

**Depressive Symptomatology and Personal
Growth Initiative:
Transcultural Comparative Study between
Portuguese and Spanish Students**

VERSÃO FINAL APÓS DEFESA

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Resumo

Este trabalho integra-se no projeto “VIOLÊNCIA 360º - Abordagem clínica, familiar, social e comunitária da violência interpessoal em diferentes populações” e tem como objetivo analisar e comparar os níveis de sintomatologia depressiva e de iniciativa de crescimento pessoal entre estudantes portugueses e espanhóis.

A transição da escola para a universidade constitui, para a maior parte dos jovens, o alcance da sua independência, contudo também pode ser encarada como uma fase crítica de adaptação às novas exigências impostas pelo meio universitário. Assim, o ajustamento à experiência universitária constitui uma altura propícia tanto a eventos negativos e a consequências nefastas na saúde mental dos estudantes, como a eventos positivos e a oportunidades de crescimento e desenvolvimento de competências transversais a todo o ciclo de vida.

A amostra é constituída por 485 participantes, dos quais cerca de metade são estudantes portugueses, da Universidade da Beira Interior (50.5%) e 49.5% são estudantes espanhóis, da Universidade de Salamanca. A amostra possui 71.5% de participantes do sexo feminino e 28.5% de participantes do sexo masculino, sendo maioritariamente constituída por participantes de 18 e 19 anos de idade. As medidas utilizadas foram o *Center for Epidemiologic Studies Depression Scale* (CES-D) e a Escala de Iniciativa de Crescimento Pessoal (EICP-II), juntamente com um questionário sociodemográfico.

Não se encontraram diferenças estatisticamente significativas entre nacionalidades no que concerne sintomas depressivos e iniciativa de crescimento pessoal. A idade apresenta um efeito isolado nos sintomas depressivos. A nacionalidade e o género apresentam um efeito de interação nas duas variáveis. Foi verificada uma correlação negativa entre sintomas depressivos e iniciativa de crescimento pessoal.

Palavras-chave

Sintomas Depressivos; Iniciativa de Crescimento Pessoal; CES-D; EICP-II; Estudantes Universitários; Portugal; Espanha.

Resumo Alargado

A presente dissertação centra-se na temática da sintomatologia depressiva e iniciativa de crescimento pessoal (ICP) em estudantes universitários portugueses e espanhóis. O principal objetivo desta pesquisa passa por comparar os níveis destas variáveis entre as duas nacionalidades, com o propósito de desenvolver um estudo transcultural comparativo.

Assim, a presente pesquisa inicia-se com um pequeno enquadramento referente à transição da escola para a universidade, abordando aspetos como a saída da casa dos pais e o alcance de uma maior independência, bem como as exigências que caracterizam este período (Costa & Moreira, 2016).

Posteriormente, é introduzida a temática da sintomatologia depressiva, começando por transmitir a informação existente acerca da prevalência de depressão em Portugal e Espanha. Em seguida, define-se brevemente aquilo que constitui sintomatologia depressiva. São ainda referidos diversos fatores associados a elevados níveis de sintomatologia depressiva, bem como as suas consequências, além de serem descritos os sintomas típicos das condições depressivas.

Procede-se a uma descrição daquilo que constitui a ICP, destacando-se a sua dimensão intencional. É ainda referido o modo como a promoção da ICP pode constituir um ponto de intervenção em universidades (Robitschek & Keyes, 2009). Seguidamente, mostra-se que a ICP pode constituir um fator de proteção face à sintomatologia depressiva (Shigemoto et al., 2017), além de serem mencionados diversos efeitos positivos decorrentes de níveis mais elevados de ICP.

Para terminar, são referidas algumas questões culturais relativas aos países inseridos neste estudo e a forma como são encaradas as populações de ambos.

Os objetivos definidos para esta pesquisa são: 1) comparar níveis de sintomas depressivos entre as duas nacionalidades, primeiro de um modo geral, e posteriormente com base na idade e no género; 2) comparar níveis de ICP entre nacionalidades, de um modo geral e tendo por base a idade e o género; 3) verificar se existe uma correlação entre sintomas depressivos e ICP, bem como entre iniciativa de crescimento pessoal e os fatores do CES-D, e entre os sintomas depressivos e as dimensões da EICP-II.

A amostra deste estudo é composta por 485 participantes, dos quais cerca de metade são estudantes portugueses (50.5%), com 49.5% de estudantes espanhóis. A amostra possui ainda 71.5% de participantes do sexo feminino e 28.5% de participantes do sexo masculino, sendo maioritariamente constituída por participantes de 18 e 19 anos. As medidas utilizadas foram o *Center for Epidemiologic Studies Depression Scale* (CES-D) e a Escala de Iniciativa de Crescimento Pessoal (EICP-II), juntamente com um questionário sociodemográfico.

O programa utilizado para análise estatística foi o *Statistical Package for the Social Sciences* (SPSS), versão 26, no qual se efetuaram análises de estatísticas descritivas e inferenciais.

As análises realizadas permitiram chegar a algumas conclusões. Assim, os resultados mais relevantes foram os seguintes:

- Não existem diferenças estatisticamente significativas no que diz respeito aos níveis de sintomatologia depressiva e de ICP;
- A idade parece apresentar um efeito isolado na sintomatologia depressiva;
- A nacionalidade e o género apresentam um efeito de interação em ambas as variáveis;
- Existe uma correlação negativa entre os sintomas depressivos e a ICP;
- Existe uma correlação negativa entre a ICP e os fatores “Afeto Negativo” e “Somático/Vegetativo” do CES-D, no entanto está presente uma correlação positiva com o fator “Afeto Positivo”;
- Existe uma correlação negativa entre os sintomas depressivos e todas as dimensões da EICP-II, não sendo estatisticamente significativa para a dimensão “Utilização de Recursos”.

Considerando estes resultados, concluiu-se que a ausência de significância estatística no que respeita aos níveis das variáveis principais entre nacionalidades poderá dever-se à relativa proximidade geográfica entre estas universidades e ao facto de ambos os países se inserirem na cultura ocidental, semelhante em diversos aspetos.

Verifica-se que este estudo é pioneiro na comparação de níveis das variáveis em estudo entre estudantes universitários de Portugal e Espanha, bem como na análise da associação entre sintomas depressivos e as dimensões da EICP-II, e da correlação entre ICP e fatores do CES-D, podendo ser de relevância no desenvolvimento de programas de saúde mental em universidades.

As limitações verificadas no estudo dizem respeito ao facto de ter por base medidas de autorrelato, bem como à amostra, constituída na sua maioria por participantes mais jovens, além de exibir uma diferença significativa de participantes espanhóis do sexo masculino, sendo o menor grupo da amostra. Outra limitação diz respeito à literatura existente acerca da ICP e a forma como esta se relaciona com a sintomatologia depressiva, bem como à ausência de estudos que comparem as variáveis em questão entre estudantes portugueses e espanhóis.

Abstract

This research is part of project “VIOLENCE 360° - Clinical, familiar, social and community approaches to interpersonal violence in different populations”, aiming to analyze and compare levels of depressive symptomatology and personal growth initiative in young college students from Portugal and Spain.

Transition from school to university constitutes, for most young people, the obtainment of independence, however it can also be seen as a critical phase of adaptation to new demands imposed by the university environment. Thus, adjustment to university experience constitutes a time period that is conducive both to negative events and harmful consequences on students’ mental health, as well as to positive events and opportunities for growth and development of skills that are transversal to all of the life cycle.

The sample is composed of 485 participants, about half of which are portuguese students, from University of Beira Interior (50.5%) and 49.5% are spanish students, from University of Salamanca. The sample has 71.5% female participants and 28.5% male participants, adding that most participants are 18 and 19 years old. The scales used were Center for Epidemiologic Studies Depression Scale (CES-D) and Personal Growth Initiative Scale (PGIS-II), along with a sociodemographic questionnaire.

There are no statistically significant differences between nationalities concerning depressive symptoms and personal growth initiative. Age has an isolated effect on depressive symptoms. Age and gender present interaction effects on both variables. A negative correlation between depressive symptoms and personal growth initiative was found.

