidal thoughts and behaviour (Adams & Adams, 1996; Brent et al., 1993; Wilson et al., 1995).

The same developmental issues that relate to adolescent self-esteem and depression as mentioned in Chapter Two also apply to adolescent suicidal ideation and suicidal behaviour. Although suicide is a serious problem across the whole life span, adolescence is a particularly pertinent time for understanding suicidal behaviour. This is due to adolescence being a unique time of developmental change and growth in the physical, psychological and social domains (Aro, Marttunen, & Lonnqvist, 1993; Pfeffer, 1994). Most adolescents cope with these changes quite successfully (Wilks & Orth, 1991). However, others do not cope as well and when life events combine with the perception of an inability to deal with the issues, adolescents can engage in suicidal behaviour. Developmental factors are strongly associated with the many diverse experiences and challenges encountered by teenagers. Thus, a developmental perspective provides a sound framework for understanding adolescent suicidal behaviour.

The Current Study

Self-esteem research that has been comprehensively studied by Harter (1982, 1988,1989, 1990,1993) and her colleagues (Harter & Monsour, 1992), from a developmental perspective has resulted in an increased interest in the period of adolescence. As a consequence, the

consistent identification of difficulties with adolescents has led Harter

(1993) and her colleagues to explore pathways linking self-esteem to

suicidal ideation in adolescence. In particular, early adolescence

(between 12-15 years) was targeted in an attempt to understand suicidal

behaviour from a preventative perspective (Harter & Marold, 1994; Harter,

et al., 1992). The research outcomes of such studies revealed that some

domains of self-esteem were found to be stronger predictors of suicidal

thoughts than other domains.

In their initial exploratory analysis of the five domains (excluding

global self-worth) that make up the Self-perception Profile for Children

(Harter, 1985), Harter et al. (1992) identified two distinct clusters that the

domains fell into. One composite was of *scholastic competence* and

behavioural conduct and the other was made up from *physical

appearance, peer likability* and *athletic competence*. Links were

identified between the composite of *scholastic competence* and

behavioural conduct, with suicidal ideation directly and also when

mediated through depression. The same composite was also associated

with low *parental support*, a domain of the social support scale, and with

suicidal ideation, whether or not mediated through depression. The

second composite (physical appearance, peer likability & athletic

competence) was linked to suicidal ideation when mediated through

depression, which may or may not be associated with peer support

(Harter et al., 1992). These results suggest that suicidal ideation in

adolescence may be influenced by a combination of specific self-esteem

variables (see Figure 1).

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┌─────────────────────────────┐
│ Competence/adequacy plus    │
│ Hopelessness (if important) │
│ for:                        │
│ PHYSICAL APPEARANCE         │
│ PEER LIKABILITY             │
│ ATHLETIC COMPETENCE         │
└─────────────────────────────┘

┌──────────────────────┐       ┌──────────────────────┐       ┌──────────────┐
│ Level of, plus       │       │ Depression Composite: │       │ SUICIDAL     │
│ Hopelessness         │       │ SELF-WORTH,          │──────▶│ IDEATION     │
│ about:               │       │ AFFECT,              │       └──────────────┘
│ PEER SUPPORT         │       │ GENERAL              │
└──────────────────────┘       │ HOPELESSNESS         │
                               └──────────────────────┘
┌──────────────────────┐
│ Level of, plus       │
│ Hopelessness about   │
│ PARENT SUPPORT       │
└──────────────────────┘

┌─────────────────────────────┐
│ Competence/adequacy plus    │
│ Hopelessness (if important) │
│ for:                        │
│ SCHOLASTIC                  │
│ COMPETENCE                  │
│ BEHAVIOURAL CONDUCT         │
└─────────────────────────────┘
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Figure 1. General model of risk factors (Harter, Marold & Whitesell, 1992)

The main purpose of this study is to explore differences between

adolescents, considered to be in the mid-adolescent period (14-18), who

are attending therapy after having had suicidal ideation (clinical sample),

and teenagers in the general population who are either depressed (depressed sample) or non-depressed (non-depressed sample). The study will explore specific components of self-esteem in adolescents, including actual self-perception and discrepancy scores between perceived *competence* and perceived *importance* in specific domains. When perceived importance is greater than perceived competence, a sense of inadequacy emerges, which according to Harter (1988) contributes to low self-esteem. Perceptions of social support perceived as being received by parents and peers will also be explored between the three groups. While Harter et al. (1992) used the Self-perception Profile for Children (1985), as appropriate for children and younger adolescents, this study will use the Self-perception Profile for Adolescents (Harter, 1988), which has additional domains, being developmentally designed specifically for adolescents. The domains are *scholastic competence, social acceptance, athletic competence, physical appearance, job competence, romantic appeal, behavioural conduct, close friendship and global self-worth*.

Consistent with Harter's (1985) theory, stating that self-esteem is determined by perceived importance outranking perceived competence on specific domains, findings from the Harter et al. (1992) study were based on discrepancy scores. This study will also assess discrepancy scores. However, due to the suicide literature reviewed by Baumeister (1990), it is also necessary to assess perceived competence in specific domains without taking into account to the importance scores.

Considering Baumeister's (1990) theory as mentioned earlier in this chapter, suicidal behaviour may result from internal thought processes that are not based on the importance of specific issues in relation to competence, but may be more associated with perceived competence and adequacy per se. Thus, the concept of a discrepancy between perceived importance and perceived competence identifying low self-esteem, as proposed by Harter (1985), may not be as common in suicidal people as in the average population. Therefore, this study will explore perceptions of competence in specific domains, indicating areas that adolescents may feel their performance or ability is less than adequate. All domains will be explored, both with and without considering importance ratings, to identify differences between the three groups of adolescents.

Four research questions will be addressed. The first is, 'Are there any differences in the nine self-perception domains between the three groups?' The second question is, 'Are there any differences in discrepancy scores, where perceived importance outranks perceived competence, in the self-perception domains between the three groups?' Global self-worth will not be included, as it does not generate a discrepancy score. The third question is, 'Are there any differences between the three groups according to perceived *parental support?*' The fourth is, 'Are there any differences between the three groups according to perceived *peer support?*'

The first hypothesis is proposed, based on literature that identifies a trend of certain domains where adolescent self-perception is reported to be particularly low (Chan, 1997; Cairns et al., 1990; Trent et al., 1994). First, it is hypothesised that the suicidal ideated adolescent group will perceive themselves as being less adequate in *global self-worth*, *scholastic competence, physical appearance, social acceptance* (the adolescent alternative to *peer likability*) and *behavioural conduct*, than those in the general population. Second, based on the findings of Harter et al. (1992) it is hypothesised that discrepancy scores, where perceived importance is greater than perceived competence, will be higher in the suicidal ideated adolescent group than in the general population in *physical appearance, social acceptance, athletic competence, scholastic competence* and *behavioural conduct*. Third, based on the Harter et al. (1992) findings, it is hypothesised that adolescent perception of *parental support* will be lower in suicidal ideated adolescents than teenagers in the general population. Fourth, also based on findings from Harter et al. (1992), it is hypothesised that the suicidal ideated adolescent group will report a lower rate of *peer support* than the depressed and the non-depressed groups.

It is anticipated that through exploring differences in domains of self-esteem in adolescents who are receiving therapy after being suicidal, and both depressed and non-depressed adolescents in the general population, some understanding will be gained of areas that are more prevalent in suicidal ideated adolescents. In particular, specific areas of

self-esteem including *self-perception* and *perceived social support* or

regard that are more prevalent in suicidal adolescents will be identified,

when compared to depressed and non-depressed adolescents in the

general population.

CHAPTER FIVE

Method

Research Design

A cross sectional design using questionnaires was used for this study. Two different approaches to data collection were taken, which involved group and individual administration. Collection of data for the depressed and non-depressed samples employed both methods, while only individual administration was used for the clinical sample. All questionnaires were self-reports and could be completed by participants after they had been given brief instructions. The value of self-report measures for 'at risk' populations is highlighted by Harter et al. (1992). They suggest that self-report measures provide people with an opportunity to reveal their innermost thoughts, exposing symptoms that are associated with internal processes.

Participants

A purposive sample was used due to the specific requirements of the study. Participants were selected ($\underline{N}$ = 78) from the general population ($\underline{n}$ = 53; 20 boys & 33 girls), and from clinics that provide services for suicidal adolescents ($\underline{n}$ = 25; 7 boys & 18 girls). The general group, were further divided into two groups according to whether they were depressed ($\underline{n}$ = 20; 6 boys & 14 girls) or non-depressed ($\underline{n}$ = 33; 13 boys & 20 girls). The majority of the non-depressed sample came from a metropolitan state high school, while others were obtained through word of mouth. To obtain a larger sample of depressed adolescents, a school

psychologist from a metropolitan state high school collected data from students (n=5), who showed significant signs of depression. Ages of participants in the non-depressed group were 14 to 18 ($\underline{m}$ = 16; $\underline{sd}$ = 1), in the depressed group were 14 to 18 ($\underline{m}$ = 15; $\underline{sd}$ =1) and in the clinical group were 14 to 18 ($\underline{m}$ =16; $\underline{sd}$ = 1).

The clinical sample was obtained through various places that provide therapy for suicidal youth. Two child and adolescent mental health service clinics (Swan Child & Adolescent Mental Health Youth Therapy Service & Youthlink) and three private practitioners were involved in the data collection. The criteria for the clinical sample were that adolescents be aged between 14 and 18 years and were receiving therapy after being diagnosed as being suicide ideated or having attempted suicide. Diagnosis was according to the clinical opinion of the therapist, most of who were clinical psychologists or counsellors specialising in youth counselling or therapy. Obtaining other information from the clinical sample was limited because the ethics committee of one of the adolescent clinics was not agreeable to divulging any further information regarding their clientele. Therefore, it was not known how long participants had been in therapy, of any other factors involved or whether they had attempted suicide as opposed to having been suicide ideated. All participants were aged between 14 and 18 years, corresponding to school years 10, 11 and 12.

General Population

A representative of the Students at Educational Risk Strategy, a division of the Education Department of Western Australia, recommended a metropolitan high school to approach for obtaining data. The school was considered to be representative of the general student population, due to its range of students from different socioeconomic areas. Following agreement from the Principal for the school to cooperate and discussion with the school psychologist regarding the method of data collection, all years 10, 11 and 12 students were invited to participate in the study (approximately 750 students). For ethical reasons, the school psychologist agreed to attend to situations where high depression scores and indicators of suicide ideation were found. Letters were distributed to students through form teachers and were addressed to parents and students (see Appendix A). Thirty-four students responded to the invitation after being given several reminders from teachers, of which two were discarded because of incorrect completion of questionnaires. Therefore, due to the low response rate, a self-selection bias must be considered in interpreting the results of this study.

Due to the poor response rate from letters sent home to students, other means of data collection were employed to obtain a more substantial sample. This led to a further 16 participants in the general community, sought through word of mouth, being recruited for the study. Adolescents who met the criteria were approached and invited to

participate. Parent consent was obtained prior to administration of

questionnaires.

Clinical Population

Participants in the clinical sample were approached individually by

their respective therapists. Clinicians working in youth clinics were

required to obtain informed consent from the participant and from their

participant's parent or legal guardian. This involved providing adequate

information for those approached to be able to make an informed

decision about their participation (for an example, see Appendix B).

Private practitioners were provided with a more general consent form to

give to potential participants (see Appendix C).

Substantial difficulty was experienced in collecting data for the

clinical sample. Only one clinic was initially involved in data collection.

However, after several months and insufficient data, other youth clinics

and private practitioners were approached to assist in data collection.

After a further substantial period of time, only a minimum sample was

obtained. This gave some indication of the difficulty in obtaining

information from adolescents who are experiencing suicidal ideation.

Feedback from some clinicians indicated that several reasons could

apply. First, suicidal adolescents initially present to receive therapy when

at a point of crisis, which is an inappropriate time to administer

questionnaires. This period can also continue for some time. Second,

they often cease attending therapy when the crisis time subsides. Third,

some have literacy problems and do not like to be involved in completing

questionnaires. Also, some adolescents experiencing deep emotional disturbances find completing questionnaires stressful and consequently decline to be involved. Therefore, obtaining information for this particular population is a challenging task.

Clinical participants varied substantially more than the non-clinical in terms of living situation, being employed and still attending school. Several were living with other family members, with partners or in hostels, fewer were employed and some no longer attended school. The demographic variables are presented in Table 1. Participants from the non-clinical sample indicated that most adolescents lived either with both parents, with one parent or in a stepfamily. All attended school and about half were employed.

Table 1

Demographic details of adolescent participants

	Group		
Variables	Non-depressed	Depressed	Clinical
n	33	20	25
Female	20	14	18
Male	13	6	7
Mean age	16	15	16
Attends school	33	20	15
Employed	15	10	7
Living situation			
Parents	19	11	5
Mother	8	6	6
Father	2	1	3
Step	4	2	1
Other	0	0	10

<u>Materials</u>

Three instruments were used for data collection, which were administered to all participants. For the clinical sample, clinicians were provided with an instruction form to assist participants in completing the scales (see Appendix D). All participants completed a demographic form to obtain general information regarding age, education level, family variables and living situation (see Appendix E). Harter's (1988) Self-perception Profile for Adolescents (SPPA), Harter's (1985) Social Support Scale for Children (SSSC) and Kovacs' (1992) Children's Depression Inventory (CDI) were also completed by all participants.

The SPPA consists of two parts and takes approximately 10 minutes to complete (see Appendix F). The `What I am Like' scale produces actual competence scores in specific domains. It consists of 45 items containing nine sub-scales (scholastic competence, social acceptance, athletic competence, physical appearance, job competence, romantic appeal, behavioural conduct, close friendship and global self-worth). The `How Important are These Things to You?' scale is used in conjunction with the 'What I am Like' scale and produces discrepancy scores, indicating where perceived importance outranks perceived competence in specific domains. It consists of 16 items representing eight sub-scales as presented above, omitting the global self-worth domain, which does not produce a discrepancy score.

Discrepancy scores between perceived competence and perceived importance on specific domains of self-perception are considered

indicators of whether self-esteem is high or low (Harter, 1988). The perceived competence score is subtracted from the perceived importance score in each domain, to derive a discrepancy score. Thus, a discrepancy score is generated when perceived importance of a certain domain of self-perception exceeds perceived competence in the same domain. This gives an indication of specific areas where self-esteem is being affected. Therefore, information is provided regarding specific areas where an individual's self-esteem may be impaired. It is worth noting that when the opposite occurs and perceived competence outranks perceived importance, it is not considered to indicate any difference to self-esteem (Harter et al., 1992).

The SPPA was specifically chosen for its multi-dimensionality. The sub-scales provide a more informative description of perceived competence than other instruments. Further, it has a strong theoretical basis, which has practical utility and was constructed according to developmental issues that are pertinent throughout the adolescent period.