Keywords

Depressive Symptoms; Personal Growth Initiative; CES-D; PGIS-II; University Students; Portugal; Spain.

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Lista de Acrónimos

DGS	Direção Geral da Saúde
WHO	World Health Organization
PGI	Personal Growth Initiative
PGIS-II	Personal Growth Initiative Scale – II
CES-D	Center for Epidemiologic Studies – Depression
ICP	Iniciativa de Crescimento Pessoal
EICP-II	Escala de Iniciativa de Crescimento Pessoal – II

Chapter 1

1.1. Introduction

The transition from school to university constitutes, for most young people, the achievement of their independence, however it can also be viewed as a critical phase of adaptation to a new environment and new demands (Costa & Moreira, 2016). With entering university, several social interactions and demands occur, which require various academic and interpersonal abilities from students (Bolsoni-Silva & Guerra, 2014). Indeed, adjustment to the university experience comprises a complex set of processes that aren't just centered on academic demands. Thus, there is a necessity of adjustment to different social circumstances, along with the attempt of integration in the university environment. As such, the development of maturity on an emotional level, necessary aptitudes for independent thought, development of self-esteem and self-confidence, and the way of dealing with change can affect general adaptation of the student to university (Horgan et al., 2016).

There is evidence that many mental problems emerge during adolescence and young adulthood (Vanheudsden et al., 2008), considering that three quarters of life-long mental problems begin before age of 24 (Kessler et al., 2005). Additionally, some studies have been verifying a significant increase in the number of university students who experience problems associated with mental health (e.g., Turner et al., 2007; Storrie et al., 2010). Effectively, upon entering university, the students' mental health condition may suffer changes, because academic demands, difficulties in the learning development and obtainment of abilities constitute occurrences of success or failure. These, along with study rhythm, teachers' requirements, peer pressure, intense workload, modifications on feeding schedules and the sleep-wake cycle, and competitiveness can affect students' health conditions (Rodas et al., 2010). These demands can intensify already existing mental health problems or increase the possibility of them occurring (Bolsoni-Silva & Guerra, 2014).

1.1.1. Depressive Symptomatology

In Portugal, according to the report of the National Epidemiological Study of Mental Health (Almeida & Xavier, 2013), the prevalence for major depressive disorder has a value of 16.7%. In respect to the annual prevalence of this clinical condition, it has a total of 6.8%, with a prevalence of 2.7% for mild disorders, 3.2% for moderate disorders and 2.6% for severe disorders. According to the National Program for Mental Health, elaborated by the Direção Geral da Saúde (DGS), the data points to 9.32% of health service users with a record of depressive disorders in 2016 (Carvalho, 2017).

In respect to Spain, the data from National Research of Mental Health (2017) points to 6.68% of prevalence of depression in the last twelve months.

Depressive symptomatology constitutes a set of psychological traits and physiological modifications usually present in depressive conditions, assisting in their diagnostic and classification. However, presence of depressive symptomatology does not necessarily indicate presence of a depressive disorder. For example, there are some depressive symptoms that coincide with symptoms of sadness, such as the loss of enthusiasm and the feelings of impotence or helplessness. Nevertheless, sadness constitutes a normal emotional response in the face of day-to-day challenges. Therefore, it is expected that, after a relatively short phase of structuring and adjustment to the situation experienced, the individual goes back to their activities and regains enthusiasm for life and confidence. In this case, there is no need for psychotherapeutic interventions (Teodoro, 2010).

Although the presence of depressive symptoms does not necessarily lead to the presence of depression, some authors defend the perspective of a depressive spectrum beginning with few depressive symptoms, going through short durations and culminating on true depressive episodes. Different studies contribute to show that depressive conditions which do not meet the criteria for depression still present an impact on health, compared to the individuals who are not in depressed states (Ayuso-Mateos et al., 2010). Fergusson et al. (2005) suggest an association between presence of depressive conditions in young people with an increased risk of developing mental problems in the future, such as suicidal behavior and depressive disorders.

Indeed, other studies associated high levels of depressive symptoms in university students with transitory phase of life, that can be associated to social and academic pressures inherent to the university context (Steptoe et al., 2007). Several studies on depression in students have identified numerous associated factors such as: gender, namely being a woman (Asante & Andoh-Arthur, 2015; Brondani et al., 2019; Ibrahim et al., 2013; Othieno et al., 2014), age (Ibrahim et al., 2013), namely being older, low socioeconomic status, higher literary qualifications (Ibrahim et al., 2013; Othieno et al., 2014), low or scarce social support (Lamis et al., 2016; Horgan et al., 2016; Asante & Andoh-Arthur, 2015; Peltzer et al., 2013; Panzarella et al., 2006), alcohol and tobacco consumption and religion (Asante & Andoh-Arthur, 2015; Othieno et al., 2014; Pérez, 2010; Quintero et al., 2004), being that in the case of the latter its presence is a protective factor (Asante & Andoh-Arthur, 2015). Additionally, poor academic performance also seems to constitute a risk factor (Othieno et al., 2014; Peltzer et al., 2013), as well as academic difficulties (Quintero et al., 2004), evaluation tests, school retentions (Medina et al., 2003) and attendance in the 1st year of the course (Othieno et al., 2014). There are also a few familiar factors, such as the separation from the family of origin (Medina et al., 2003) or a poor family history (Salmela-Aro et al., 2008), as well as social and relational factors, such as affective losses, adaptation difficulties (Medina et al., 2003), relational difficulties (Pérez, 2010) or lack of social skills. This last one can cause difficulties in problem solving and in the way of facing university challenges (Brondani et al., 2019).

Medina and colleagues (2003) observed that the difficulty in fulfilling the student's expectations towards university and career, the lack of economic support to respond to demands as a student, and assuming new and complex academic and personal responsibilities seem to constitute risk factors. Other elements associated to depressive symptomatology in students are the presence of mild to severe sleep disorders (Peltzer et al., 2013; Carneiro & Baptista, 2012) or stress in general (Carneiro & Baptista, 2012). It should be added that academic stress appears as one of the main factors linked to depression, which can be a precipitating factor to its development, as well as an element that maintains the disorder (Rodas et al., 2010). In general, university demands (in studying, in contacting with authorities, unknown people and distancing from family members, friends and significant others) can strengthen aversive social interactions or the contact with stressors (Brondani et al., 2019).

There are factors even more intrinsic to the university experience that can interfere in the university students' mental health. For example, the fact that certain universities are characterized by a spirit of competitiveness, demand, technification and poor communication, coupled with the perspective of low employability, can soon be felt in classes in the form of disappointment, fear, frustration, passivity, immaturity, among others. The risk of unemployment they face even after finishing the course can contribute to the development of depressive symptoms (Pérez, 2010).

With regard to this stage of life, it indeed appears that the presence of several stressors throughout a university course can influence the physical and mental health of students (Carlotto, 2013). It should be added that, according to Costa and Moreira (2016), about 60% of cases of depressive episodes in students are preceded by the occurrence of stressors, especially of a psychosocial nature. Gress-Smith et al. (2015) cite the study of Furr and colleagues (2001), in which they found that 53% of young adults experience some degree of depressive symptoms during university. With the advancement of technologies and global transformations at economic, financial and psychosocial levels, it is possible that, over the years, this percentage has increased.

The presence of depressive symptoms can have cognitive, social and emotional effects on the student's life (Carlotto, 2013). This can influence school effectiveness, productivity at work and interpersonal relationships, whether with family, friends or the community (World Health Organization [WHO], 2020). University students with depressive symptoms exhibit a greater deficit of social skills, extended to all social interactions and regardless of requiring more or less assertiveness (Bolsoni-Silva & Guerra, 2014). As a consequence, they get little reinforcements in social interactions, which can contribute to maintain their clinical condition (Costa & Moreira, 2016). In addition to a lack of energy, depressive symptoms also lead to a lack of motivation, resulting in less involvement in academic activities (Song et al., 2008). Thus, learning difficulties, poor academic performance, attentional difficulties and greater consumption of

medication, especially antidepressants, can interfere with the student's quality of life (Carlotto, 2013).

1.1.2. Personal Growth Initiative

In view of the challenges that university poses to students, this phase can be defined as a time that is conducive both to negative events and harmful consequences on students' mental health, as well as to positive events and opportunities for growth and development of skills that are transversal to all of the life cycle (i.e., soft skills).

Thus, when faced with significant decision making during this phase of life, regarding their professional future, current friendships, affective relationships, religious participation, connection to the family and health choices, students are faced with several possibilities for personal growth (Stevic & Ward, 2008; Yalcin & Malkoc, 2013). Usually, university represents a time in which the individuals develop a sense of identity – of who they are, what they want to be and the roles they will play throughout their lives. Thus, many deal with stress and academic challenges by forming new bonds, planning the future and associating themselves with different activities. However, other students are less able to actively promote their personal growth (Stevic & Ward, 2008). Nonetheless, personal growth initiative (PGI) has a significant function in the transition from university to the labor market, as students must systematically strive for development in preparation for the next stage (Stevic & Ward, 2008; Yalcin & Malkoc, 2013).

Personal growth is one of the dimensions of psychological well-being, being accompanied by other dimensions such as self-acceptance, meaning of life, autonomy, positive relationships and environmental mastery (Ryff & Singer, 2008). It illustrates the processes of realizing the maximum possible potential and of self-education at mental, behavioral, social and emotional levels (Yalcin & Malkoc, 2013). Thus, personal growth initiative is related to the subject's involvement in his own process of self-improvement, in an active and intentional way (Robitschek, 1998). As such, it concerns change as a process intentionally developed by the subject (Freitas et al., 2016), constituting an orientation directed to change and growth in various areas of life (Sharma & Rani, 2014). Additionally, it has been seen as a promising construct with regard to the subject's human development and personal fulfillment (Beri & Jain, 2016), requiring a minimum of autonomous motivation for growth and the ability to act independently (Robitschek, 2003; Robitschek et al., 2009).

It is important to highlight its intentional dimension, given that personal growth, as a construct, does not occur by chance, but on purpose. As such, intentional involvement constitutes a fundamental element for the concept of PGI, since recognizing the occurrence of changes over time is not the same as being actively dedicated to changing the self (Robitschek et al., 2012; Robitschek et al., 2009).

Personal growth constitutes a necessary element for the management of stressors and challenges that we face throughout life. When growth occurs in a non-intentional way, individuals do not know how to sustain the change that has occurred, especially when they face stressors (Robitschek et al, 2012). In this sense, PGI encompasses a set of skills that favor the occurrence of changes that promote the positive development of individuals (Weigold & Robitschek, 2011, cit in Freitas et al., 2016), constituting itself as a group of developed skills that include behavior, attitude, motivation and cognition, which are carried by the individual in any life experience (Robitschek et al., 2009).

Robitschek and Keyes (2009) state that the promotion of PGI can constitute a parsimonious intervention that aims at the multidimensional emphasis on the mental health of university students. These types of interventions aimed at prevention can play a protective role against the onset of mental disorders, as well as increase the quality of life of individuals who already experience them by improving their mental health.

1.1.3. PGI and mental health, depression and depressive symptoms

PGI can be thought as a protective factor in the face of impaired or negative functioning, distress (Robitschek et al., 2012) and depression (Shigemoto et al., 2017), since the lack of skills related to PGI is associated with negative repercussions on the lives of individuals (Freitas et al., 2016).

Thus, with regard to depression, facing adverse situations as opportunities for personal growth contradicts the dysfunctional cognitions typical of this clinical condition. For this reason, it is expected that, through the cognitive process in question, PGI will inhibit the development of depression and other psychological difficulties (Robitschek et al., 2012). Personal characteristics, such as the perception of adverse situations as challenges to grow and the search for experiences that promote personal growth, present relational patterns with PGI that lead us to consider PGI skills as a personal resource (Freitas et al., 2016). In addition, individuals with higher levels of PGI may have a greater tendency to detect when change becomes necessary, since they are able to more readily recognize what that change is and the steps required for it to occur, as well as involve themselves in the steps planned for it (Thoen & Robitschek, 2013).

In respect to the relationship between PGI and depressive symptoms, high levels of PGI are associated with lower levels of depression (Shigemoto et al., 2017). Robitschek and colleagues (2019) studied the levels of these variables in patients with depressive disorders in partial hospitalization and verified that individuals who initiated treatment with better developed PGI skills had lower levels of depressive symptoms at admission. A plausible explanation is that there is a greater awareness of the need for help with personal changes that mitigate the symptoms, as well as the use of resources (e.g., partial hospitalization) at an early stage of the evolution of the disorder.

In the same study, it was found that patients who showed a reliable and clinically significant improvement in PGI skills during treatment also exhibited the greatest decrease in the levels of depressive symptoms, after considering the admission levels. When PGI abilities are poorly developed, they can partially reflect the inability to change one's life or self, resulting in depressive hopelessness. Likewise, abilities associated with intentional behavior that are poorly developed may partially manifest themselves in the typical depressive symptom that is the decrease in engaging in pleasurable activities (Robitschek et al., 2019). In addition, it is proposed that individuals with high levels of PGI may experience low levels of depressive symptoms by involving themselves in a more constructive type of rumination, abstaining from rumination that is not productive (Shigemoto et al., 2017).

Thus, the literature refers to several operations through which PGI skills are favorable in the course of the disorder. First, individuals with strengthened PGI skills who experience depressive symptoms are more likely to seek treatment before symptoms worsen (Robitschek et al., 2019). Additionally, PGI can constitute a protective dimension in the face of severe depressive symptomatology and may lead the individual to perceive traumatic events or stressors as opportunities for growth, instead of threats (Spering et al., 2011, cit in Robitschek et al., 2019). Third, individuals with better developed PGI skills may exhibit greater ability to use psychological treatments, viewing them as a chance for personal growth, as well as a greater capacity to take advantage of this opportunity and greater intrinsic motivation to do so (Thoen & Robitschek, 2013). Finally, these abilities can have an indirect influence on depressive symptoms by improving social functioning, serving as a protective factor (Robitschek & Anderson, 2011).

In a study with university students, those who showed a more intentional involvement in self-improvement (i.e., higher levels of PGI) exhibited greater self-acceptance, had better relationships with others, perceived greater mastery and control over the environment, saw more purpose in life and had a greater sense of autonomy and self-direction regarding their lives and daily choices. Additionally, they presented a greater understanding of the social world surrounding them, a greater sense of connection and a sense of contribution to the community, a perspective of society oriented towards the future, and a more beneficial view of the people around them, in general. Higher levels of PGI are also associated with greater satisfaction with life, more positive feelings and a greater feeling of happiness. Finally, this study concluded that the individuals who seek personal growth more actively exhibited better mental health (Robitschek & Keyes, 2009). There is also evidence that individuals with high levels of PGI may exhibit a better coping ability in view of the developmental tasks of life (Robitschek et al., 2009).

1.1.4. Overview and goals of the study

Since this study has a population of portuguese and spanish university students, it's mainly aimed at comparing the levels of depressive symptoms and personal growth initiative between two nationalities, so that we can infer if there are any relevant differences between cultures. It is

important to note that, although this sample is comprised of students from two different countries, these universities have a very close proximity to each other geographically speaking. Even so, by being a part of two different countries, they of course present differences when it comes to their students and their way of functioning. In addition, in spite of Portugal and Spain bordering each other, these two countries undoubtedly reflect differences in their culture.

In this sense, Gouveia et al. (2003) refer to the Spanish's *simpatía*, which reflects the great meaning they give to the affective bonds between people. Furthermore, they are characterized by Triandis et al. (1984, cit in Gouveia et al., 2003) as warm, pleasant and friendly people who like to entertain, as well as being respectful to others and trying to develop harmonious interpersonal relationships. Finally, the Spanish also seem to typically show a social pattern focused on sharing within the community and promoting a sense of belonging, by manifesting altruistic and generous behaviors, giving presents and regarding relationships as eternal (Fiske, 1992, cit in Gouveia et al., 2003).

On the other hand, the Portuguese are described by Cunha and Cunha (2010) as tenacious and pragmatic people, characterized by their adaptability.