Moderate to high internal consistent reliability was obtained for all sub-scales (.74 - .92) in the psychometric testing of the original scale. Factor analysis revealed a clear eight-item factor pattern emerging for the eight specific domains, plus a domain for global self-worth (Harter, 1988). Marsh and Holmes (1990) provide further support for construct validity. Trent et al.,(1994) found support for internal consistency reliability with an Australian sample.

The SSSC consists of four sub-scales (parent support, classmate support, teacher support and friend support) and takes approximately five minutes to complete (see Appendix G). It is designed to ascertain participants' perceived *support* or *regard* manifested toward themselves, from significant other people in their lives. That is, it provides a measure of perceived support or regard generated from other people toward the self. In the scale construction, a factor analysis indicated that four distinct factors emerged for adolescents. Also, validity studies have indicated that support from significant others moderately predict global self-worth (r = .69) (Harter, 1985). Further self-esteem research with depressed and suicidal ideated adolescents by Harter et al. (1992) indicates that specific domains of support from significant others (i.e. parent support & peer support) are associated with specific domains of self-concept as measured by the SPPA (see Figure 1). Teacher support has not been identified as being a significant predictor of self-perception domains.

The CDI has five sub-scales (negative mood, interpersonal problems, ineffectiveness, anhedonia and negative self-esteem) and takes approximately five minutes to complete (see Appendix H). According to Compass et al. (1993), the CDI is a widely used instrument for measuring child and adolescent depression and includes symptoms and emotions that accurately assess features that are relevant to depression (Compass et al., 1993). The CDI is a state measure rather than a trait measure, which provides an indication of current depressive symptomatology. It has high internal consistency reliability among

various populations (α = .71-.89) and good discriminant validity between psychiatrically diagnosed and non-clinical samples (Kovacs, 1992). Participants with scores of less than 10 were assigned to the non-depressed group.

Procedure

The participating school arranged a classroom to be available for test administration at an appointed time. Participants were instructed to complete the demographic form and then complete the remaining questionnaires. They were instructed that there were no right or wrong answers and that the questions were to obtain information, regarding who they are as a person. They were given the example provided at the top of the "What I Am Like" scale (see Appendix F). Instructions were given in the same format as provided to individually tested participants. Students were informed that written instructions were provided with the CDI (see Appendix H).

Individual administration for the remaining general sample was presented in the same format. An instruction sheet was provided to participants, as was given to the clinicians for administration of instruments to the clinical sample (see Appendix D).

Participants in the clinical sample were administered instruments by their respective therapists. The procedure was initially explained to the therapists to enable them to administer the instruments in a consistent manner. The instruction form, as presented in Appendix D, was used to provide ease in administration and to maximise consistency. The same

verbal explanations were given to participants as described above. No names were recorded on forms. However, a coding system was devised for clinicians to record an abbreviation of the clinic name, the clinician's personal initials and a unique number to identify the participant. Each clinician kept a list that connected participants to their respective numbers. As some clinical participants were no longer attending school, clinicians were instructed to ask them to answer school related items based on their most recent experiences. This was deemed to be suitable, considering the age group of the participants, as those who had left school, would have done so fairly recently and may still be affected by their school performance and experiences.

Clinicians were provided with individual feedback for each client who participated in the study. This consisted of a report page and three profiles. The profiles illustrated the results from the SPPA, the SSSC and the CDI (for an example, see Appendix I). Results were either posted or personally delivered to clinicians. Feedback from clinicians indicated that the results provided some valuable information and were useful for therapeutic purposes.

CHAPTER SIX

Results

Two different types of analyses, Multivariate Analysis of Variance (MANOVA) and Analysis of Variance (ANOVA) were conducted on SPSS to address the four different research questions.

A between-subjects, one-way MANOVA was conducted on nine dependent variables: scholastic competence, social acceptance, athletic competence, physical appearance, job competence, romantic appeal, behavioural conduct, close friendship and global self-worth, to ascertain differences in actual self-perception scores between the three groups (non-depressed, depressed & clinical). A second MANOVA was conducted on eight dependent variables: scholastic competence, social acceptance, athletic competence, physical appearance, job competence, romantic appeal, behavioural conduct and close friendship, to assess differences in discrepancy scores, where perceived importance scored higher than perceived competence, between the three groups (non-depressed, depressed and clinical).

A between subjects, one-way ANOVA was conducted to assess differences between the three groups, in perceived parental support. A second between subjects, one-way ANOVA was conducted to assess differences between the three groups in perceived peer support. Due to the differences in school attendance between groups, the classmate support and friend support variables were combined to give an overall peer support score. Consistent with Harter et al. (1992), preliminary data

analysis indicated that teacher support had no effect on the three groups. Therefore, teacher support was not included in the study.

Assumptions for the use of MANOVA, including normality, homogeneity of variance-covariance, linearity and multicollinearity were checked and provided adequate results. There were no univariate or multivariate outliers detected with the use of a $p < .001$ criterion for Mahalanobis distance. Testing of assumptions for the ANOVA analyses were deemed to be satisfactory.

Differences in Self-Perception

Results from the MANOVA conducted to assess differences between groups in the nine domains of self-perception (MANOVA 1) indicated a significant multivariate effect with the use of Pillai's statistic $F(2, 75) = 4.25$, $p < .001$. Pillai's statistic, considered robust for MANOVA yielded an observed power ($\alpha = .05$) of 1.00. MANOVA results for discrepancy scores between self-perception domains and their perceived importance (MANOVA 2) also indicated a significant multivariate effect with the use of Pillai's statistic $F(2, 75) = 2.33$, $p < .01$. Observed power ($\alpha = .05$) was .98.

Univariate tests were then employed using a Bonferroni adjusted α level (calculated by SPSS) to allow for familywise error. Results indicated that for MANOVA 1, significant differences occurred between all three groups in two domains. *Global self-worth* differed significantly $F(2, 75) = 43.69$, $p < .001$ between the non-depressed and depressed groups $p < .001$, the non-depressed and clinical groups $p < .001$ and the depressed

and clinical groups $p < .01$. *Physical appearance* differed significantly $F(2, 75) = 14.43$, $p < .001$ between the non-depressed and depressed groups $p < .05$, the non-depressed and the clinical groups $p < .001$ and the depressed and clinical groups $p < .05$.

Significant differences were found in the *scholastic competence* domain $F(2,75) = 11.57$, $p < .001$ between the non-depressed and depressed groups $p < .05$ and the non-depressed and clinical groups $p < .001$, but not between the depressed and clinical groups. The *social acceptance* domain also yielded significant differences $F(2, 75) = 5.58$, $p < .01$ between the non-depressed and depressed groups $p < .01$ and between the non-depressed and clinical groups $p < .05$, but did not significantly differ between the depressed and clinical groups. Significant differences were also found in the *athletic competence* domain $F(2, 75) = 6.04$, $p < .01$ between the non-depressed and depressed groups $p < .001$ and between the non-depressed and the clinical groups $p < .05$, but not between the depressed and the clinical groups. Domains in which the clinical sample were uniquely different to the non-depressed sample were in the *job competence* domain $F(2, 75) = 11.09$, $p < .001$ and the *behavioural conduct* domain $F(2, 75) = 4.0$, $p < .05$. Significant results are presented in Table 2. The two DVs not presented, *close friendship* and *romantic appeal,* showed no significant differences among the three groups.

The results indicate that suicidal ideated adolescents have a

considerably lower self-perception than both non-depressed and

depressed teenagers from the general population, in their global sense of

Table 2

Significant Differences in Domains of Self-perception: Comparisons
Between Non-depressed and Depressed Groups

Dependent Variable	N Mean	N Sd	D Mean	D Sd	Mean Diff	F	p
Athletic competence	2.8	.82	2.0	.76	.80	6.04	.001
Global self-worth	3.2	.46	2.4	.50	.84	43.69	.001
Physical appearance	2.6	.60	2.1	.63	.46	14.43	.05
Scholastic competence	3.1	.56	2.5	.73	.59	11.57	.01
Social acceptance	3.3	.46	2.7	.55	.57	5.58	.01

Significant Differences in Domains of Self-perception: Comparisons
Between Non-depressed and Clinical Groups

Dependent Variable	N Mean	N Sd	C Mean	C Sd	Mean Diff	F	p
Athletic competence	2.8	.82	2.3	.95	.53	6.04	.05
Behavioural conduct	3.0	.64	2.5	7.1	.49	4.00	.05
Global self-worth	3.2	.46	1.9	.67	1.32	43.69	.001
Job competence	3.4	.42	2.7	.71	.70	11.09	.001
Physical appearance	2.6	.60	1.6	.71	.92	14.43	.001
Scholastic competence	3.1	.56	2.2	.91	.91	11.57	.001
Social acceptance	3.3	.46	2.8	.90	.43	5.58	.05

Significant Differences in Domains of Self-perception: Comparisons
Between Depressed and Clinical Groups

Dependent Variable	D Mean	D Sd	C Mean	C Sd	Mean Diff	F	p
Global self-worth	2.4	.50	1.9	.67	.48	43.69	.01
Physical appearance	2.1	.63	1.6	.71	.46	14.43	.05

df = 2, 75
N = Non-depressed; D = Depressed; C = Clinical; Mean Diff = Mean Difference
Note: Self-perception scores possible range = 1-4

self-worth and their perceived physical appearance. Further, they perceive themselves as being less competent than non-depressed adolescents in their ability to perform either at work or at school. They also see their performance in athletics, their behaviour and their ability to be socially acceptable to be less adequate than non-depressed teenagers. Depressed teenagers have a considerably lower perceived sense of global self-worth than non-depressed teenagers. They also perceive themselves to be less competent in their athletic ability, academic ability, physical appearance and their ability to be accepted socially than non-depressed adolescents do.

Differences in Discrepancy Scores

Prior to conducting the analysis of discrepancy scores in MANOVA 2, the discrepancy scores that indicated a higher competence rating than importance rating were computed as zero. This was necessary to ensure that only importance > competence scores were included in the analysis, consistent with the theoretical rationale for assessing only discrepancy scores where perceived importance was greater than perceived competence. As competence > importance scores do not have any theoretical influence on self-esteem, the scores were set to zero so that the negative scores would not be included in the analysis.

Using a Bonferroni adjusted α level (as calculated by SPSS) the analysis identified significant differences in three domains, *athletic competence, physical appearance* and *scholastic competence*. Discrepancy scores (that is, where importance > competence) differed

significantly $F(2, 75) = 3.32$ $p < .05$, for *athletic competence* between the

non-depressed and depressed groups. Discrepancy scores (where

importance > competence) differed significantly $F(2, 75) = 7.15$ $p < .001$,

for *physical appearance* between the non-depressed and clinical groups.

Discrepancy scores (where importance > competence) were significantly

different $F(2, 75) = 6.79$ $p < .01$, for *scholastic competence* between the

non-depressed and clinical groups $p < .01$ and between the non-

depressed and depressed group $p < .05$. Significant results are

presented in Table 3. The other domains showed no significant

differences in discrepancy scores, where perceived importance was

greater than perceived competence.

Table 3

Significant Differences in Competence / Importance Discrepancy Scores:
Comparisons Between Non-depressed and Depressed Groups

Dependent Variable	N Mean	N Sd	D Mean	D Sd	Mean Diff	F	p
Athletic competence	.12	.28	.37	.50	.241	3.32	.05
Scholastic competence	.36	.40	.85	.70	.178	6.79	.05

Significant Differences in Competence / Importance Discrepancy Scores:
Comparisons Between Non-depressed and Clinical Groups

Dependent Variable	N Mean	N Sd	C Mean	C Sd	Mean Diff	F	p
Physical appearance	.52	.60	1.4	1.1	.235	7.15	.001
Scholastic competence	.36	.40	.92	.79	.166	6.79	.01

df = 2, 75
N = Non-depressed; D = Depressed; C = Clinical; Mean Diff = Mean Difference
Note: Discrepancy score possible range = 0-3
(No table is presented for comparisons between the Depressed and Clinical groups
because there were no significant differences)

Discrepancy scores identified physical appearance and scholastic competence as being major factors contributing to low self-esteem in suicide ideated adolescents, when compared to non-depressed teenagers. Discrepancy scores also indicated that academic ability and athletic ability were higher in depressed adolescents, when compared with non-depressed teenagers. This suggests that suicidal ideated adolescents experience low self-esteem through their perception of how they appear physically. They also have a lower sense of their own self-esteem, through perceiving themselves as having poor academic ability. Depressed adolescents have lower self-esteem through their academic and athletic ability, when compared with non-depressed adolescents.

Differences in Social Support

Differences in parental support between the three groups (non-depressed, depressed, and clinical), analysed with a one-way analysis of variance (ANOVA 1) were statistically significant, $F(2,75) = 18.14$, $p <$ .001. Post hoc comparisons using the Tukey HSD test revealed that significant differences were found between the clinical group and both the non-depressed and depressed groups. Descriptive statistics are shown in Table 4. There was no significant difference between the non-depressed and depressed groups. Mean differences between groups are presented in Table 5.

Results from the ANOVA, testing differences in peer support between the three groups (non-depressed, depressed, and clinical) were not statistically different, $F(2, 75) = 2.64$, $p > .05$. Therefore, perceived

peer support did not differ between suicidal ideated or depressed

adolescents. However, perceived parental support was lower for suicidal

ideated adolescents than for teenagers in the normal population, whether

depressed or non-depressed. Descriptive statistics are presented in

Table 6.

Table 4

Mean Scores of Perceived Parental Support in Non-depressed,
Depressed and Suicidal Ideated Adolescents.

Group	n	m	sd
Non-depressed	33	3.53	.52
Depressed	20	3.30	.59
Clinical	25	2.40	1.0

Differences between groups are statistically significant at α = .001.

Table 5

Mean Differences of Perceived Parental Support in Non-depressed,
Depressed and Suicidal Ideated Adolescents

Groups	Mean Difference	p
Non-depressed / Depressed	.23	.50
Non-depressed / Clinical	1.13	.000*
Depressed / Clinical	.90	.000*

*$F(2, 75) = 18.14$ p < .001

The main findings from this study were that non-depressed teenagers, depressed teenagers and those who are receiving therapy after having suicidal ideation all differed significantly in their sense of global self-worth. Non-depressed teenagers had the highest sense of global self-worth ($\bar{x}$ = 3.2; *sd* = .46), which was considerably lower for the depressed group ($\bar{x}$ = 2.4; *sd* = .50) and lower again for the clinical group ($\bar{x}$ = 1.9; *sd* = .67). Though these results are as would be expected, the other multi-dimesional domains give a far more informative account of specific self-esteem issues that are more pertinent to suicidal ideated adolescents. In particular, suicidal ideated adolescents were different in their perceived job competence ($\bar{x}$ = 2.7; *sd* = .71) to non-depressed teenagers ($\bar{x}$ = 3.4; *sd* = .42) and in their behavioural conduct ($\bar{x}$ = 2.5; *sd* = 7.1) than non-depressed teenagers ($\bar{x}$ = 3.0; *sd* = .64). All three groups differed in their perceived physical appearance, with non-depressed teenagers perceiving their appearance as being most favourable ($\bar{x}$ = 2.6; *sd* = .60), the depressed group less favourable ($\bar{x}$ = 2.1; *sd* = .63) and the clinical group being least favourable ($\bar{x}$ = 1.6; *sd* = .71). Non-depressed adolescents also perceived themselves as being more competent than both the depressed adolescents and clinical adolescents in their academic performance, their athletic competence and their ability to be socially accepted.