As such, the general and specific goals that are intended to be achieved in this research are:

1. To compare depressive symptoms levels between portuguese and spanish university students.
 1. To compare depressive symptoms levels between portuguese and spanish university students based on age.
 2. To compare depressive symptoms levels between portuguese and spanish university students based on gender.
2. To compare personal growth initiative levels between portuguese and spanish university students.
 1. To compare levels of personal growth initiative between portuguese and spanish university students based on age.
 2. To compare levels of personal growth initiative between portuguese and spanish university students based on gender.
3. To verify a correlation between depressive symptoms and personal growth initiative.
 1. To verify a correlation between personal growth initiative (PGIS-II) and the factors "Depressed Affect", "Positive Affect" and "Somatic/Vegetative" from CES-D scale.
 2. Verify a correlation between depressive symptoms (CES-D) and the dimensions from PGIS-II.

Chapter 2

2.1. Method

2.1.1. Participants

The population in this study consists of college students from the University of Beira Interior in Covilhã, Portugal and from the University of Salamanca in Spain. Many participants were excluded from the sample of this study based on the following criteria: 1) they were under 18 years old or over 25 years old; 2) they were from nationalities other than Portuguese or Spanish; and 3) they were Portuguese participants enrolled in the Spanish university or vice-versa, as this could elicit cultural difficulties in the sense that we aren't aware of their current situation (i.e., born in Portugal but living in Spain since childhood, studying there for a year only, or other types of circumstances).

That said, the final sample is composed of 485 participants, of which 138 (28.5%) are male students and 347 (71.5%) are female students. Concerning the participants' ages, 53.8% are 18 years old, 25.2% are 19, 10.1% are 20, 6% are 21, 2.3% are 22, 0.8% are 23, 1.6% are 24 and, finally, 0.2% are 25 years old. Additionally, the mean age in this sample is 18.88, with a standard deviation of 1.300.

About 50.5% (N = 245) of the participants are Portuguese and 49.5% (N = 240) are Spanish. With regards to the academic year, 455 (93.8%) are on their first year of college, 27 (5.6%) are on the second year and 2 (0.4%) are on the third year, with one participant (0.2%) who didn't respond.

Table 1

Sociodemographic Characteristics of the Sample (N = 485)

		N (%)
Gender	Male	138 (28.5%)
	Female	347 (71.5%)
Age	18 years old	261 (53.8%)
	19 years old	122 (25.2%)
	20 years old	49 (10.1%)
	21 years old	20 (6%)
	22 years old	11 (2.3%)
	23 years old	4 (0.8%)
	24 years old	8 (1.6%)
	25 years old	1 (0.2%)

Nationality	Portuguese	245 (50.5%)
	Spanish	240 (49.5%)
Academic year	1st year	455 (93.8%)
	2nd year	27 (5.6%)
	3rd year	2 (0.4%)

2.1.2. Measures

In order to gather data for this study, three instruments were used. These instruments are described as follows.

Center for Epidemiologic Studies Depression Scale (CES-D)

The portuguese version of this scale was developed by Gonçalves and Fagulha (2004). The purpose of this scale is to evaluate the occurrence of depressive symptoms in the general population (Gonçalves & Fagulha, 2004).

The CES-D is a questionnaire consisting of 20 items that reflect the main aspects of depressive symptoms (Radloff, 1977, cit in Gonçalves & Fagulha, 2004). The answers are shown on a scale of four points, which correspond to the frequency of a certain symptom during the last week, as evaluated by the respondent. The total score ranges between 0 and 60, with higher scores pointing to a larger quantity of symptoms, with 20 being the cut-off point (Gonçalves & Fagulha, 2004).

The scale is composed of four factors: depressive affect, positive affect, somatic and retarded activity, and interpersonal (Gonçalves & Fagulha, 2004).

In regard to the scale's internal consistency, Radloff (1977, cit in Gonçalves & Fagulha, 2004) found in his study a Cronbach's alpha of .85. On the portuguese adaptation of CES-D the authors found consistency values of .92, .89 and .87 in samples A, B and C, respectively (Gonçalves & Fagulha, 2004).

We calculated the internal consistency using Cronbach's alpha, with a value of .763 for the global scale, which reflects a good internal consistency according to Pereira and Patrício (2016). Furthermore, we calculated Cronbach's alpha for each factor, with an internal consistency of .875 for Depressed Affect, .689 for Positive Affect, .707 for Somatic/Vegetative and .492 for Interpersonal.

Personal Growth Initiative Scale-II (PGIS-II)

The PGIS-II was developed following its original and first version with the purpose of being a multidimensional scale, involving cognitive and behavioral components (Robitschek et al., 2009).

This scale contains 16 items, using a Likert response scale that ranges from 0 (Disagree Strongly) to 5 (Agree Strongly). The PGIS-II comprises four dimensions: Intentional Behavior, which reflects an intentional attitudinal process; Using Resources, which is related to obtaining help from resources exterior to one's self, concerning the process of personal growth; Planfulness, which relates to "planning the process of personal growth" (p. 278); and Readiness for Change, which addresses the individual's preparedness to execute certain changes in themselves (Robitschek et al., 2012).

In this regard, Planfulness and Readiness for Change are part of the cognitive component of the scale, whilst Intentional Behavior and Using Resources belong to the behavioral factor (Robitschek et al., 2012).

We used Cronbach's alpha to calculate the internal consistency, with a value of .917 for the global scale, .826 for Intentional Behavior, .871 for Planfulness, .803 for Readiness for Change and .741 for Using Resources.

Sociodemographic Questionnaire

A questionnaire was built in order to measure sociodemographic variables. This questionnaire includes aspects such as: age, gender, nationality, university course, year of university, place of residence, parents' educational level and professions, who the subject lives with usually and during the academic year, whether the individual has children and how many, parents' marital situation and for how long, questions pertaining to current and/or past intimate relationships, sexual orientation and, finally, if they have any type of psychological and/or psychiatric support.

2.1.3. Procedure

This research is conducted by a group of teachers/researchers from the Department of Psychology and Education of the University of Beira Interior, aiming to analyze the levels of depressive symptomatology and personal growth initiative in young college students.

The questionnaires were handed out to students from the University of Beira Interior and the University of Salamanca, thus the population from the study was sampled by convenience.

The statistical analysis was made on the software Statistical Package for the Social Sciences (SPSS), version 26. Firstly, we analyzed the descriptive statistics of the sample, namely the mean, standard deviation, minimum value and maximum value of a few of the sociodemographic variables, specifically gender, age, nationality and academic year. Afterwards, we calculated the internal consistency of both scales and their factors/dimensions using Cronbach's alpha.

Given that we have a sample of 485 participants, therefore a population of $N > 30$, we assumed the normality of the data distribution according to the central limit theorem. On that premise, we used parametric tests to analyze the differences between variables. We began by using a T-

Test for Independent Samples to analyze the differences between nationalities regarding depressive symptoms and personal growth initiative, followed by the calculation of Pearson's correlation coefficient to verify the association between depressive symptoms and personal growth initiative. We then used a One-Way ANOVA Test to analyze the differences between nationalities and age, and between nationalities and gender, regarding depressive symptomatology and personal growth initiative. Finally, we calculated Pearson's correlation coefficient to verify the associations between depressive symptoms and all the dimensions of the PGIS-II, and between personal growth initiative and all the factors of the CES-D scale, excluding "Interpersonal" given its low consistency value. It is important to note that, to study the variable regarding age, we created two categories – 18 years old and 19 or older – in order to create more homogeneous groups.

Chapter 3

3.1. Results

3.1.1. Descriptive Statistics

Regarding the CES-D scale (Table 2), the minimum value is 5 and the maximum 50, with a mean value of 20.03 and a standard deviation of 7.31 ($M = 20.03$, $SD = 7.31$). The factor “Depressed Affect” has a minimum of 0 and a maximum of 21, with $M = 5.17$ and $SD = 4.53$, the factor “Positive Affect” has a minimum of 0 and a maximum of 12, with a mean value of 7.24 and a standard deviation of 2.62 ($M = 7.24$, $SD = 2.62$). In its turn, the factor “Somatic/Vegetative” has a mean level of 6.60 and a standard deviation of 3.60 ($M = 6.60$, $SD = 3.60$), with a minimum of 0 and a maximum of 19 and, finally, the factor “Interpersonal” has a minimum of 0 and a maximum of 6, with a mean value of 1.05 and a standard deviation of 1.26 ($M = 1.05$, $SD = 1.26$).