Discrepancy scores, indicating low self-esteem in specific domains, revealed that adolescents receiving therapy after being suicidal ideated experienced lower self-esteem, as generated from their physical

appearance and their academic ability, than non-depressed teenagers

did. Further, depressed adolescents showed that they had lower self-

esteem than non-depressed teenagers through their academic ability and

also their athletic performance.

Table 6

Mean Scores of Perceived Peer Support in Non-depressed, Depressed
and Suicidal Ideated Adolescents.

Group	n	m	sd
Non-depressed	33	6.8	.76
Depressed	20	6.4	.95
Clinical	25	6.3	1.48

Differences between groups are not statistically significant at α = .05

The results also revealed that adolescents receiving therapy after

being suicidal ideated perceive support or regard from their parents to be

significantly lower than teenagers in the general population ($\underline{p}$.< .001),

whether they were depressed or non-depressed. This suggests that low

self-esteem in suicidal ideated adolescents may occur through their

perception of their parents' level of support or regard toward them. This

difference is unique to the clinical sample, as the non-depressed and

depressed groups did not significantly differ from one another. Perceived

peer support does not appear to present any differences between the

three groups, indicating that suicide ideated adolescents' perception of

peers does not have the same impact on their self-esteem as does

perception of parent support or regard.

CHAPTER SEVEN

Discussion

This study endeavored to explore differences in specific domains of self-esteem between adolescents attending therapy following diagnosis of being suicidal ideated and adolescents in the general population, who are either depressed or non-depressed. Harter's multi-dimensional measures of self-esteem were used (SPPA & SSSC), to assess specific domains that provide information regarding particular areas that indicate where self-esteem is affected. Adolescent self-perception in nine domains: global self-worth, scholastic competence, social acceptance, athletic competence, physical appearance, job competence, romantic appeal, behavioural conduct and close friendship (Harter, 1988) were measured. Perceived social support or regard adolescents received from parents and peers was also assessed, giving an indication of how they see themselves from the perspective of significant people in their lives (Harter, 1985).

This chapter will address the research questions and outcomes for each hypothesis. It will then discuss the significant findings under the headings of the specific domains of each self-esteem scale used in the study. Each domain in the Self-perception Profile for Adolescents will be addressed according to both perceived competence and the discrepancy scores, where perceived importance is greater than perceived competence. Discrepancy scores indicate specific areas that affect self-esteem as they measure perceptions of inadequacy (Harter, 1988).

Significant findings from the Social Support Scale for Children will be discussed regarding perceived social support. Practical implications and limitations to this study will then be addressed, followed by some suggestions for future research in terms of self-esteem variables in suicidal ideated adolescents.

Research Questions and Hypotheses

Four research questions were addressed in this study. The first question explored actual self-perception in specific domains and asked, "Are there any differences in self-perception domains between the three groups?" The second question explored determinants of self-esteem in specific domains and asked, "Are there any differences in discrepancy scores, where perceived importance is greater than perceived competence between the three groups?" The third asked, "Are there any differences between the three groups according to perceived parental support?" The fourth question asked, "Are there any differences between the three groups according to perceived peer support?"

Four hypotheses were proposed. The first was based on the literature, which suggested that self-perception is generally lower in certain domains for suicidal ideated adolescents(Chan, 1997; Cairns et al., 1990; Trent et al., 1994). It was hypothesised that this group would perceive themselves as being less adequate in *global self-worth*, *scholastic competence*, *physical appearance*, *social acceptance* and *behavioural conduct* than adolescents in the general population. The second was based on findings from Harter et al. (1992), and proposed

that suicidal ideated adolescents would have higher discrepancy scores, where perceived importance is greater than perceived competence, than the general population in *physical appearance, social acceptance, athletic competence, scholastic competence* and *behavioural conduct*. The third and fourth were also based on findings from Harter et al. (1992) and hypothesised that suicidal ideated adolescents would report (a) lower perceived parental support and (b) lower perceived peer support respectively.

The results indicated that the first hypothesis was supported. However, this study provided further information that distinguished suicidal ideated adolescents from adolescents in the general population, either depressed or non-depressed. Only two domains varied across all three groups, *global self-worth* and perceived *physical apearance*. Domains of self-perception that were uniquely different between the non-depressed adolescent group and the clinical group, without differing in the depressed group, were *job competence* and *behavioural conduct*. This indicates that perceived performance in the employment area and in general behaviour, was considerably lower in suicidal ideated adolescents than adolescents in the general population, whether depressed or not.

The most significant differences between the non-depressed group and the clinical group were *global self-worth, job competence, physical appearance* and *scholastic competence*. Of these, *job competence* emerged as being the only domain identified as being significantly

different, other that those that were hypothesised. However, other domains that significantly differed between the non-depressed and the clinical groups were *athletic competence*, *behavioural conduct* and *social acceptance*. Of these, *athletic competence* was the only domain that emerged that was not hypothesised. *Romantic appeal* and *close friendship* were the only domains that did not emerge as being significantly different between the clinical and non-depressed groups. These results suggest that suicidal ideated adolescents generally have lower self-perception than non-depressed adolescents do in certain areas. In particular, they have a generally lower opinion of themselves, of how they look and how they perform either in their employment situation or at school. However, they also have lower self-perception than non-depressed adolescents in their athletic ability, in the way they behave and in their ability to be accepted in social circumstances.

The second hypothesis, that suicidal ideated adolescents would have higher discrepancy scores (with perceived importance being greater than perceived competence in specific domains) than non-depressed adolescents in the general population, was only partly supported. As hypothesised, the clinical sample scored higher discrepancy scores in *physical appearance* and in *scholastic competence.* However, there were no significant differences between the clinical group and the non-depressed group in *social acceptance, athletic competence,* or *behavioural conduct*, nor were there differences in any other domains. It is interesting to note that *scholastic competence* also differed between

the non-depressed and the depressed groups. In addition, *athletic competence* differed between the non-depressed and the depressed groups. There were no other significant differences among the eight domains between the non-depressed group and depressed group. Also, no significant differences emerged among the eight domains between the non-depressed group and the depressed group in self-esteem, indicated by discrepancy scores, where perceived importance was greater than perceived competence.

These findings suggest that *physical appearance* was the major single domain of self-perception that uniquely contributed to low self-esteem in the suicidal ideated group of adolescents. Although scholastic competence was another contributor to low self-esteem in the clinical group, it also differed significantly between the non-depressed group and the depressed group. As there were no significant differences in discrepancy scores that contribute to self-esteem between the depressed group and the clinical group, it is not clear whether poor academic ability is likely to be a factor associated with depression rather than suicidal thoughts. The difference between the discrepancy scores in the non-depressed group and the depressed group in *athletic competence* may not have presented in the clinical group because 40% of the participants in the clinical group were no longer attending school. Therefore, it is less likely that self-esteem would be affected by their ability to perform athletically, as it is less likely to be important to those no longer attending school.

The third hypothesis, that *parental support* would be lower in suicidal ideated adolescents than adolescents in the general population was supported. The clinical group reported significantly lower parental support than the non-depressed group. The clinical group also reported significantly lower parental support than the depressed group. There was no significant difference between the non-depressed and depressed group. These results suggest that perceived support or regard from parents is a significant factor that contributes to lower self-esteem in suicidal ideated adolescents than in the general population of adolescents, whether depressed or not. That is, the suicidal ideated group of adolescents perceive themselves as being less valued through the eyes of their parents than do adolescents in the general population. This variable is unique to the clinical group, as there was no difference between the non-depressed and depressed groups, yet the clinical group differed significantly to both other groups.

The fourth hypothesis, that *peer support* would be lower in suicidal ideated adolescents than adolescents in the general population was not supported. No significant differences emerged among the three groups, indicating that perceived support of friends or classmates did not differ from the general population, depressed or non-depressed, in terms of self-esteem being affected. That is, the suicidal ideated adolescent group did not differ from depressed or non-depressed adolescents in the general population in how they perceive themselves through the eyes of their friends and classmates.

In the following sections, the significant findings obtained in the specific domains of self-perception will be discussed and contextualised in terms of the researched literature. Then significant findings regarding perceived social support from significant others will be discussed.

Global Self-worth

The findings from this study, revealing a decrease in *global self-worth* among the three groups, from the non-depressed group, to the depressed group and to the clinical group, were not surprising. This further supports findings by Harter et al. (1992), who presented *global self-worth* as a central factor associated with specific domains of self-esteem, depression and suicidal ideation in adolescents. From an attempt to understand how depressed adolescents differed from suicidal ideated adolescents, Harter et al. (1992) found that suicidal adolescents were more likely to report themselves to be inadequate in specific domains of perceived competency. These domains were *scholastic competence* and *behavioural conduct* and were also strongly associated with perceived *parental support*. *Global self-worth* was not differentiated between suicidal ideated adolescents and depressed adolescents. Therefore, the results from this study suggest that *global self-worth* is more likely to reflect the increase in depressive symptoms amongst adolescents with suicidal ideation.

Developmental processes may also affect the decrease in *global self-worth* in the depressed and clinical groups. As Erikson (1968) describes adolescence as being a time for the development of identity,

with a tendency to be preoccupied with self, it is understandable that a

decrease in self-worth is associated with an increase in depression, due

to the increase in self-focus. Fischer's (1980) theory of 'abstract

mapping' in middle adolescence adds a further possible explanation for

decreased *global self-worth* in depressed adolescents. He proposes that

this time of development present problems for adolescents, as they are

able to detect inconsistencies in their personality, without having the

maturity to integrate and make sense of them. Similarly, Damon and Hart

(1982) propose that throughout the development of adolescence, the

awareness of the self increases and adolescents become more aware of

their thoughts and feelings. Thus, adolescent development involves a

process that continuously affects self-evaluations (Damon & Hart, 1982;

Heaven, 1994). These theories on adolescent development provide vital

information in the understanding of how adolescents go about forming

their identity and their sense of worth as a person. As *global self-worth*

gives a general view of how people see themselves, the impact of

adolescent development on *global self-worth* is essential for an

understanding self-esteem issues. Therefore, consideration of

developmental factors in evaluating *global self-worth* needs to be taken

into account.

Physical Appearance

As *global self-worth* produced significant results between the three

groups of adolescents in this study, so did perceived *physical*

appearance. The results indicated that perceived *physical appearance*

was lower in the depressed group than in the non-depressed group and lower in the clinical group than in the depressed group. However, the most revealing finding from this study was that discrepancy scores differentiated the clinical group from the depressed group, as well as from the non-depressed group. This presented a unique difference, suggesting that self-esteem is affected by *physical appearance*, with adolescents who had been suicidal ideated having lower self-esteem, generated from perceived *physical appearance*, than those in the general population, whether depressed or not. *Physical appearance* was the only variable among the domains of self-perception that emerged as being significantly different in discrepancy scores. This means that adolescents' perceptions of their own physical appearance needs to be considered in clinical populations where suicidal thoughts and behaviour are present.

One possible explanation for this finding emerges from the works of Harter (1990), who explored the processes underlying the formation of self-concept in adolescents and, Baumeister (1990), who investigated the tendency for suicidal people to escape from an aversive awareness of self. Harter (1990) proposed that adolescents have an ability to construct two selves, an actual self and an imagined self. This can also be termed as the real self and the ideal self. Thus, a discrepancy emerges between the two, providing the capacity for adolescents to hold onto two different concepts at one time. As mentioned in Chapter Two, self-perceptions can differ according to how things really are and how the person would

like them to be, either at the time or in the future. Baumeister (1990) suggests that failure to meet unrealistic expectations and standards are a major factor involved in suicidal thoughts and behaviour. This could be reflected in the discrepancies between perceived importance and perceived competence in the clinical group. Thus, where suicidal adolescents may feel that their physical appearance is important, but they don't feel they are attractive, they set themselves up for personal failure, due to their perceived standard of physical appearance being less than desired. This is further impacted by the fact that one cannot significantly change one's physical appearance. Baumeister (1990) suggests that failure to meet unrealistic expectations results in a form of hopelessness, which can lead to suicidal thinking.

Another possible explanation for how physical appearance lowers self-esteem in suicidal ideated adolescents relates to the concept that adolescents invest more of their time and place increasing value on *physical appearance* as they mature into later adolescence (Harter, 1990). This also applies to *scholastic competence* and *peer popularity* or *social acceptance* and indicates a higher awareness of personal achievement and competence as adolescents mature. These variables may also be impacted by the pressure on adolescents to achieve, with many expectations, demands and challenges on their lives, as outlined by Zubrick et al. (1997) in Chapter One. This can be further exacerbated by the influence of the media on young people, to have perfect bodies and be physically attractive. Adolescents can become preoccupied with their

physical appearance, due to the increase in self-focus that is typical in adolescent development (Erikson, 1968). This in turn may generate a sense of hopelessness and consequent suicidal thinking. Harter's (1990) suggestion, that research continuously finds physical appearance to correlate most strongly with global self-worth, supports this conclusion.

Job Competence

Perception of competence in employment differed between the clinical group and the non-depressed group, but no differences emerged in the depressed group. Considering some participants from the clinical group are no longer at school, it is surprising that this variable did not produce significant discrepancy scores, where perceived importance of employment was considered and factored into the perceived competence domain. This is even more surprising when considering that Mortimer et al. (1996) suggested that employment has become more important to adolescents in recent years. However, should Baumeister's (1990) model be accurate in suggesting that an escapist frame of mind underlies suicidal ideation, it makes reasonable sense that the perceived importance of specific domains may not be as applicable to suicidal ideated adolescents as it would be to those in the general population. Thus, while the clinical group may perceive their work performance as being poor, they may be somewhat complacent about their employment situation, accepting their sense of inadequacy. This may explain why perceived job importance was significantly lower in the clinical group than the non-depressed group, yet did not produce a discrepancy score

indicating perceived importance to be greater than perceived competence.

Behavioural Conduct

Perceived behavioural conduct was also significantly lower in the clinical group than in the non-depressed group, without any differences emerging in the depressed group. What would be interesting to know about perceived behaviour is what reasons could exist to explain why suicidal adolescents have a lower perception of their behaviour, than non-depressed adolescents, while depressed adolescents do not. Heaven (1994) provides a plausible explanation for this, which makes reference to a psychological perspective on suicidal behaviour. The perspective, which takes a psychoanalytic approach, suggests that suicidal people have very critical and harsh attitudes toward themselves, which are generated from feelings of guilt. This is an 'acting out' of low self-esteem and the act or idea of suicide releases the person from the effects of the low self-esteem (Heaven, 1994). In other words, this suggests that the suicidal ideated person, due to unresolved guilt, may be more likely to be self critical than the average person.