Table 2

Descriptive Statistics of the CES-D Scale and its Factors

	<i>N</i>	Minimum	Maximum	<i>M</i>	<i>SD</i>
Depressed Affect	483	0	21	5.17	4.53
Positive Affect	485	0	12	7.24	2.62
Somatic/Vegetative	484	0	19	6.60	3.60
Interpersonal	484	0	6	1.05	1.26
Total Score	481	5	50	20.03	7.31

In respect to the PGIS-II scale (Table 3), the minimum value is 13 and maximum 80, with a mean level of 53.26 and a standard deviation of 12.35 ($M = 53.26$, $SD = 12.35$). The dimension “Readiness for Change” has a minimum of 2 and a maximum of 20, with a mean value of 13.67 and a standard deviation of 3.47 ($M = 13.67$, $SD = 3.47$), the dimension “Planfulness” has a mean level of 16.67 and a standard deviation of 4.54 ($M = 16.67$, $SD = 4.54$), with a minimum of 0 and a maximum of 25. The dimension “Using Resources” has a minimum of 0 and a maximum of 15, with $M = 8.48$ and $SD = 3.32$, and the dimension “Intentional Behavior” has a minimum of 1 and a maximum of 20, with $M = 14.23$ and $SD = 3.61$. Furthermore, its median value is 54, which will be used as a cut-off point.

Table 3

Descriptive Statistics of the PGIS-II Scale and its Dimensions

	<i>N</i>	Minimum	Maximum	<i>M</i>	<i>SD</i>	Median
Readiness for Change	483	2	20	13.67	3.47	
Planfulness	485	0	25	16.67	4.54	
Using Resources	483	0	15	8.48	3.32	
Intentional Behavior	483	1	20	14.23	3.61	
Total Score	479	13	80	53.26	12.35	54

3.1.2. Inferential Statistics

3.1.2.1. Depressive Symptoms

General Goal 1: *To compare depressive symptoms levels between portuguese and spanish university students.*

The obtained results show that the portuguese participants present a higher mean level of depressive symptoms ($M = 20.51$, $SD = 7.77$). According to Levene's test for equality of variances, there are no equal variances assumed ($p = .043$). So, there are no statistically significant differences regarding the portuguese participants and the spanish participants when accounting for depressive symptomatology, $t(471) = 1.448$, $p > .05$ (Table 4).

Table 4

T-Test for Independent Samples to Analyze the Differences Between Portuguese and Spanish Participants Regarding Depressive Symptoms

	Portuguese	Spanish	
	(<i>N</i> = 241)	(<i>N</i> = 240)	
	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	<i>t</i> (471)
Depressive symptoms (CES-D total score)	20.51 (7.77)	19.55 (6.80)	1.448

Specific Goal 1.1: *To compare depressive symptoms levels between portuguese and spanish university students based on age.*

Regarding the interaction effects between both variables (i.e., age and nationality), considered altogether, we can conclude that there are no statistically significant differences on the effect of age for both portuguese and spanish students in respect to depressive symptoms, as $F(3, 1) = .473$, $p = .492$ (Table 5).

As to the main effects of the two independent variables on depressive symptoms, the results allow us to verify that such effects are statistically significant for age. This is seen by $F(3, 1) =$

6.542, $p = .011$, and it means that age has an effect on the levels of depressive symptoms when thought of as an isolated variable. In regard to nationality, its effects aren't statistically significant. This is verified by $F(3, 1) = 3.767$, $p = .053$ (Table 5).

Table 5

One-Way ANOVA Test to Analyze the Differences on Depressive Symptoms According to Age and Nationality

	$F(3, 1)$	p
Age	6.542	.011
Nationality	3.767	.053
Age*Nationality	.473	.492

By analyzing the mean values between the groups, we can infer that portuguese students who are 18 years old are the participants who present a higher level of depressive symptoms ($M = 21.78$, $SD = 8.14$), followed by 18 year old spanish students ($M = 19.98$, $SD = 7.04$). Closely behind are the portuguese students who are 19 or older ($M = 19.56$, $SD = 7.37$), and lastly the spanish students who are 19 or older are the ones with the lowest mean levels of depressive symptoms ($M = 18.70$, $SD = 6.25$), as seen in Table 6.

Table 6

Descriptive Statistics of the Variables Age and Nationality Regarding Depressive Symptoms (One-Way ANOVA Test)

	Age	N	M	SD
Nationality	Portuguese	18	103	21.78
		≥ 19	138	19.56
	Spanish	18	158	19.98
		≥ 19	82	18.70

Specific Goal 1.2: *To compare depressive symptoms levels between portuguese and spanish university students based on gender.*

In regard to the interaction effects between both variables (i.e., nationality and gender), we can verify that such effects are statistically significant, $F(3, 1) = 5.871$, $p = .016$ (Table 7). This means that belonging to one of the nationalities and one of the genders specifically has an effect on the levels of depressive symptoms. We will specify these groups on the following analysis of the

mean values. Additionally, given this result, analyzing the main effects of the variables becomes unnecessary, however, the results will also be shown in Table 7.

Table 7

One-Way ANOVA Test to Analyze the Differences on Depressive Symptoms According to Nationality and Gender

	<i>F</i> (3, 1)	<i>p</i>
Nationality	8.926	.003
Gender	8.117	.005
Nationality*Gender	5.871	.016

Concerning the mean values of all the groups, we determine that the portuguese female students show higher levels of depressive symptoms ($M = 20.65$, $SD = 7.67$), followed by the portuguese male students ($M = 20.31$, $SD = 7.95$). Thirdly, we have spanish female students ($M = 20.20$, $SD = 6.91$), and lastly spanish male students with the lowest levels of depressive symptoms ($M = 15.97$, $SD = 4.83$), as seen in Table 8.

Table 8

Descriptive Statistics of the Variables Nationality and Gender Regarding Depressive Symptoms (One-Way ANOVA Test)

	Gender	<i>N</i>	<i>M</i>	<i>SD</i>	
Nationality	Portuguese	Female	142	20.65	7.67
		Male	99	20.31	7.95
	Spanish	Female	203	20.20	6.91
		Male	37	15.97	4.83

3.1.2.2. Personal Growth Initiative

General Goal 2: *To compare personal growth initiative levels between portuguese and spanish university students.*

The results show a slightly higher mean level of personal growth initiative on portuguese participants ($M = 54.36$, $SD = 12.65$). With an assumed equality of variances ($p = .558$), there are no statistically significant differences regarding the levels of personal growth initiative when comparing the two nationalities, $t(477) = 1.952$, $p > .05$ (Table 9).

Table 9

T-Test for Independent Samples to Analyze the Differences Between Portuguese and Spanish Participants Regarding Personal Growth Initiative

	Portuguese	Spanish	
	(<i>N</i> = 239)	(<i>N</i> = 240)	
	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	<i>t</i> (477)
Personal growth initiative (PGIS-II total score)	54.36 (12.65)	52.16 (11.97)	1.952

Specific Goal 2.1: *To compare levels of personal growth initiative between portuguese and spanish university students based on age.*

Concerning the effects of both variables (i.e., nationality and age) when interacting with each other, we can verify that there are no statistically significant differences on the effect of age for both portuguese and spanish students regarding personal growth initiative levels, $F(3, 1) = 2.265, p = .133$ (Table 10).

In respect to the main effects of both variables on personal growth initiative levels, when isolated, we verify that there are no statistically significant effects on personal growth initiative. Regarding nationality, we can see this by $F(3, 1) = 2.580, p = .109$. In respect to age, this is shown by $F(3, 1) = .487, p = .486$ (Table 10).

Table 10

One-Way ANOVA Test to Analyze the Differences on Personal Growth Initiative According to Nationality and Age

	<i>F</i> (3, 1)	<i>p</i>
Nationality	2.580	.109
Age	.487	.486
Nationality*Age	2.265	.133

Additionally, we conclude that portuguese students who are 18 years old are the ones who present higher levels of personal growth initiative ($M = 54.91, SD = 13.86$), followed by older portuguese students ($M = 53.97, SD = 11.74$) and older spanish students ($M = 53.85, SD = 10.50$). Lastly, lowest levels are present on the spanish students who are 18 years old ($M = 51.29, SD = 12.61$), as seen in Table 11.

Table 11

Descriptive Statistics of the Variables Nationality and Age Regarding Personal Growth Initiative (One-Way ANOVA Test)

		Age	N	M	SD
Nationality	Portuguese	18	100	54.91	13.86
		≥ 19	139	53.97	11.74
	Spanish	18	158	51.29	12.61
		≥ 19	82	53.85	10.50

Specific Goal 2.2: *To compare levels of personal growth initiative between portuguese and spanish university students based on gender.*

Interaction effects of both variables (i.e., nationality and gender) on personal growth initiative levels show statistical significance, $F(3, 1) = 4.538, p = .034$ (Table 12). Considering this, there is no point in analyzing the results on both variables isolatingly, however the respective values are shown on Table 12.

Table 12

One-Way ANOVA Test to Analyze the Differences on Personal Growth Initiative According to Nationality and Gender

	$F(3, 1)$	p
Nationality	.201	.654
Gender	.928	.336
Nationality*Gender	4.538	.034

Regarding the mean values of personal growth initiative, we conclude that spanish male students present the highest levels ($M = 55.72, SD = 9.70$), closely followed by portuguese female students ($M = 55.02, SD = 12.13$) and portuguese male students ($M = 53.44, SD = 13.34$). Lastly, spanish female students present lowest levels ($M = 51.51, SD = 12.25$), as seen on Table 13.

Table 13

Descriptive Statistics of the Variables Nationality and Gender Regarding Personal Growth Initiative (One-Way ANOVA Test)

	Gender	<i>N</i>	<i>M</i>	<i>SD</i>	
Nationality	Portuguese	Female	139	55.02	12.13
		Male	100	53.44	13.34
	Spanish	Female	203	51.51	12.25
		Male	37	55.72	9.70

3.1.2.3. Association between depressive symptoms and PGI

General Goal 3: *To verify a correlation between depressive symptoms and personal growth initiative.*

According to Pearson's correlation coefficient, we can verify that there is a negative association between depressive symptoms and personal growth initiative. Furthermore, this association is statistically significant, as shown by $r(473) = -.140, p = .002$ (Table 14).

Table 14

Pearson's Correlation Coefficient to Verify the Association Between Depressive Symptomatology and Personal Growth Initiative (N = 475)

	CES-D (total score)	
PGIS-II (total score)	<i>r</i>	<i>p</i>
	-.140	.002

Specific Goal 3.1: *To verify a correlation between personal growth initiative (PGIS-II) and the factors "Depressed Affect", "Positive Affect" and "Somatic/Vegetative" from CES-D scale.*

Results allow to determine that there is a negative association between personal growth initiative and the factors "Depressed Affect" and "Somatic/Vegetative", which are also statistically significant, $r(477) = -.222, p < .01$ when it comes to "Depressed Affect" and $r(477) = -.226, p < .01$ regarding "Somatic/Vegetative" (Table 15).

Additionally, there is a positive association between personal growth initiative and the factor "Positive Affect". This association is statistically significant, $r(477) = .377, p < .01$ (Table 15).

Table 15

Association Between Personal Growth Initiative and the Factors "Depressed Affect", "Positive Affect" and "Somatic/Vegetative" (N = 479)

	PGIS-II (total score)
--	-----------------------

CES-D (factors)	<i>r</i>	<i>p</i>
Depressed Affect	-.222	.000*
Positive Affect	.377	.000*
Somatic/Vegetative	-.226	.000*

* $p < .001$

Specific Goal 3.2: *Verify a correlation between depressive symptoms (CES-D) and the dimensions from PGIS-II.*

The results in the calculation of Pearson’s correlation coefficient show us that negative associations are present between depressive symptoms and all of the dimensions from PGIS-II. All of the correlations are statistically significant, excluding the association between depressive symptoms and the dimension “Using Resources”, which is not statistically significant. This is seen by $r(479) = -.097, p = .034$ regarding “Readiness for Change”, $r(479) = -.152, p = .001$ in relation to “Planfulness”, $r(479) = -.028, p = .548$ in respect to “Using Resources” and $r(479) = -.154, p = .001$ concerning “Intentional Behavior” (Table 16).

Table 16

Association Between Depressive Symptomatology and the PGIS-II Dimensions (N = 481)

PGIS-II (dimensions)	CES-D (total score)	
	<i>r</i>	<i>p</i>
Readiness for Change	-.097	.034*
Planfulness	-.152	.001**
Using Resources	-.028	.548*
Intentional Behavior	-.154	.001**

* $p < .005$

** $p < .001$

In view of these results, a multiple linear regression was calculated, in order to analyze if PGIS-II dimensions significantly predict depressive symptoms in general. Through this analysis, it is possible to determine that the PGIS-II dimensions only predict 3.6% of depressive symptoms (CES-D) ($R^2 = .036, F(4, 470) = 4.363, p = .002$), however this value is only statistically significant in respect to the dimensions “Planfulness” ($\beta = -.145, t(480), p = .048$) and “Intentional Behavior” ($\beta = -.134, t(480), p = .042$) (Table 17).

Table 17

Multiple Linear Regression to Determine the Degree of Prediction of the PGIS-II Dimensions in Relation to CES-D

Variable	Model			
	<i>B</i>	<i>SE B</i>	β	<i>p</i>
Depressive symptoms (CES-D)				
Readiness for Change	.106	.146	.050	.465
Planfulness	-.235	.119	-.145	.048
Using Resources	.188	.120	.085	.116
Intentional Behavior	-.274	.134	-.134	.042
R ²	.036			
<i>F</i>	4.363			

Chapter 4

4.1. Discussion

4.1.1. Depressive Symptoms

General Goal 1: *To compare depressive symptoms levels between portuguese and spanish university students.*

Through the analysis of the differences between portuguese and spanish students concerning depressive symptoms levels, we verify that there are no differences between both nationalities. Indeed, this confirms our hypothesis that there are no expected significant differences regarding the levels of depressive symptoms when compared between portuguese and spanish students. Although portuguese students show a mean value slightly above the cut-off point (i.e., 20), it isn't a very significant value.

There isn't research focusing on depressive symptoms between these two specific nationalities. What we can infer from the mean values is that portuguese students present slightly higher levels of depressive symptoms compared to spanish students. One possible explanation for these results could be the cultural differences between countries, as Spanish people are generally regarded as warm and friendly people (Triandis et al., 1984, cit in Gouveia et al., 2003), contrary to Portuguese, who are viewed as tenacious and pragmatic (Cunha & Cunha, 2010). These results are also according to the available data relating to prevalence of depression, where Portugal's percentages are slightly higher compared to Spain's.

Specific Goal 1.1: *To compare depressive symptoms levels between portuguese and spanish university students based on age.*

By analyzing the differences on depressive symptoms according to age and nationality, we determine that these variables do not have an interaction effect on depressive symptoms levels. In the same way, nationality does not have any effect on depressive symptomatology. However, age has an isolated effect on the levels of depressive symptoms.

Moreover, the mean values show that portuguese students who are 18 years old are the group with the highest levels of depressive symptoms, with a result slightly higher than the cut-off point. This confirms our hypothesis "The younger portuguese students present higher levels of depressive symptoms". The rest of the groups present mean values below the cut-off point, although 18-year-old spanish students and portuguese students who are 19 or older are very close to that value.

Most studies found no statistically significant differences regarding age (Campo-Cabal & Segura, 2001; Matud et al., 2003; Santos et al., 2012; Asante & Andoh-Arthur, 2015; Gress-Smith et al., 2015). In its way, Chen et al. (2013) found that older students are more vulnerable to depression. These researches don't corroborate our findings that age has an effect on depressive symptoms levels, nor that it affects a younger group in our sample. However, if we consider the year of attendance in university, these results are according to those of Brandtner and Bardagi (2009) and Bayram and Bilgel (2008), as well as Othieno et al. (2014), who found that students beginning the course present more indicators of depression. Contrary to this, Santos et al. (2012) observed that 3rd year students manifest higher levels of depression, followed by 1st years, while Horgan et al. (2016) verified a higher possibility of presenting depressive symptoms in 2nd year students, although the authors consider this might be because of the sample's areas of education (i.e., nursery and midwifery). Nevertheless, Chen et al. (2013) and Medina et al. (2003) found no significant correlation between depressive symptoms and year of attendance.