Another possible explanation for why the clinical sample perceived their behaviour to be significantly lower than the non-depressed group did, could lie in the fact that the very reason they are attending therapy is due to some kind of negative behaviour. Either social learning theory or cognitive behavioural theory as outlined in Chapter Four may explain this. According to Heaven (1994), social learning theory suggests that

behaviour is shaped by childhood experiences, where aggression can turn inward and express itself through self-harm. Alternatively, from a cognitive behavioural perspective, a 'negative cognitive set', linking feelings of hopelessness to depression and suicide (Heaven, 1994), may mean that suicidal adolescents have a poor perception of their own behaviour. Either or both of these explanations may be plausible. However, because negative behaviour, whether in thought or action, is responsible for the adolescent attending therapy, the reasons for the negative behaviour need to be explored and understood.

<u>Scholastic Competence</u>

Perceived scholastic competence or academic ability presented a different picture among the three groups. Significant direction of differences emerged between the non-depressed group and both the depressed group and the clinical group. However, there was no significant difference between the depressed and clinical groups. This indicates that adolescent perception of academic ability is more likely to be related to depression than to suicidal ideation in the studied sample. The same pattern emerged in differences between discrepancy scores, where perceived importance was greater than perceived competence. This provides evidence to suggest that self-esteem is affected in depressed and suicidal ideated adolescents due to their perceived inadequacy to perform academically.

As academic performance was not uniquely associated with the clinical group, but was associated with the depressed group, it is more

likely to be related to depression in adolescents. As outlined in Chapter

Three, there are many causes and antecedents of depressive

experiences in adolescence. This can include a range of biological

processes and psychosocial factors (Harrison et al., 1998; Heaven, 1994;

Peterson et al., 1993). However, the main consideration needs to be

focused on the fact that the need to perform academically places

considerable pressure on adolescents (Zubrick et al., 1997). This is also

evident through previous studies (Beer & Beer, 1992; Bekhuis, 1994;

Cairns et al., 1990; Harter et al., 1992; Marsh, 1986; Trent et al., 1994).

Therefore, the results in this study are as would be expected. However,

what is of interest, is that the depressed group and the clinical group

reported similar results, thereby indicating that both groups feel

inadequate in their ability to perform academically, when compared to

non-depressed adolescents in the general population.

Athletic Competence

The results regarding athletic competence presented stronger

differences between the non-depressed and the depressed groups than

between the non-depressed and the clinical groups. Although both these

differences were significant, the results indicate that the depressed group

presented with the lowest perception of athletic ability of the three groups.

A significantly different discrepancy score was also found between the

non-depressed group and the depressed group, indicating that perceived

importance was greater than perceived competence. Therefore, self-

esteem is affected by athletic competence in the depressed group.

As athletic performance is typically a school-related task which often does not continue after leaving school, it is more likely that those who still attend school would have stronger opinions or feelings regarding their ability to perform athletically. Therefore, the results of this study make sense, considering that 40% of the clinical group no longer attend school. Also, as Harter (1990) suggests, through the school system where subjects are graded, children and adolescents learn to make comparisons between themselves and others. Therefore, it makes sense that depressed adolescents who are still attending school may perceive themselves as being inadequate in the athletic field. On the other hand, troubled adolescents who are no longer at school may not give much consideration to athletic ability. Thus, their self-esteem is less likely to be affected.

Social Acceptance

Social acceptance also identified significant differences between the non-depressed group and both the depressed and the clinical groups, without any difference emerging between the depressed and clinical groups. This is consistent with the findings of Harter et al. (1992), as *peer likability*, the child equivalent to adolescent *social acceptance* in the Harter scales, did not predict suicidal ideation directly, but only through the depression composite, addressing self-worth, affect and general hopelessness. Therefore, social acceptance is an important factor that may be considered a risk to depression, which may in turn impact on suicidal thoughts and behaviour. However, it does not appear to be

directly associated with suicidal ideation. The next section will discuss the significant outcome from perceived social support.

Parental Support

An important endeavour of this study was to see if any differences existed between the three groups in terms of perceived support that was received from significant others in the lives of the adolescents. *Parental support* and *classmate support,* were considered by Harter et al. (1992) to be the two support systems that adolescents consider most important. However, due to the differences between the non-depressed and the depressed groups, who were all attending school and the clinical group, some of who were no longer attending school, *friend support* and *classmate support* were combined and renamed *peer support* to allow for variation in support systems between the groups. Results indicated that perceived *peer support* did not significantly differ between the three groups.

Perceived *parent support,* however, showed significant differences between the clinical group and both the non-depressed and depressed groups. The clinical group reported significantly lower rates of perceived *parental support* than the other two groups. However, the scores between the non-depressed and depressed groups did not differ, but were very similar. These results indicated that adolescents who were receiving therapy after being suicidal ideated perceived support or regard from their parents to be considerably lower than adolescents in the general population, whether depressed or non-depressed. Theoretically,

this means that the clinical group of adolescents saw themselves

considerably less favourably through the eyes of their parents, when

compared with adolescents from the general population, whether

depressed or non-depressed.

There could be several reasons for this finding. First, perceived

support from parents could be low due to the fact that almost half of those

in the clinical group were not living in the same household as their

parents. Therefore, the opportunity for adolescents to see their parents

as supportive may be limited. Second, the family backgrounds of the

clinical group of adolescents may have involved situations where parents

were not present. For example, some may have been raised as wards of

the state in various foster care situations. As explained in Chapter Four,

family structure has been found to be associated with suicide attempts in

adolescents (Garnefski & Diekstra, 1997; National Action Plan for Suicide

Prevention, 1999). Third, adolescents who are having difficulties are

often experiencing conflict with parents simultaneously (Garland & Zigler,

1993). This could be an exaggeration of the normal conflict that typically

exists between parents and their adolescents, due to developmental

processes in teenagers who are forming their identity and challenging

parental values (Erikson, 1968). Another explanation could be

associated with parental expectations. For instance, Baumeister (1990)

suggests that suicidal college students often have higher grades, yet at

the same time, have parents who have excessively high expectations of

their teenagers. Therefore, should parental expectations be higher than

what is reasonable regarding their adolescents in any area, it is understandable that suicidal thoughts and behaviour may emerge as an outcome of feeling a sense of hopelessness from not living up to parental expectations.

Social systems also affect adjustment in adolescence considerably (Bronfenbrenner, 1989). As outlined in Chapter Two, under normal circumstances, the social roles of adolescents have a considerable impact on self-esteem (Harter, 1990; Hoffman et al., 1988; Killeen & Forehand, 1998; Rosenberg et al., 1989). According to Harter (1990), the process of adolescent development generates conflict in adolescents, which peaks at middle adolescence, usually between 14 and 16 years. As social roles increase during adolescence, cognitive processes develop and struggle to integrate different social roles in the adolescent's life. Consequently, adapting to the social pressures that emerge from increased social roles can be problematic until cognitive development has matured enough for the adolescent to cope with them. This may provide some plausible explanation for why adolescents who are having stressful life experiences may perceive support from parents to be low. Also, another consideration is that parents may actually be less supportive.

It is evident that there are several possible and plausible explanations for why suicidal ideated adolescents would perceive themselves less favourably through the eyes of their parents, than teenagers in the general population. Therefore, finding reasons for suicidal behaviour in adolescence is not a simple process, but one that

requires much attention to the details surrounding each individual. Also, reasons surrounding suicidal behaviour are many (Deikstra, 1989). Although these results appear to frame parents of adolescents in a less than favourable manner, it does not necessarily mean that parents are responsible for their adolescents' suicidal behaviour. Many other potentially influencing factors exist that need to be explored in each situation. However, based on the findings of this study, combined with the strong evidence of family factors influencing suicidal behaviour in adolescence (Garnefski & Diekstra, 1997; Harter et al., 1992; National Action Plan for Suicide Prevention, 1999), it is suggested that family structures and relationships within those structures, be thoroughly explored when treating suicidal adolescents.

Summary of Main Findings

In summary, the main findings from this study indicate that *global self-worth* provided useful information, differentiating the three groups of adolescents in terms of their general sense of worth as a person. However, the specific domains provided considerably more detailed information. In particular, it was interesting that only *physical appearance* differed in self-perception between all three groups. Differences also emerged in discrepancy scores between the non-depressed and the clinical groups. Differences in *scholastic competence* also emerged between the non-depressed and clinical groups in both perceived competence and discrepancy scores. In fact, *physical appearance* and *scholastic competence* were the only two variables that differed

significantly in discrepancy scores between the clinical and non-depressed groups. Specific information was also obtained, which identified perceived parental support as being significantly lower in the clinical group than both the non-depressed and depressed groups. This gives valuable information regarding specific self-esteem issues that are particularly pertinent to adolescents with recent suicidal experiences.

Other specific domains provided finer details, regarding different aspects of self-perception that were more prevalent in the clinical group or various combinations of differences between groups. *Job competence* and *behavioural conduct* were the only two domains that were significantly different between the clinical group and the non-depressed group, without differing between the non-depressed and depressed groups and the depressed and clinical groups. This provides a clear illustration of some differences between normal healthy teenagers and those who are in therapy following recent suicidal experiences. A combination of other variations in specific domains of self-perception emerged as being significantly different among the three groups.

Practical Implications

The most interesting information emerging from this study refers to the significant difference between the clinical group and the non-depressed group in perceived physical appearance. As differences emerged in both perceived competence and in discrepancy scores, the influence of adolescent perception of their own outward appearance in those who have had recent suicidal experiences was apparent. These

results suggest that not only does self-perception of physical attractiveness differ in suicidal ideated adolescents, but also low self-esteem is generated from that self-perception. This highlights the importance of addressing self-acceptance issues regarding physical attributes in adolescents presenting with suicidal thoughts and behaviour.

Another area that presented as differing between the clinical group and the other groups in self-perception, where self-esteem was also affected was perceived academic ability. As this area presented differences in both actual self-perception and in discrepancy scores, it is important to understand that this specific area is likely to have an impact on suicidal adolescents' overall self-esteem. Therefore, it is necessary to explore the area of academic expectations and perceived achievement with troubled teenagers. This applies to depressed adolescents as well as teenagers who are suicidal, as a similar pattern emerged between the non-depressed and depressed groups as it did between the non-depressed and clinical groups.

Differences of perceived job performance and actual behaviour between the non-depressed and clinical groups present a different view, as they provide a distinct difference between recently suicidal ideated adolescents and normal healthy teenagers. This suggests that employment issues regarding suicidal adolescents need to be explored, in terms of expectations adolescents may have on their own ability to perform in a work situation. This may be worth exploring whether or not adolescents are employed, as they may feel inadequate to even attempt

an employment situation for fear of not performing to the expected standard. Adolescents' view of their own behaviour also needs to be explored, especially in terms of what they believe others expect of them, what they expect of themselves and what that means to them.

The information emerging from this study provides valuable guidance to clinical practitioners who are working with suicidal and depressed adolescents. Exploring variables in self-esteem issues presents specific details regarding personal views of the self. Conversely, the main theme associated with suicidal behaviour is to engage in finding ways to destroy the self or to have self-destructive thoughts. Therefore, it makes sense that aspects of self-esteem that have been found to be more prevalent in adolescents with recent suicidal experiences be thoroughly assessed and monitored during the course of therapy. Thus, the need to incorporate evaluations of self-perceptions in various aspects of life into assessment tools becomes apparent. The critical areas that need to be explored are self-perceptions of physical appearance and school performance. However, all the other aspects of self-esteem, as addressed in this study, should be explored for potential areas that are causing adolescents to feel bad about themselves, due to the many variations in variables between the groups. In particular, this study highlights the importance of covering self-esteem issues in the process of the clinical interview when suicidal adolescents present in therapy.

Limitations

There were several limitations to this study that must be considered in evaluating the outcomes. First, the details surrounding the suicidal thoughts and behaviour of the clinical sample are not known. For instance, it is not known whether participants had either actually attempted suicide or whether they had ideated only. Therefore, it is not known how self-esteem variables differ in those who actually attempt suicide and those who have only had serious thoughts of suicide. However, this variable was not differentiated in the Harter et al. (1992) study either. Thus, the sample in this study is comparable to the study on which it is based.

Another limitation relates to the length of therapy each participant in the clinical group had been engaged in. The only criteria for participation in this study was that participants were still receiving therapy after having been diagnosed by their respective therapists as being suicidal ideated or having attempted suicide. This variable needs to be given considerable attention in evaluating the outcomes of this study. For instance, it would be expected that those who have been in therapy for six months would present differently to those who have only been receiving therapy for six weeks. The main reason this would have an impact on this study is because some may have already worked through self-esteem issues during the course of their therapy. Therefore, their reports on domains of self-esteem variables may be influenced by

therapy rather than how they feel about themselves at the time of being
suicidal.

Therapists involved in data collection commented that obtaining
data from suicidal people is very difficult and has some serious
implications. For instance, it is not appropriate to administer testing
instruments to people who initially attend therapy after experiencing
suicidal thoughts or behaviour. This is because they are in a crisis
situation and in most cases, too distraught to complete questionnaires.
By the time it becomes suitable to administer the tests, the suicidal crisis
is over. Thus, the results do not give an indication of the person's state at
the critical time of being suicidal but rather their state after the crisis has
subsided. Therefore, it is important to note that the results from the
clinical sample in this study are obtained from adolescents who have
been attending therapy, with suicidal thoughts and behaviour being
present at the time therapy commenced. This sample may present quite
differently to a population of adolescents who are actually suicidal at the
time self-esteem variables are assessed.

There are also other clinical variables related to suicidal ideated
adolescents that are not known. For instance, suicidal ideation may be
resulting from the effects of a previous history of abuse. This could be
sexual, physical or emotional abuse, or it may involve a childhood
experience of neglect, any of which can have a direct impact on suicidal
thoughts and behaviour (Garland & Zigler, 1993; Heaven, 1994; NHMRC,
1997). Further, it is not known whether any of the participants had

psychiatric disorders, which can have a direct effect on suicidal behaviour (Harrison et al., 1998). Also, as stated in Chapter Three, there is a common interplay between low self-esteem and depression (Harter, 1993; Peterson et al., 1993; Rosenberg et al., 1989). This consideration can be viewed according to the literature on depression (NHMRC, 1997; Peterson et al., 1993), which suggests that there are different types of depression, some of which are serious disorders. Therefore, some participants may have had long term severe depressive disorders that led to their suicidal thoughts or behaviour. Such clinical issues need to be considered, as these potential confounding variables could have a considerable impact on self-esteem in the clinical group of adolescents.

Another limitation of this study relates to the variations of family living situations between the three groups of adolescents. There was very little difference between the non-depressed and the depressed groups in their living situation. However, the clinical group presented a very different profile. While all participants in the depressed or non-depressed groups were living in family situations with either or both parents, some being in a stepfamily, 40% of the participants in the clinical group lived in another situation. This meant that they either lived with extended family members, with friends, in hostels or with another person in a relationship. This could make a difference to the level of parental support some adolescents in the clinical group may perceive they are receiving. Despite this, it is worth noting that parental support has been shown to be a valid determinant of self-esteem (Harter, 1993). However,

what is not known is whether living with at least one parent optimises the chances of support being expressed by parents, thereby increasing the chances of adolescents being aware of their parents concern for them.

Other demographic details that may influence the results of this study relate to school attendance and employment. While all participants in the non-depressed and the depressed groups were still attending school, only 60% of those in the clinical group were still attending school. This means that 40% of the clinical group's reports of school variables would have been according to what they recall from their most recent school experiences, rather than current school experiences. As the intensity of school problems are somewhat lessened after leaving school, scores on academic competence may be less in the clinical group than they would have been if all participants were still attending school. Also, while approximately half of the participants in the non-depressed and depressed groups had part-time employment, less than one third of the participants in the clinical group were employed. This also suggests that reports on employment variables may be less than what would be expected if more adolescents had current employment experiences.

Finally, a limitation that generates a need for caution in the interpretation of the results, is the limited sample size of the clinical and depressed groups. As stated in Chapter Five, a considerable length of time was taken in collecting data to obtain this sample of clinical participants. This resulted in less than half the desired clinical participants being involved in the study. The numbers required for the

depressed group also involved extra time, as the process required

additional means of data collection to boost the sample size of the

depressed group that emerged from the general population. Although a

school psychologist assisted the process, this involved more time and

planning, resulting in a limited sample size for the depressed group. So

caution needs to be exercised in evaluating the outcomes of this study

due to the reasonably small and uneven sample size among the three

groups.

<u>Conclusions and Suggestions for Future Research</u>

This study has provided substantial information regarding the

different components of self-esteem, as proposed by Harter (1985, 1988),

in adolescents attending therapy after being suicidal ideated, when

compared with adolescents in the general population, both depressed

and non-depressed. It is anticipated that this information would provide

clinicians working with suicidal adolescents, an understanding of some

vital issues that are relevant to the population they are working with. It is

also anticipated that the information will be used to assist in the

formulation of suicide intervention strategies that specifically target

adolescent populations. For this reason, this study has taken a

developmental approach to understanding self-esteem issues that are

pertinent to adolescence. However, the results should be interpreted

according to the limitations outlined in this chapter, such as those

referring to the sample size and demographic differences in family,

education and employment.

Further research is warranted in the same area, evaluating specific self-esteem variables in suicidal adolescents to provide more information regarding adolescent self-evaluations as they apply to suicidal thoughts and behaviour. It would be advantageous to replicate this study using a larger sample, to see if similar patterns emerge and if they provide a richer source of information. Also, obtaining more clinical information about the participants, such as how long they have been in therapy, whether they have actually attempted suicide or ideated only or whether they have a diagnosed psychiatric disorder, would be useful in order to ascertain the influence of confounding variables. More information regarding participants' relationships with their parents would also give a clearer account of why parental support is perceived to be particularly low amongst suicidal adolescents. Further, due to the various interpretations of adolescent development issues, it would be interesting to conduct a longitudinal study on domains of self-esteem, following adolescents presenting with suicidal thoughts and behaviour, from early to late adolescence. This would provide information regarding changes that take place in self-esteem issues throughout the period of adolescence.

In conclusion, this research was undertaken to assess differences in self-esteem variables between adolescents who have been recently suicidal and teenagers from the general population, who are either depressed or not depressed. It responded to a report that emerged from the WA Child Health Survey (Zubrick et al., 1997), that indicated a need to explore various types of problems associated with emotional distress in

adolescents. This study has provided a unique contribution to research on specific aspects of self-esteem in three different groups of adolescents. No similar research has been previously conducted in Western Australia, nor has it been done elsewhere using the same methodology. Obtaining information from the populations required for the study was a challenging procedure, which presented with substantial constraints and difficulties. However, the information obtained from taking a multi-dimensional approach is invaluable in providing insights into a range of self-esteem issues as they apply to recently suicidal adolescents or teenagers in the general population, some of who are depressed some who are not depressed. It is hoped that these insights be used to guide clinical practitioners and inform program development for adolescents, especially those who are experiencing suicidal thoughts and behaviour.

REFERENCES

Adams, J. & Adams, M. (1996). The association among negative life events, perceived problem solving alternatives, depression, and suicidal ideation in adolescent psychiatric patients. Journal of Child Psychology and Psychiatry, 37(6), 715-720.

Aro, H. M., Marttunen, M. J. & Lonnqvist, J. K. (1993). Adolescent development and youth suicide. Suicide and Life Threatening Behavior, 23(4), 359-365.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

Bachman, J. G. & Schulenberg, J. (1993). How part-time work intensity relates to drug use, problem behaviour, time use, and satisfaction among high school seniors: Are these consequences or merely correlates? Developmental Psychology, 29, 220-235.

Baumeister, R. F. (1990). Suicide as escape from self. Psychological Review, 97(1), 90-113.

Beer, J. & Beer, J. (1992). Depression, self-esteem, suicide ideation, and GPAs of high school students at risk. Psychological Reports, 71(3/1), 889-902.

Bekhuis, T. C. H. M. (1994). The self-esteem of adolescents in American public high schools: A multilevel analysis of individual differences. Personality & Individual Differences, 16(4), 579-588.

Bogan, J. (1988). The assessment of self-esteem: A cautionary note. Australian Psychologist, 23(3), 383-389.

Brage, D. & Meredith, W. (1994). A causal model of adolescent depression. The Journal of Psychology, 128(4), 455-468.

Brent, D. A., Perper, J. A., Moritz, G., Baugher, M., Roth, C. Balach, L. & Schweers, J. (1993). Stressful life events, psychopathology and adolescent suicide: A case control study. Suicide and Life-Threatening Behavior, 23(3), 179-187.

Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Developmental-Psychology, 22(6), 723-742.

Cairns, E., McWhirter, L., Duffy, U. & Barry, R. (1990). The stability of self-concept in late adolescence: Gender and situational effects. Personality & Individual Differences, 11(9), 937-944.

Capes, M. (1975). Adolescence and change. In S. Meyerson (Ed.), Adolescence: The crisis of adjustment. London: George Allen & Unwin Ltd.

Carey, T. C., Carey, M. P. & Kelley, M. L. (1997). Differential emotions theory: Relative contribution of emotion, cognition, and behavior to the prediction of depressive symptomatology in non-referred adolescents. Journal of Clinical Psychology, 53(1), 25-34.

Chan, D. W. (1997). Self-concept domains and global self-worth among chinese adolescents in Hong Kong. Personality & Individual Differences, 22(4), 511-520.

Chubb, N. H., Fertman, C. I. & Ross, J. L. (1997). Adolescent self-esteem and locus of control: A longitudinal study of gender and age differences. Adolescence, 32(125), 113-129.

Compas, B. E., Ey, S. & Grant, K. E. (1993). Taxonomy, assessment, and diagnosis of depression during adolescence. Psychological Bulletin,114(2), 323-344.

Compas, B. E., Oppedisano, G., Connor, J. K., Gerhardt, C. A., Hinden, B. R., Achenbach, T. M. & Hammen, C. (1997). Gender differences in depressive symptoms in adolescence: Comparison of national samples of clinically referred and nonreferred youths. Journal of Consulting & Clinical Psychology, 65(4), 617-626.

Damon, W. & Hart, D. (1982). The development of self-understanding from infancy through adolescence. Child Development, 53, 841-864.

Demo, D. H. (1985). The measurement of self-esteem: Refining our methods. Journal of Personality & Social Psychology, 48(6), 1490-1502.

Diekstra, R. F. W. (1989). Suicidal behavior in adolescents and young adults: The international picture. Crisis, 10(1), 16-35.

Diekstra, R. F. W. (1995). Depression and suicidal behaviors in adolescence: Sociocultural and time trends. In M. Rutter (Ed.), Psychosocial disturbances in young people: Challenges for prevention (pp. 212-243). Melbourne: Cambridge University Press.

Drummond, W. J. (1997). Adolescents at risk: Causes of youth suicide in New Zealand. Adolescence, 32(128), 925-934.

DuBois, D. L., Bull, C. A., Sherman, M. D. & Roberts, M. (1998). Self-esteem and adjustment in early adolescence: A social-contextual perspective. Journal of Youth and Adolescence, 27(5), 557-583.

Dusek, J. B. (1996). Adolescent development and behavior (3rd ed.). Sydney: Prentice Hall of Australia Pty Ltd.

Eiser, C. Eiser, J. R. & Havermans, T. (1995). The measurement of self-esteem: Practical and theoretical considerations. Personality & Individual Differences, 18(3), 429-432.

Eley, T. C. (1997). Depressive symptoms in children and adolescents: Etiological links between normality and abnormality. Journal of Child Psychology & Psychiatry & Allied Disciplines, 38(7), 861-865.

Erikson, E. (1963). Childhood and society. Sydney: Paladin Grafton Books.

Erikson, E. (1968). Identity: Youth and crisis. New York: W. W. Norton & Company.

Fischer, K. W. (1980). A theory of cognitive development: The control and construction of hierarchies of skills. Psychological Review, 87, 477-531.

Garland, A. & Zigler, E. (1993). Adolescent suicide prevention: Current research and policy implications. American Psychologist, 48, 169-182.

Garnefski, N. & Diekstra, R. F. W. (1997). Adolescents from one parent, stepparent and intact families: emotional problems and suicide attempts. Journal of Adolescence, 20, 201-208.

Harrison, P. Geddes, J. & Sharpe, M. (1998). Psychiatry (8th ed.).
Carlton, Victoria: Blackwell Science Pty Ltd.

Harter, S. (1982). The perceived competence scale for children.
Child Development, 53, 87-97.

Harter, S. (1985). Manual for the social support scale for children.
Nebraska: University of Denver.

Harter, S. (1988). Manual for the self-perception profile for
adolescents. Nebraska: University of Denver.

Harter, S. (1989). Causes, correlates and the functional role of
global self-worth: A life-span perspective. In J. Kolligian & R. Sternberg
(Eds.), Perceptions of competence and incompetence across the life-
span (pp. 67-97). New Haven, Ct: Yale University Press.

Harter, S. (1990). Processes underlying adolescent self-concept
formation. In R. Montemayor (Ed.), Transition from childhood to
adolescent self-concept (pp. 205-239). CA: Sage Publications.

Harter, S. (1993). Causes and consequences of low self-esteem
in children and adolescents. In R. F. Baumeister (Ed.), Self-esteem: The
Puzzle of low self-regard (pp.87-116). New York: Plenum Press.

Harter, S. & Marold, D. B. (1994). Psychosocial risk factors
contributing to adolescent suicide ideation. In G. G. Noam and S. Borst
(Eds.), Children, youth, and suicide: Developmental perspectives (pp. 71-
91). San Francisco: Jossey-Bass Publishers.

Harter, S. Marold, D. B. & Whitesell, N. R. (1992). Model of

psychosocial risk factors leading to suicidal ideation in young

adolescents. Development & Psychopathology, 4, 167-188.

Harter, S. & Monsour, A. (1992). Developmental analysis of

conflict caused by opposing attributes in the adolescent self-portrait.

Developmental Psychology, 28(2), 251-260.

Heaven, P. C. L. (1994). Contemporary adolescence: A social

psychological approach. Melbourne: Macmillan Education Australia Pty

Ltd.

Hewitt, P. L., Newton, J., Flett, G. L. & Callander, L. (1997).

Perfectionism and suicide ideation in adolescent psychiatric patients.

Journal of Abnormal Child Psychology, 25(2), 95-101.

Hoffman, M. A., Levy-Shiff, R. & Ushpiz, V. (1993). Moderating

effects of adolescent social orientation on the relation between social

support and self-esteem. Journal of Youth & Adolescence, 22(1), 23-31.

Hoffman, M. A., Ushpiz, V & Levy-Shiff, R. (1988). Social support

and self-esteem in adolescence. Journal of Youth & Adolescence, 17(4),

307-316.

Jackson, H., McCartt Hess, P. & van Dalen, A. (1995).

Preadolescent suicide: How to ask and how to respond. Families in

Society, 52, 267-280.

Killeen, M. R. & Forehand, R. (1998). A transactional model of

self-esteem. Journal of Family Psychology, 12(1), 132-148.

Kovacs, M. (1992). Children's Depression Inventory Manual. New York: Multi-Health Systems, Inc.

Lasko, D. S., Field, T. M., Gonzalez, K. P. Harding, J., Yando, R. & Bendell, D. (1996). Adolescent depressed mood and parental unhappiness. Adolescence, 31(121), 49-57.

Levy, S. R., Jurkovic, G. L. & Spirito, A. (1995). A multisystems analysis of adolescent suicide attempters. Journal of Abnormal Child Psychology, 23(2), 221-234.

MacLean, G. (1990). Suicide in children and adolescents. Canada: Hogrefe & Huber Publishers.

Marcotte, D. (1996). Irrational beliefs and depression in adolescence. Adolescence, 31(124), 935-954.

Marsh, H. W. (1986). Global self-esteem: Its relation to specific facets of self-concept and their importance. Journal of Personality & Social Psychology, 51(6), 1224-1236.

Marsh, H. W. & Gouvernet, P. J. (1989). Multidimensional self-concepts and perceptions of control: Construct validation of responses by children. Journal of Educational Psychology, 81(1), 57-69.

Marsh, H. W. & Holmes, I. W. M. (1990) Multidimensional self-concepts: Construct validation of responses by children. American Educational Research Journal, 27(1), 89-117.

Mitchell, P. (1998). National youth suicide prevention strategy. Youth Suicide Prevention Bulletin, 1, 3-6.

Mortimer, J. T., Finch, M. D., Ryu, S., Shanahan, M. J. & Call, K. T. (1996). The effects of work intensity on adolescent mental health, achievement, and behavioural adjustment: New evidence from a prospective study. Child Development, 67, 1243-1261.

National Action Plan for Suicide Prevention (1999). [on line] http://www.aifs.or.au/external/ysp/actionmenu.htm1.

National Health and Medical Research Council (1997). Clinical practice guidelines: Depression in young people. Canberra: AGPS.

Nottelman, E. D. (1987). Competence and self-esteem during transition from childhood to adolescence. Developmental Psychology, 23(3), 441-450.

Peterson, A. C., Compas, B. E., Brooks-Gunn, J., Stemmler, M., Ey, S. & Grant, K. E. (1993). Depression in adolescence. American Psychologist, 43(2), 155-168.

Pfeffer, C. R. (1994). Developmental issues in child and adolescent suicide: A discussion. In G. G. Noam and S. Borst (Eds.), Children, youth, and suicide: Developmental perspectives (pp. 109-114). San Francisco: Jossey-Bass Publishers.

Piaget, J. & Inhelder, B. (1969). The psychology of the child. London: Routledge & Kegan Paul.

Priester, M. J. and Clum, G. A. (1993). The problem-solving diathesis in depression, hopelessness, and suicide ideation: A longitudinal analysis. Journal of Psychopathology and Behavioral Assessment, 15(3), 239-254.