Specific Goal 1.2: *To compare depressive symptoms levels between portuguese and spanish university students based on gender.*

The results allow to conclude that nationality and gender interact with each other, having an effect on depressive symptoms levels. Specifically, by analyzing the mean values, it is possible to verify that portuguese female students are the group with the highest levels of depressive symptoms, thus confirming our hypothesis that the female portuguese students present higher levels of depressive symptoms. This hypothesis is derived from the cultural differences between countries given that, as previously mentioned, Spanish people are generally described as warmer and friendlier people (Triandis et al., 1984, cit in Gouveia et al., 2003).

This is according to the study of Steptoe et al. (2007), where the authors found that women presented significantly higher levels of depressive symptoms compared to men. Pérez (2010) and Quintero et al. (2004) also found higher levels of depressive symptoms in the female gender. In another study, it was verified that women showed higher percentages of mild and severe depressive symptoms than men, which also corroborates our study when it comes to mild levels of symptomatology (Santos et al., 2012). In sum, various studies found significantly higher levels of depressive symptoms in women (Medina et al., 2003; Mikolajczyk et al., 2008; Sokratous et al., 2014; Gress-Smith et al., 2015; Kamimura et al., 2016).

However, some studies found no statistically significant differences between genders (Campo-Cabal & Segura, 2001; Bayram & Bilgel, 2008; Al-Busaidi et al., 2011; Chen et al., 2013; Vergara et al., 2013; Othieno et al., 2014; Shigemoto et al., 2017). The differences concerning gender could be explained by considering multiple psychosocial factors and how they interact with the psychobiological structure, resulting in a higher vulnerability from the female gender towards depression (Yonkers & Steiner, 2001, cit in Cohen et al., 2019; Justo & Calil, 2006; Quintero et al., 2004; Rodas et al., 2010). In this sense, Justo and Calil (2006) note the changes that have occurred in the past few decades in respect to women's roles in society and family, and more

specifically how those changes led to the intensification and increase of women's responsibilities. This, along with biological factors such as the endocrinous structure (Justo & Calil, 2006), premenstrual syndrome, stress, thyroid conditions, hormonal changes, among others (Quintero et al., 2004) could explain the differences between levels. Another explanation could pertain to a different manifestation of depression by the male gender (Medina et al., 2003). In addition, it can also be considered that men present a greater tendency to hide the symptoms and not seek help (Cohen et al., 2019). Finally, Matud et al. (2003) also explain it recurring to the social, economic and legal discrimination that women are victims of, which could lead to low self-esteem, low aspirations, feelings of indefensiveness and dependency on others.

It's important to note that spanish male students are the group with the lowest N compared to the other groups, but it also presents the lowest mean value, making it the only group who is significantly below the cut-off point (i.e., 20). Nevertheless, the lower N indicates that the results should be considered with caution.

In general, though, the three other groups present mean values that are slightly above the cut-off point, which indicates that they are considered a clinical population, but the results aren't significantly higher than that same point (i.e., 20).

4.1.2. Personal Growth Initiative

General Goal 2: *To compare personal growth initiative levels between portuguese and spanish university students.*

When comparing the differences on personal growth initiative levels between portuguese and spanish students, we conclude that there are no differences between nationalities. Once again, this confirms our hypothesis that there are no expected significant differences regarding the levels of personal growth initiative when compared between portuguese and spanish students. Similarly to the previous analysis, even though portuguese students show a mean value slightly above the median (i.e., 54), this value isn't very significant.

By analyzing the mean values, we determine that portuguese students present slightly higher levels of personal growth initiative, however, there isn't literature on these two nationalities in specific to corroborate or contest our findings.

Specific Goal 2.1: *To compare levels of personal growth initiative between portuguese and spanish university students based on age.*

The results show that there are no statistically significant effects of the variables on the levels of personal growth initiative – specifically, there are no interaction effects and no main effects for both nationality and age.

By analyzing the mean values, portuguese students who are 18 years old present the highest levels of personal growth initiative, while also being the only group who is above the median (i.e., 54). This goes against our hypothesis, which stated that the older spanish students present higher levels of personal growth initiative. These results are contradictory with the results of younger portuguese students presenting the highest levels of depressive symptoms, based on our findings of a negative correlation between personal growth initiative and depressive symptoms, presented down below. One possible explanation could be linked to the scales used in this study in the sense that, while CES-D pertains to the last week, PGIS-II considers a general period of time. This reflects a significant difference in the periods of time, thus the results on CES-D represent only one week of the subject's life and may not reflect a presence of depressive symptoms in general. Another possible explanation could be linked to the self-perception of some of the participants, who may view themselves as more active on some aspects of personal growth, in spite of the presence of depressive symptoms.

Thoen and Robitschek (2013) found no significant correlations between personal growth initiative and age, which corroborates our findings. However, other studies go against our findings when it comes to the mean values. Specifically, Borowa et al. (2018) found that both PGI and the ability to use resources could increase with age. Similarly, Straaten et al. (2016) found that the older students presented a stronger intent on changing, being more actively engaged in the processes of change and definition of goals. More specifically, they also verified that younger students did not yet show readiness for change and growth. It is important to note that the majority of our sample's participants are younger students, which leads to difficulties when trying to compare these levels with those of older participants.

Specific Goal 2.2: *To compare levels of personal growth initiative between portuguese and spanish university students based on gender.*

The results allow to conclude that nationality and gender interact with each other, having an effect on personal growth initiative levels. According to the mean values, spanish male students are the ones with the highest levels, which would confirm our hypothesis that the male spanish students present higher levels of personal growth initiative. However, as previously mentioned, this group has a lower *N* compared to the other three, so these results should be considered with caution.

Concerning gender, there are no studies corroborating our findings. Specifically, Straaten et al. (2016) found higher values of PGI in females compared to males. On the other hand, some studies found no significant differences between genders (Thoen & Robitschek, 2013; Beri & Jain, 2016; Borowa et al., 2018). Robitschek (2001, cit in Robitschek, 2003) found similar levels between men and women.

In general, portuguese female students and spanish male students are the only groups who are above the median value, although portuguese male students are very close to that value, making spanish female students the only group who is significantly below the median.

4.1.3. Association between depressive symptoms and PGI

General Goal 3: *To verify a correlation between depressive symptoms and personal growth initiative.*

In respect to the association between depressive symptoms and personal growth initiative, there is a negative correlation which is statistically significant between both variables, which confirms our hypothesis that stated the presence of a negative correlation between depressive symptoms and personal growth initiative.

This is corroborated by the literature, where studies also found a significant negative correlation between both variables (Shigemoto et al., 2017; Danitz et al., 2018). This means that the higher the levels of depressive symptoms, the lower the levels of personal growth initiative, which would make sense if we consider that PGI is thought of as a protective factor against depression (Shigemoto et al., 2017). These results were expected, given that the intentionality that is behind PGI as a construct does not typically correspond to common depressive symptoms, such as lack of motivation, low energy, low self-esteem, hopelessness, among others.

Specific Goal 3.1: *To verify a correlation between personal growth initiative (PGIS-II) and the factors “Depressed Affect”, “Positive Affect” and “Somatic/Vegetative” from CES-D scale.*

The factors “Depressed Affect” and “Somatic/Vegetative” show a negative and statistically significant association with personal growth initiative. The factor “Positive Affect” has a positive and statistically significant association with personal growth initiative. This confirms our hypotheses that “Depressed Affect” and “Somatic/Vegetative” would have a negative association with personal growth initiative, and that “Positive Affect” would present a positive correlation with PGIS-II. It is important to note that there are no studies verifying the correlation between PGIS-II and the factors from CES-D.