Rosenberg, M. (1965). Society and the adolescent self-image. Princeton, NJ: Princeton University.

Rosenberg, M. Schooler, C. & Schoenbach, C. (1989). Self-esteem and adolescent problems: Modeling reciprocal effects. American Sociological Review, 54, 1004-1018.

Schonert-Reichl, K. A. & Muller, J. R. (1996). Correlates of help-seeking in adolescence. Journal of Youth & Adolescence, 25(6), 705-731.

Smollar, J. & Youniss, J. (1985). Adolescent self-concept development. In R. L. Leahy (Ed.), The development of the self (pp. 247-265). Sydney: Academic Press, Inc.

Steele, A. A. & McLennan, J. (1995). Suicidal and counter-suicidal thinking. Australian Psychologist, 30(2), 149-152.

Steer, R. A., Kumar, G. & Beck, A. T. (1993). Hopelessness in adolescent psychiatric inpatients. Psychological Reports, 72, 559-564.

Strachen, A. & Jones, D. (1982). Changes in identification during adolescence: A personal construct theory approach. Journal of Personality Assessment, 46(5), 529-535.

Trent, L. M. Y., Russell, G. & Cooney, G. (1994). Assessment of self-concept in early adolescence. Australian Journal of Psychology, 46(1), 21-28.

Wilks, J. & Orth, M. A. (1991). "Who know what?" Youth Studies, 10(4), 36-40.

Wilson, K. G., Stelzer, J. S., Bergman, J. N., Kral, M. J.,

Inayatullah, M. & Elliott, C. A. (1995). Problems solving, stress, and

coping in adolescent suicide attempts. <u>Suicide and Life-Threatening</u>

<u>Behavior, 25</u>(2), 241-252.

Zubrick, S. R., Silburn, S. R., Gurrin, L., Teoh, H., Shepherd, C.,

Carlton, J. & Lawrence, D. (1997). <u>Western Australian child health</u>

<u>survey: Education, health and competence.</u> Perth: Australian Bureau of

Statistics and the TVW Telethon Institute for Child Health Research.

TABLE OF APPENDICES

Dear Student & Parent / Guardian,

Mount Lawley Senior High School has agreed to take part in a research project with Edith Cowan University about how teenagers feel about themselves. We know that each teenager is different, so to help us get an idea of the whole range of teenagers we need as many as possible.

Are you willing to help? This will only take about 20-30 minutes of the student's time during a selected English period. Students will be asked to complete a survey about themselves and their feelings and ideas. There are no right or wrong answers and no embarrassing questions. Students do not need to put their names on the forms and no one but the researchers will ever see the answers. Students can choose not to answer any questions and can stop at any time if they wish. All those who take part in the study will receive a small chocolate bar to say thank you.

Please return the attached slip to Ms Cook **as soon as possible**, whether or not you are willing to help. If you have any queries please feel free to contact Mrs Worthingon at the school, myself on ████████ or my supervisor, Lis Pike on ████████ Thank you for your help.

Yours sincerely,

_____
Wendy Nicholls (Masters student, ECU) 14th May 1999

PLEASE RETURN THIS FORM AS SOON AS POSSIBLE
WHETHER OR NOT YOU ARE WILLING TO HELP

STUDENTS NAME:_____

PARENT: Please tick one
[ ] I am happy for my teenager to take part in the survey.
[ ] I would rather my teenager did not take part in the survey.

Please sign_____

STUDENT: Please tick one
[ ] I am happy to take part in the survey.
[ ] I would rather not take part in the survey.

Please sign_____

Thank you for your help to those families who have already agreed to take part in the survey.

JOONDALUP CAMPUS	MOUNT LAWLEY CAMPUS	CHURCHLANDS CAMPUS	CLAREMONT CAMPUS	BUNBURY CAMPUS
100 Joondalup Drive, Joondalup	2 Bradford Street, Mount Lawley	Pearson Street, Churchlands	Goldsworthy Road, Claremont	Robertson Drive, Bunbury
Western Australia 6027	Western Australia 6050	Western Australia 6018	Western Australia 6010	Western Australia
Telephone (08) 9400 5555	Telephone (08) 9370 6111	Telephone (08) 9273 8333	Telephone (08) 9442 1333	Telephone (08) 9780 7777

Consent Form

DIFFERENCES IN VARIOUS ASPECTS OF SELF-ESTEEM BETWEEN ADOLESCENTS IN THERAPY AFTER HAVING SUICIDAL THOUGHTS AND NON-SUICIDAL ADOLESCENTS: EC 98/102

Chief Investigator: Ms Wendy J. Nicholls, Master of Psychology Student (Clinical) ECU

Introduction

A recent survey conducted in WA expressed some concern over the increase in adolescent suicide in recent years. Loss of self-esteem was identified as being a contributor, affecting the adolescents' sense of self worth and the way they feel about various aspects of their lives. There is little evidence at this stage to suggest how self esteem differs in adolescents who have either attempted or had thoughts of suicide and adolescents who are not suicidal. We are now wanting to carry out a study to investigate the various aspects of self-esteem and how they differ in the two different groups of adolescents.

What is involved?

This will require the voluntary participation of adolescents aged between 14 and 17 years. Some will come from schools in the community and others will be recruited from places such as Youthlink and other organisations that provide therapy services for adolescents. Participants will be asked to complete a set of questionnaires, which will take approximately 20 to 30 minutes. Those who attend clinics can complete these either directly before or after therapy appointments. This will involve the participants answering some questions about themselves and their feelings and ideas. There are no right or wrong answers and no embarrassing questions asked. Names will not be recorded on any questionnaires, to ensure confidentiality. Further, should any future report be published regarding the study, no one will be identified.

Benefits and risks

The main potential benefit from the study is that the information gained from this research project will provide some valuable and useful information that can assist professionals who work with adolescents in the future. The only risk inolved is that some participants may feel some distress after completing the questionnaires. However, the questionnaires are appropriate to use for therapy purposes and should any issues arise, they can be discussed with your therapist directly after completing them.

Withdrawal from the study

Participation in this research project is entirely voluntary. It does not bind the participant to any contract in any way and he or she is free to withdraw at any time. Further, the participant is not under any obligation

Further information

This research project has been approved by the Ethics Committee at Royal Perth Hospital. Further information may be obtained from Ms Wendy Nicholls (08) ████████ her supervisor, Ms Lisbeth Pike (08) ████████ or from Clin Prof J A Millar, Chairman of the Ethics Committee, telephone (08)████████.

DIFFERENCES IN VARIOUS ASPECTS OF SELF-ESTEEM BETWEEN ADOLESCENTS IN THERAPY AFTER HAVING SUICIDAL THOUGHTS AND NON-SUICIDAL ADOLESCENTS: EC 98/102

I .... agree to participate in the above study. I have read and understood the attached Information Sheet and I have retained a copy of it. I have been given the opportunity to ask questions about the study. I understand that I may withdraw from the study at any time.

Signed .... Date ....

Parent/Guardian .... Date ....

Signature of Investigator .... Date ....

EDITH COWAN UNIVERSITY

PERTH WESTERN AUSTRALIA
JOONDALUP CAMPUS

100 Joondalup Drive, Joondalup
Western Australia 6027
Telephone +61 8 9400 5555
Facsimile +61 8 9300 1257

To the parent or guardian of _____

A Masters Clinical Psychology student at Edith Cowan University is conducting a research project about adolescent self-esteem. Your son or daughter is being asked to participate. This will involve answering some questions about themselves and their feelings and ideas. There are no right or wrong answers and no embarrassing questions.

This will only take about 20 –30 minutes and can be done directly before or after their next appointment. Research participation will be completely confidential, as the forms will not have any names to identify the participant. However, the information obtained will be given to the therapist who sees your son or daughter to assist with therapy.

Could you please sign and return the attached form as soon as possible. It is important that both parent and son or daughter sign the form. Should you have any queries regarding the research, you can call Wendy Nicholls on ██████████ or Lis Pike on █████████ from Edith Cowan University. Thank you for your cooperation!

PLEASE RETURN THIS FORM AS SOON AS POSSIBLE

NAME of TEENAGER_____

PARENT: Please tick one
[ ] I am happy for my teenager to take part in the research.
[ ] I would rather my teenager did not take part in the research.

Please sign_____

TEENAGER: Please tick one
[ ] I am happy to take part in the research.
[ ] I would rather not take part in the research.

Please sign_____

JDONDALUP CAMPUS
100 Joondalup Drive, Joondalup
Western Australia 6027
Telephone (08) 9400 5555

MOUNT LAWLEY CAMPUS
2 Bradford Street, Mount Lawley
Western Australia 6050
Telephone (08) 9370 6111

CHURCHLANDS CAMPUS
Pearson Street, Churchlands
Western Australia 6018
Telephone (08) 9273 8333

CLAREMONT CAMPUS
Goldsworthy Road, Claremont
Western Australia 6010
Telephone (08) 9442 1333

BUNBURY CAMPUS
Robertson Drive, Bunbury
Western Australia
Telephone (08) 9780 7777

INSTRUCTIONS FOR THE ADOLESCENT SELF-ESTEEM RESEARCH (CLINICAL)

The following forms will take approximately 20 minutes to complete. They are questions about you, your feelings and ideas. There are no right or wrong answers and no embarrassing questions. You should have a code number at the top of the page. This is so that your answers can remain anonymous for this research, while your therapist can receive some information from it.

You should find the following in front of you:
1. A DEMOGRAPHIC FORM
2. WHAT I AM LIKE (3 PAGES)
3. HOW IMPORTANT ARE EACH OF THESE THINGS TO YOU (1 PAGE)
4. PEOPLE IN MY LIFE (2 PAGES)
5. CDI (ATTACHED TO THE BACK WITH FRONT COVER OF INSTRUCTIONS AND FRONT & BACK OF THE QUESTIONNAIRE)

PLEASE FOLLOW THE FOLLOWING SIMPLE INSTRUCTIONS:

STEP 1
Complete DEMOGRAPHICS form

STEP 2
WHAT I AM LIKE .
You will see a sample sentence above the dark line near the top of the page. First ask yourself, which teenager is more like me? Is it the one who likes to go to the movies in their spare time? Or is it the one who would rather go to sports events? You may like to do both. If so, choose the one that you like to do most. When you decide, go to that side of the page and then ask yourself, is that really true for me or just sort of true for me? Then tick the appropriate box. **Important - You only have one box ticked for each line. Do not tick both sides.**
Now you can complete the 3 pages.

STEP 3
HOW IMPORTANT ARE THESE THINGS TO YOU?
This is done in the same way as the previous scale, only the emphasis is on how important those things are to you.

STEP 4
PEOPLE IN MY LIFE
This has a sample question and is about different types of people in you life. It is also done in the same way as the previous scales describing which comment is more true for you.

STEP 5
CDI
This is a measure of how your mood has been over the past 2 weeks. Instructions are attached to the questionnaire. **Please complete both front and back of the form.**

MANY THANKS FOR PARTICIPATING IN THIS RESEARCH!

TEENAGE SELF-ESTEEM RESEARCH

This is a research project about how teenagers feel about themselves. We know that each teenager is different, so to help us get an idea of the whole range of teenagers we need as many teenagers as possible.

Are you willing to help? This is for teenagers aged between 14 & 17 years and will only take about 20 –30 minutes. Students will be asked to complete a survey about themselves and their feelings and ideas. There are no right or wrong answers and no embarrassing questions. Students do not have to put their names on the forms but it is important to keep all the forms attached.

Instructions

You will find you have a bundle of forms. These are:
>   DEMOGRAPHICS FORM FOR SCHOOL PARTICIPANTS (front page)
>   WHAT I AM LIKE (3 pages)
>   HOW IMPORTANT ARE EACH OF THESE THINGS TO YOU? (1 page)
>   PEOPLE IN MY LIFE (2 pages)

&   CDI attached to the back with front cover of instructions and front & back of the questionnaire.

1st   Complete <u>demographics form</u>

2nd   WHAT I AM LIKE
You will see a sample sentence above the dark line near the top of the page. First ask yourself, which teenager is more like me? Is it the one who likes to go to the movies in their spare time? Or is it the one who would rather go to sports events? When you decide, you go to that side of the page and ask yourself, is that really true for me? Or is it sort of true for me? Then you tick the appropriate box. This means that <u>you only have one box ticked for each line</u>. You do not tick both sides, just one or the other. Now you can go ahead with the 3 pages.

3rd   HOW IMPORTANT ARE THESE THINGS TO YOU? This is done in the same format as the one above only the emphasis is on the importance of those things.

4th   PEOPLE IN MY LIFE has a sample question and is in the same format again describing which comment is more true for you.

5th   CDI is a measure of how your mood has been over the past 2 weeks. Instructions are attached to the questionnaire. Please complete front and back of form.

<u>THANK YOU VERY MUCH FOR YOUR HELP. IT IS GREATLY APPRECIATED!</u>

Demographics Form for Clinical Participants

Please tick the appropriate spaces, boxes or answers below.

1. Are you Male_____Female_____?

2. What was your age last birthday?

13	14	15	16	17	18

3. Do you attend school? Yes_____No_____
   If so, what year are you in at school?

10	11	12

4. Do you live: at home with both parents
   at home with your mother
   at home with your father
   with other family members
   with mother and step-father
   with father and step-mother
   with foster parents
   other (please state briefly)

_____

5. Do you live with any brothers & sisters? Yes_____No_____

    If so, how many brothers_____and how many sisters_____do you have?

6. What position are you among your brothers and sisters? (eg. 1st 2nd)_____

7. Are you currently working? Yes_____No_____

                        Part-time_____Full-time_____

8. Do you wish to make any other comments?

_____

_____

_____

_____

Demographics Form for School Participants

Please tick the appropriate spaces, boxes or answers below.

1. Are you male_____ or female_____?

2. What was your age last birthday?

| 13 | 14 | 15 | 16 | 17 | 18 |

3. What year are you in at school?

| 10 | 11 | 12 | |

4. Do you live: at home with both parents
                    at home with your mother
                    at home with your father
                    with foster parents
                    with other family members
                    other (please state briefly)
                    _____

5. Do you live with any brothers and sisters? Yes_____No_____

   If so, how many brothers_____and how many sisters_____do you have?

6. What position are you among your siblings? (eg. 1st 2nd 3rd)_____

7. Do you have a part–time job out of school hours?

              Yes_____No_____

8. Do you wish to make any other comments?

   _____

   _____

   _____

   _____

What I Am Like

SAMPLE SENTENCE

Really True for Me	Sort of True for Me				Sort of True for Me	Really True for Me
☐	☐	Some teenagers like to go to movies in their spare time	BUT	Other teenagers would rather go to sports events.	☐	☐
☐	☐	Some teenagers feel that they are just as smart as others their age	BUT	Other teenagers aren't so sure and wonder if they are as smart.	☐	☐
☐	☐	Some teenagers find it hard to make friends	BUT	For other teenagers it's pretty easy.	☐	☐
☐	☐	Some teenagers do very well at all kinds of sports	BUT	Other teenagers don't feel that they are very good when it comes to sports.	☐	☐
☐	☐	Some teenagers are not happy with the way they look	BUT	Other teenagers are happy with the way they look.	☐	☐
☐	☐	Some teenagers feel that they are ready to do well at a part-time job	BUT	Other teenagers feel that they are not quite ready to handle a part-time job.	☐	☐
☐	☐	Some teenagers feel that if they are romantically interested in someone, that person will like them back	BUT	Other teenagers worry that when they like someone romantically, that person won't like them back.	☐	☐
☐	☐	Some teenagers usually do the right thing	BUT	Other teenagers often don't do what they know is right.	☐	☐
☐	☐	Some teenagers are able to make really close friends	BUT	Other teenagers find it hard to make really close friends.	☐	☐
☐	☐	Some teenagers are often disappointed with themselves	BUT	Other teenagers are pretty pleased with themselves.	☐	☐
☐	☐	Some teenagers are pretty slow in finishing their school work	BUT	Other teenagers can do their school work more quickly.	☐	☐
☐	☐	Some teenagers have a lot of friends	BUT	Other teenagers don't have very many friends.	☐	☐
☐	☐	Some teenagers think they could do well at just about any new athletic activity	BUT	Other teenagers are afraid they might not do well at a new athletic activity.	☐	☐

	Really True for Me	Sort of True for Me				Sort of True for Me	Really True for Me

	Really True for Me	Sort of True for Me				Sort of True for Me	Really True for Me
13.	☐	☐	Some teenagers wish their body was different	BUT	Other teenagers like their body the way it is.	☐	☐
14.	☐	☐	Some teenagers feel that they *don't* have enough skills to do well at a job	BUT	Other teenagers feel that they *do* have enough skills to do a job well.	☐	☐
15.	☐	☐	Some teenagers are *not* dating the people they are really attracted to	BUT	Other teenagers *are* dating those people they are attracted to.	☐	☐
16.	☐	☐	Some teenagers often get in trouble for the things they do	BUT	Other teenagers usually *don't* do things that get them in trouble	☐	☐
17.	☐	☐	Some teenagers do have a close friend they can share secrets with	BUT	Other teenagers do not have a really close friend they can share secrets with	☐	☐
18.	☐	☐	Some teenagers don't like the way they are leading their life	BUT	Other teenagers do like the way they are leading their life.	☐	☐
19.	☐	☐	Some teenagers do very well at their classwork	BUT	Other teenagers don't do very well at their classwork.	☐	☐
20.	☐	☐	Some teenagers are very hard to like	BUT	Other teenagers are really easy to like.	☐	☐
21.	☐	☐	Some teenagers feel that they are better than others their age at sports	BUT	Other teenagers don't feel they can play as well.	☐	☐
22.	☐	☐	Some teenagers wish their physical appearance was different	BUT	Other teenagers like their physical appearance the way it is.	☐	☐
23.	☐	☐	Some teenagers feel they are old enough to get and keep a paying job	BUT	Other teenagers do not feel they are old enough, yet, to really handle a job well	☐	☐
24.	☐	☐	Some teenagers feel that people their age will be romantically attracted to them	BUT	Other teenagers worry about whether people their age will be attracted to them.	☐	☐
25.	☐	☐	Some teenagers feel really good about the way they act	BUT	Other teenagers *don't* feel that good about the way they often act	☐	☐
26.	☐	☐	Some teenagers wish they had a really close friend to share things with	BUT	Other teenagers *do* have a close friend to share things with.	☐	☐
27.	☐	☐	Some teenagers are happy with themselves most of the time	BUT	Other teenagers are often not happy with themselves.	☐	☐
28.	☐	☐	Some teenagers have trouble figuring out the answers in school	BUT	Other teenagers almost always can figure out the answers.	☐	☐

	Really True for Me	Sort of True for Me				Sort of True for Me	Really True for Me
29.	☐	☐	Some teenagers are popular with others their age	BUT	Other teenagers are not very popular.	☐	☐
30.	☐	☐	Some teenagers don't do well at new outdoor games	BUT	Other teenagers are good at new games right away.	☐	☐
31.	☐	☐	Some teenagers think that they are good looking	BUT	Other teenagers think that they are not very good looking.	☐	☐
32.	☐	☐	Some teenagers feel like they could do better at work they do for pay	BUT	Other teenagers feel that they are doing really well at work they do for pay.	☐	☐
33.	☐	☐	Some teenagers feel that they are fun and interesting on a date	BUT	Other teenagers wonder about how fun and interesting they are on a date.	☐	☐
34.	☐	☐	Some teenagers do things they know they shouldn't do	BUT	Other teenagers hardly ever do things they know they shouldn't do.	☐	☐
35.	☐	☐	Some teenagers find it hard to make friends they can really trust	BUT	Other teenagers are able to make close friends they can really trust.	☐	☐
36.	☐	☐	Some teenagers like the kind of person they are	BUT	Other teenagers often wish they were someone else.	☐	☐
37.	☐	☐	Some teenagers feel that they are pretty intelligent	BUT	Other teenagers question whether they are intelligent.	☐	☐
38.	☐	☐	Some teenagers feel that they are socially accepted	BUT	Other teenagers wished that more people their age accepted them.	☐	☐
39.	☐	☐	Some teenagers do not feel that they are very athletic	BUT	Other teenagers feel that they are very athletic.	☐	☐
40.	☐	☐	Some teenagers really like their looks	BUT	Other teenagers wish they looked different.	☐	☐
41.	☐	☐	Some teenagers feel that they are really able to handle the work on a paying job	BUT	Other teenagers wonder if they are really doing as good a job at work as they should be doing	☐	☐
42.	☐	☐	Some teenagers usually don't go out with the people they would really like to date	BUT	Other teenagers do go out with the people they really want to date.	☐	☐
43.	☐	☐	Some teenagers usually act the way they know they are supposed to	BUT	Other teenagers often don't act the way they are supposed to.	☐	☐
44.	☐	☐	Some teenagers don't have a friend that is close enough to share really personal thoughts with	BUT	Other teenagers do have a close friend that they can share personal thoughts and feelings with.	☐	☐
45.	☐	☐	Some teenagers are very happy being the way they are	BUT	Other teenagers wish they were different.	☐	☐

F

HOW IMPORTANT ARE EACH OF THESE THINGS TO YOU?

Really True for Me	Sort of True for Me				Sort of True for Me	Really True for Me
☐	☐	Some teenagers think it is important to be intelligent	BUT	Other teenagers don't think it is important to be intelligent	☐	☐
☐	☐	Some teenagers don't think its all that important to have a lot of friends	BUT	Other teenagers think that having a lot of friends is important	☐	☐
☐	☐	Some teenagers think its important to be good at sports	BUT	Other teenagers don't care much about being good at sports	☐	☐
☐	☐	Some teenagers don't really think that their physical appearance is all that important	BUT	Other teenagers think that their physical appearance is important	☐	☐
☐	☐	Some teenagers don't care that much about how well they do on a paying job	BUT	Other teenagers feel its important that they do well on a paying job	☐	☐
☐	☐	Some teenagers think its important that the people they are romantically interested in like them back	BUT	Other teenagers don't really care that much whether someone they are interested in likes them that much	☐	☐
☐	☐	Some teenagers don't think its that important to do the right thing	BUT	Other teenagers think that doing the right think is important	☐	☐
☐	☐	Some teenagers think its important to be able to make really close friends	BUT	Other teenagers don't think making close friends is all that important	☐	☐
☐	☐	Some teenagers don't think that doing well in school is really that important	BUT	Other teenagers think that doing well in school is important	☐	☐
0. ☐	☐	Some teenagers think its important to be popular	BUT	Other teenagers don't care that much about whether they are popular	☐	☐
1. ☐	☐	Some teenagers don't think that being athletic is that important	BUT	Other teenagers think that being athletic is important	☐	☐
2. ☐	☐	Some teenagers think that how they look is important	BUT	Other teenagers don't care that much about how they look	☐	☐
3. ☐	☐	Some teenagers think its important to do their best on a paying job	BUT	Other teenagers don't think that doing their best on a job is all that important	☐	☐
4. ☐	☐	Some teenagers don't care that much whether they are dating someone they are romantically interested in	BUT	Other teenagers think its important to be dating someone they are interested in	☐	☐
5. ☐	☐	Some teenagers think its important to act the way they are supposed to	BUT	Other teenagers don't care that much whether they are acting the way they are supposed to	☐	☐
8. ☐	☐	Some teenagers don't care that much about having a close friend they can trust	BUT	Other teenagers think its important to have a really close friend you can trust	☐	☐

PEOPLE IN MY LIFE

Really True for Me	Sort of True for Me		Sample Item			Sort of True for Me	Really True for Me
☐	☐	Some kids like to do fun things with a lot of other people	BUT	Other kids like to do fun things with just a few people.		☐	☐
☐	☐	Some kids have parents who *don't* really *understand* them	BUT	Other kids have parents who really *do* understand them.		☐	☐
☐	☐	Some kids have class-mates who like them the way they are	BUT	Other kids have class-mates who wish they were *different*.		☐	☐
☐	☐	Some kids have a teacher who *helps* them if they are *upset* and have a problem	BUT	Other kids *don't* have a teacher who helps them if they are upset and have a problem.		☐	☐
☐	☐	Some kids have a close friend who they can tell *problems* to	BUT	Other kids *don't* have a close friend who they can tell problems to.		☐	☐
☐	☐	Some kids have parents who *don't* seem to want to hear about their children's problems	BUT	Other kids have parents who *do* want to *listen* to their children's problems.		☐	☐
☐	☐	Some kids have class-mates that they can become friends with	BUT	Other kids *don't* have classmates that they can become friends with.		☐	☐
☐	☐	Some kids *don't* have a teacher who *helps* them *to do* their very best	BUT	Other kids *do* have a teacher who *helps* them to do their very best.		☐	☐
☐	☐	Some kids have a close friend who really under-stands them	BUT	Other kids *don't* have a close friend who understands them.		☐	☐
☐	☐	Some kids have parents who *care* about their feelings	BUT	Other kids have parents who *don't* seem to care very much about their children's feelings.		☐	☐
☐	☐	Some kids have class-mates who sometimes make fun of them	BUT	Other kids *don't* have classmates who make fun of them.		☐	☐
☐	☐	Some kids *do* have a teacher who *cares* about them	BUT	Other kids *don't* have a teacher who cares about them.		☐	☐

(OVER)

Really True for Me	Sort of True for Me				Sort of True for Me	Really True for Me

2. ☐ ☐ Some kids have a close friend who they can talk to about things that bother them **BUT** Other kids *don't* have a close friend who they can talk to about things that bother them. ☐ ☐

3. ☐ ☐ Some kids have parents who treat their children like a *person* who really matters **BUT** Other kids have parents who *don't* usually treat their children like a person who matters. ☐ ☐

4. ☐ ☐ Some kids have classmates who pay attention to what they say **BUT** Other kids have classmates who usually don't pay attention to what they say. ☐ ☐

5. ☐ ☐ Some kids *don't* have a teacher who is *fair* to them **BUT** Other kids *do* have a teacher who is fair to them. ☐ ☐

6. ☐ ☐ Some kids *don't* have a close friend who they like to spend time with **BUT** Other kids *do* have a close friend who they like to spend time with. ☐ ☐

7. ☐ ☐ Some kids have parents who like them the *way they are* **BUT** Other kids have parents who wish their children were *different*. ☐ ☐

8. ☐ ☐ Some kids *don't* get asked to play in games with classmates very often **BUT** Other kids *often* get asked to play in games by their classmates. ☐ ☐

19. ☐ ☐ Some kids *don't* have a teacher who cares if they feel bad **BUT** Other kids *do* have a teacher who cares if they feel bad. ☐ ☐

20. ☐ ☐ Some kids *don't* have a close friend who really *listens* to what they say **BUT** Other kids *do* have a close friend who really listens to what they say. ☐ ☐

21. ☐ ☐ Some kids have parents who *don't* act like what their children do is *important* **BUT** Other kids have parents who *do* act like what their children do is important. ☐ ☐

22. ☐ ☐ Some kids often spend recess being *alone* **BUT** Other kids spend recess playing with their classmates. ☐ ☐

23. ☐ ☐ Some kids have a teacher who treats them like a *person* **BUT** Other kids *don't* have a teacher who treats them like a person. ☐ ☐

24. ☐ ☐ Some kids *don't* have a close friend who cares about their feelings **BUT** Other kids *do* have a close friend who cares about their feelings. ☐ ☐

Name: _____ Age: _____ Birthdate: _____
Grade in school: _____ Sex: _____ Today's date: _____

CDI

MHS

Maria Kovacs, Ph.D.

Kids sometimes have different feelings and ideas.

This form lists the feelings and ideas in groups. From each group of three sentences, pick one sentence that describes you *best* for the past two weeks. After you pick a sentence from the first group, go on to the next group.

There is no right answer or wrong answer. Just pick the sentence that best describes the way you have been recently. Put a mark like this ✗ next to your answer. Put the mark in the box next to the sentence that you pick.

Here is an example of how this form works. Try it. Put a mark next to the sentence that describes you *best*.

Example:

> ☐ I read books all the time.
> ☐ I read books once in a while.
> ☐ I never read books.

When you are told to do so, tear off this top page. Then, pick the sentences that describe you best on the first page. After you finish the first page, turn to the back. Then, answer the items on that page.

Remember, pick out the sentences that describe you best in the PAST TWO WEEKS.

CDI

Item 1
- ☐ I am sad once in a while.
- ☐ I am sad many times.
- ☐ I am sad all the time.

Item 2
- ☐ Nothing will ever work out for me.
- ☐ I am not sure if things will work out for me.
- ☐ Things will work out for me O.K.

Item 3
- ☐ I do most things O.K.
- ☐ I do many things wrong.
- ☐ I do everything wrong.

Item 4
- ☐ I have fun in many things.
- ☐ I have fun in some things.
- ☐ Nothing is fun at all.

Item 5
- ☐ I am bad all the time.
- ☐ I am bad many times.
- ☐ I am bad once in a while.

Item 6
- ☐ I think about bad things happening to me once in a while.
- ☐ I worry that bad things will happen to me.
- ☐ I am sure that terrible things will happen to me.

Item 7
- ☐ I hate myself.
- ☐ I do not like myself.
- ☐ I like myself.

Item 8
- ☐ All bad things are my fault.
- ☐ Many bad things are my fault.
- ☐ Bad things are not usually my fault.

Item 9
- ☐ I do not think about killing myself.
- ☐ I think about killing myself but I would not do it.
- ☐ I want to kill myself.

Item 10
- ☐ I feel like crying every day.
- ☐ I feel like crying many days.
- ☐ I feel like crying once in a while.

Item 11
- ☐ Things bother me all the time.
- ☐ Things bother me many times.
- ☐ Things bother me once in a while.

Item 12
- ☐ I like being with people.
- ☐ I do not like being with people many times.
- ☐ I do not want to be with people at all.

Item 13
- ☐ I cannot make up my mind about things.
- ☐ It is hard to make up my mind about things.
- ☐ I make up my mind about things easily.

Item 14
- ☐ I look O.K.
- ☐ There are some bad things about my looks.
- ☐ I look ugly.

Remember to fill out the other side

CDI

Remember, describe how you have been in the past two weeks.....

Item 15

☐ I have to push myself all the time to do my schoolwork.

☐ I have to push myself many times to do my schoolwork.

☐ Doing schoolwork is not a big problem.

Item 16

☐ I have trouble sleeping every night.

☐ I have trouble sleeping many nights.

☐ I sleep pretty well.

Item 17

☐ I am tired once in a while.

☐ I am tired many days.

☐ I am tired all the time.

Item 18

☐ Most days I do not feel like eating.

☐ Many days I do not feel like eating.

☐ I eat pretty well.

Item 19

☐ I do not worry about aches and pains.

☐ I worry about aches and pains many times.

☐ I worry about aches and pains all the time.

Item 20

☐ I do not feel alone.

☐ I feel alone many times.

☐ I feel alone all the time.

Item 21

☐ I never have fun at school.

☐ I have fun at school only once in a while.

☐ I have fun at school many times.

Item 22

☐ I have plenty of friends.

☐ I have some friends but I wish I had more.

☐ I do not have any friends.

Item 23

☐ My schoolwork is alright.

☐ My schoolwork is not as good as before.

☐ I do very badly in subjects I used to be good in

Item 24

☐ I can never be as good as other kids.

☐ I can be as good as other kids if I want to.

☐ I am just as good as other kids.

Item 25

☐ Nobody really loves me.

☐ I am not sure if anybody loves me.

☐ I am sure that somebody loves me.

Item 26

☐ I usually do what I am told.

☐ I do not do what I am told most times.

☐ I never do what I am told.

Item 27

☐ I get along with people.

☐ I get into fights many times.

☐ I get into fights all the time.

MHS

Remember to fill out the other side

Youthlink - Participant Feedback Sheet

Participant RW1

Self-Perception Profile for Adolescents (SPPA)

The SPPA measures the perceived level of importance on specific domains of competency, in association with one's own performance. Thus, discrepancy scores indicate areas of concern affecting self-esteem, where the perceived level of importance exceeds the perceived level of competence. Scores range from 1-4 (average=2.5).

The profile on the above participant indicates that she is perceiving herself as being inadeqate in three major areas and to a lesser degree in three other areas. The largest discrepancy scores were found in the 'job competence', 'scholastic competence' and 'close friendship' domains. Minor disrepancies occurred in the 'athletic competence', 'physical appearance' and 'behavioural conduct' domains. Her global self-worth is very low at 1.2.

Social Support Scale for Children (SSSC)

The SSSC measures the degree to which a person's own self worth is acknowledged by significant others. The scale measures perceived positive regard and social support as reflected through other people. Scores range from 1-4 (average=2.5).

This person scored highest for friend support, which was above average. However, parent, classmate and teacher support scores were all below average.

Children's Depression Inventory (CDI)

The CDI is a measure of depression in children aged between seven and 17 years. It provides a profile, presenting five different sub-scales to indicate specific areas in which depression can be identified in a child or adolescent. Standard T-scores are provided, having a mean of 50 and a standard deviation of 10. The guidelines for T-scores are as follows:

T-Score	Guideline
Above 70	Very much above average
66-70	Much above average
61-65	Above average
56-60	Slightly above average
45-55	Average
40-44	Slightly below average
35-39	Below average
30-34	Much below average
Below 30	Very much below average

The CDI profile indicates that this person scored a total of 43 in her total CDI (depression) placing her in the very much above average domain. Other sub-scales in the very much above average domain were 'interpersonal problems', 'ineffectiveness', 'anhedonia' and 'negative self-esteem'. 'Negative mood' scored in the above average domain.

(I)

self-perception profile (YL JP1)
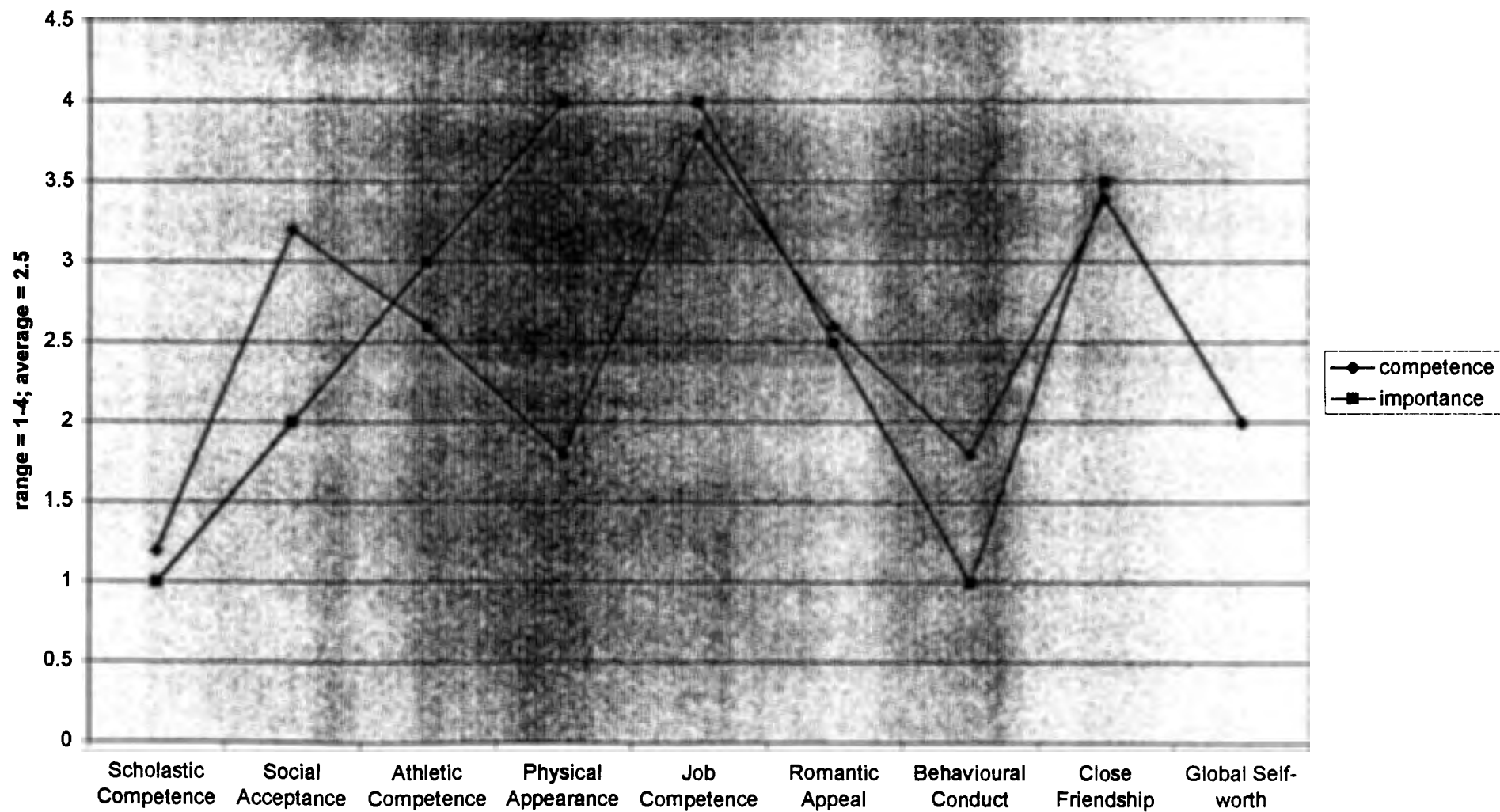
social support scale (YL JP1)

APPENDIX I
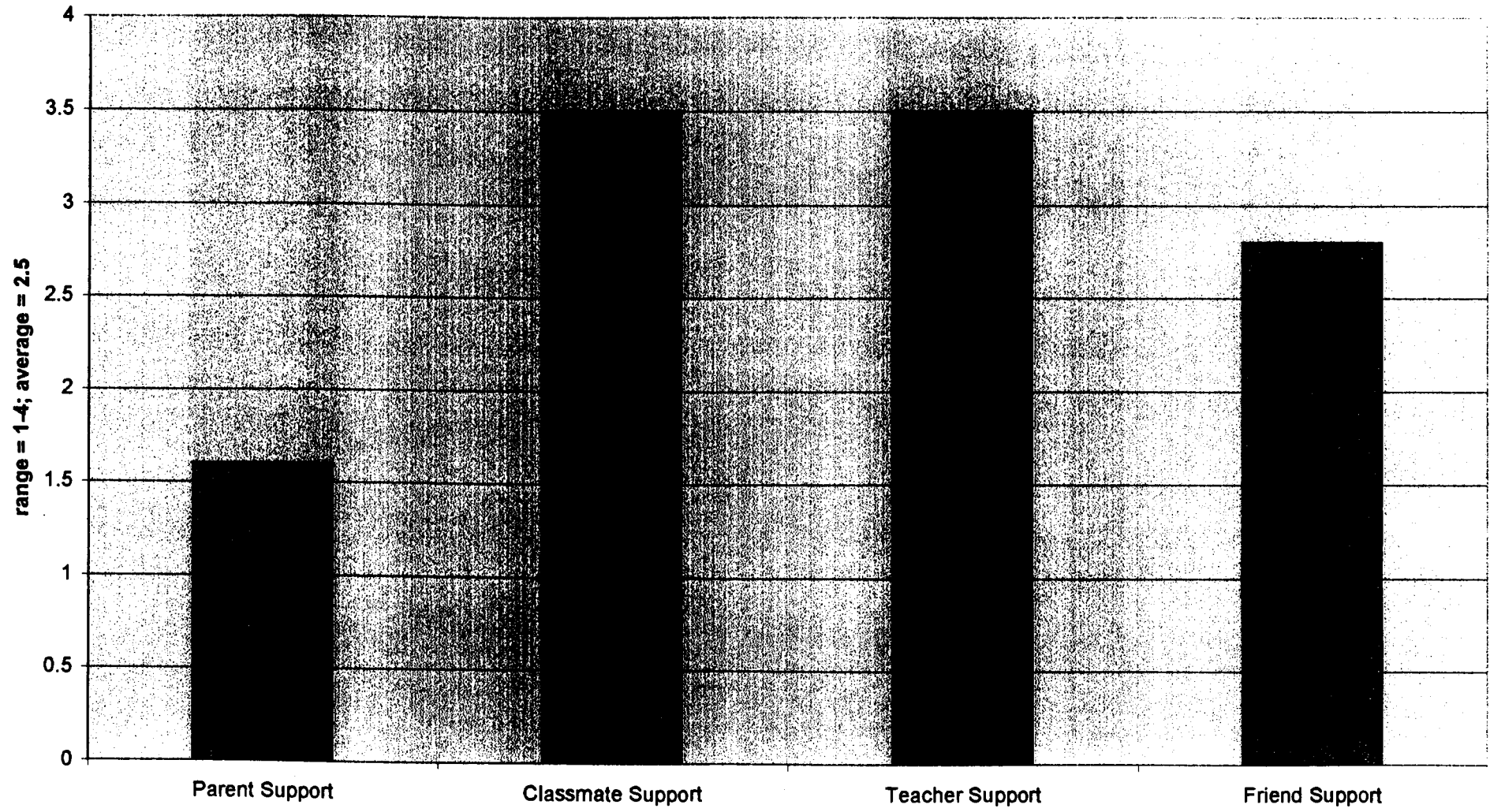
Kovacs' Children's Depression Inventory (CDI) Profile Form

Child's Name: _____   Child's Age: _____   Date: _____

T	Total CDI Score				Negative Mood				Interpersonal Problems				Ineffectiveness				Anhedonia				Negative Self Esteem				T
	Boys 7-12	Girls 7-12	Boys 13-17	Girls 13-17	Boys 7-12	Girls 7-12	Boys 13-17	Girls 13-17	Boys 7-12	Girls 7-12	Boys 13-17	Girls 13-17	Boys 7-12	Girls 7-12	Boys 13-17	Girls 13-17	Boys 7-12	Girls 7-12	Boys 13-17	Girls 13-17	Boys 7-12	Girls 7-12	Boys 13-17	Girls 13-17	
100	48+		53+	41+	12			12		5+		6+							16					10	100
99	47	44	52			12			8																99
98	46	43	51														16								98
97			50	39				11																	97
96	45	42			11													15		16					96
95	44	41	49	38												8							10	9	95
94	43	40	48			11	12				8	5					15				10				94
93			47	37															15						93
92	42	39	46	36				10	7									14							92
91	41	38	45		10																		9		91
90	40			35													14						9		90
89		37	44	34		10	11			4										14				8	89
88	39	36	43								7					7		13			9				88
87	38	35	42	33											8				14						87
86	37		41	32				9									13							9	86
85		34	40		9		10		6											13					85
84	36	33		31		9						4						12				8			84
83	35		39								6						12		13		8			7	83
82		32	38	30																12					82
81	34	31	37	29				8							7	6							8		81
80	33		36		8		9						8		8				12						80
79	32	30	35	28		8											11					7			79
78				27					5	3										11	7				78
77	31		34															10							77
76	30		33	26			8				5								11				7	6	76
75	29	27	32		7							7	7	6			10								75
74		26	31	25		7						3			7	5				10					74
73	28		30	24														9				6			73
72	27	25																			6				72
71	26	24	29	23			7	6	4								9			9					71
70		23	28	22	6								6	5										5	70
69			27			6					4				6			8							69
68	24	22	26	21																				5	68
67	23	21									2						8			8	5				67
66			25	20			6									4			8						66
65	22	20	24	19																			5		65
64	21	19	23		5	5		5	3			2	5	4	5		7	7						4	64
63	20	18	22	18			5				3									7					63
62			21	17															7		4	4			62
61	19	17																6							61
60	18	16	20	16															6	6			4		60
59			19		4	4							4		4	3									59
58	17	15	18	15														5				3		3	58
57	16	14	17	14				4	2												3				57
56	15	13	16							1	2						5			5	3				56
55				13															5				3		55
54	14	12	15	12	3	3		3				1	3					4							54
53	13	11	14				3								3										53
52	12		13	11										2		2	4			4				2	52
51		10	12																4		2	2			51
50	11	9	11	10		2						1						3					2		50
49	10	8		9	2				1				2		2				3	3					49
48	9		10				2	2																	48
47		7	9	8										1											47
46	8	6	8	7														2			1	1	1		46
45	7		7			1				0						1	2		2	2				1	45
44	6	5	6	6	1		1		0			0	1												44
43		4						1			0				1										43
42	5	3	5	5	0				0									1							42
41	4		4	4										0			1		1	1					41
40		2	3			0															0	0	0		40
39	3	1	2	3			0						0											0	39
38	2			2	0										0	0									38
37	1	0	1					0									0	0		0					37
36			0																						36
35	0																								35
34				0																					34