These results show the higher the levels of PGI, the lower the levels of “Depressed Affect” and “Somatic/Vegetative”, which would make sense if we consider the fact that PGI is considered a protective factor against depression, with higher levels of PGI being associated with lower levels of depressive symptoms (Shigemoto et al., 2017). In addition, PGI seems to decrease the risk of psychological distress (Ayub & Iqbal, 2012). One possible explanation could be that the cognitive, emotional and physical symptoms of depression would not typically be associated with a more active participation in one’s change. This is because depressive symptoms in themselves diminish the individual’s willingness to make change happen even in a smaller way. This would be according to the perspective defended by Robitschek et al. (2019), in which poorly

developed PGI abilities may partially manifest themselves in the decrease in engaging pleasurable activities, which is a typical symptom of depression.

The fact that “Positive Affect” has a positive association with PGI was also expected, since this is the only factor in CES-D that contradicts the symptoms which are typical from depressive conditions. By reflecting more positive emotions, it was expected that it would be positively associated with PGI, meaning that the higher the levels of PGI, the higher the levels of positive affect. Literature also shows a positive association between PGI and positive affect as a general construct (Robitschek & Keyes, 2009; Yang & Chang, 2014; Hardin et al., 2007, cit in Freitas et al., 2016; Shigemoto et al., 2017;).

Specific Goal 3.2: *Verify a correlation between depressive symptoms (CES-D) and the dimensions from PGIS-II.*

All of the dimensions from PGIS-II have a negative association with depressive symptoms. However, the dimension “Using Resources” is the only one with no statistical significance. Our hypothesis was that every dimension from PGIS-II would have a negative correlation with depressive symptoms, which was confirmed. We did not confirm this hypothesis for the dimension “Using Resources” since there is no statistical significance. Additionally, there are no studies in the literature correlating depressive symptoms and the dimensions from PGIS-II.

These results were expected, since there is a negative correlation between depressive symptoms and PGI overall. It does make sense that an individual with some degree of depressive symptoms would present a lower engagement in the process of change, as was previously mentioned based on the hypothesis of Robitschek et al. (2019) in which poorly developed PGI abilities may, in part, be associated with the decrease in the engagement in pleasurable activities. Another possible explanation could be the fact that these skills, when poorly developed, can represent inability to change one’s life or self, leading to depressive hopelessness (Robitschek et al., 2019). Finally, it could also be hypothesized that individuals with depression may feel they are unable to involve themselves in the growth process in an active way (Weigold et al., 2020).

The fact that the dimension “Using Resources” wasn’t statistically significant could once again be linked to the participants’ self-perception, in the way that they might believe they do more about their condition than they actually do. It could also be related to the fact that our sample has a larger number of female students compared to male students, if we consider the hypothesis of Cohen et al. (2019), in which men present a greater tendency to hide the symptoms and not seek help, thus decreasing the levels associated with the use of resources.

Conclusions

This research allows to determine that portuguese students present slightly higher levels of depressive symptoms and personal growth initiative compared to spanish students. However, the differences between portuguese students and spanish students are not statistically significant, which could be due to the fact that, although these are two different countries, they are both part of Western culture, which is similar in various aspects. It could also be explained by the very close proximity between both universities (i.e., about 200km).

It was possible to verify that nationality and gender play a combined role both in the levels of depressive symptoms and personal growth initiative. However, these results should be considered with caution, since spanish male students are the group with littlest participants in our sample. Further research could confirm this interaction effect and analyze the way in which they interact with each other to influence the levels of these variables.

Another possible conclusion pertains to the fact that age seems to have an isolated effect on the levels of depressive symptoms, more specifically younger age. This could be related to the transitory phase of life they are in upon entering university. Future studies could focus on this transition, the changes and responsibilities that accompany it and how much impact it has in 1st year student's mental health.

This study is pioneer in comparing levels of depressive symptoms and personal growth initiative between university students from Portugal and Spain. It could help to better understand the role of these variables in students' quality of life and academic performance. Moreover, it presents an important contribution to literature which could help Psychosocial services in universities in respect to promoting prevention and intervention programs focused on the training of personal growth initiative skills and mitigation of depressive symptoms, as well as early intervention in depressive conditions, which could also benefit from training of PGI skills to decrease depressive symptoms. Finally, it is also pioneer in analyzing the association between depressive symptoms and PGIS-II dimensions, as well as personal growth initiative and CES-D factors, which again presents an important contribution to the development of mental health programs in universities.

However, this research presents some limitations. First, it is comprised of measures of self-report. Participants typically respond to self-report measures in socially desirable ways, rather than selecting the real response (Ayub & Iqbal, 2012). Another limitation pertains to the sample, which is largely composed of younger participants. This poses a challenge when comparing variables regarding age. As mentioned previously, spanish male participants are the littlest group in our sample, which also creates difficulties in comparing and analyzing results pertaining to gender, as we were not able to create homogeneous groups. Given the fact that

cultures also vary between regions (Cunha & Cunha, 2010), it could be interesting that further research would focus on a larger sample, extended to more universities from Portugal and Spain. Finally, another limitation pertains to existing literature, more specifically on personal growth initiative and how it relates to depressive symptoms. There is a scarce number of studies focusing on these aspects, and no studies analyzing the relationship between these variables based on the scales' factors and dimensions. Furthermore, there is no literature comparing the levels of depressive symptoms and/or personal growth initiative between portuguese students and spanish students.

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Apêndices

Apêndice 1

Conforme Vizzotto et al. (2017), a trajetória para cada nova etapa de vida reflete-se sempre em experiências de grande importância para o desenvolvimento a nível psicológico, biológico, cultural e social de qualquer pessoa. Assim, não seria diferente no que diz respeito aos estudantes universitários, que se constituem como um grupo particular de pessoas que experienciam uma fase crítica de transição na qual passam de adolescentes a adultos e onde fazem escolhas de vida importantes (Chen et al., 2013). Embora possam existir estudantes universitários mais velhos, as idades correspondentes ao maior número de estudantes universitários estão associadas, efetivamente, à adolescência e adultez emergente (Medina et al., 2003), situando-se habitualmente entre os 18 e os 25 anos. Deste modo, é importante considerar as dimensões evolutivas inerentes a essas fases de vida e que podem constituir-se como aspetos de vulnerabilidade (Medina et al., 2003), já que constitui um período de desenvolvimento com particularidades próprias a um nível demográfico e subjetivo, bem como no que diz respeito à exploração da identidade (Arnett, 2000, cit in Matud et al., 2003). Como tal, a experiência universitária pode configurar, para muitos jovens, a saída de casa, o distanciamento da família e a inserção em atividades distintas das que caracterizam o ensino secundário. Isto traduz-se, inevitavelmente, em modificações no estilo de vida, no modo de viver e no sistema académico anteriormente praticados (Vizzotto et al., 2017).

Posto isto, a universidade acarreta diversos desafios, como a forma distinta de estudar, o lidar com os professores (e.g., autoridade), falar em público, criar amizades, morar com outras pessoas e a respetiva divisão de tarefas, cuidar de si próprio e dos seus bens, pagar renda e mesmo trabalhar para poder sustentar os seus estudos (Bolsoni-Silva & Guerra, 2014). A experiência universitária pode ainda ser influenciada pela cidade onde o estudante se encontra. Os contextos de natureza mais acolhedora podem possibilitar, mais rapidamente, a formação de novas amizades e um melhor relacionamento com professores; por outro lado, contextos de cariz mais cosmopolita podem não facilitar os laços afetivos mas, pela sua natureza mais competitiva, podem favorecer o desenvolvimento da autonomia (Soares et al., 2011).

1.1. Sintomatologia Depressiva

Uma vez que não constituem o mesmo e apresentam diferenças, consideramos importante começar por fazer uma distinção entre a sintomatologia depressiva e a depressão.

Sumariando as diferenças explicitadas no enquadramento teórico, os sintomas depressivos têm algumas semelhanças com sintomas de emoções normais como a tristeza. As diferenças residem no facto de que a depressão, em comparação com a tristeza, revela-se com uma intensidade mais forte, podendo ter uma duração de meses ou anos, e prejudica significativamente a vida do indivíduo a nível profissional, social, pessoal e familiar (Teodoro, 2010). Importa referir que a perturbação depressiva apresenta uma baixa prevalência até ao começo da adolescência, seguindo-se um aumento nos finais da meia idade, momento após o qual existe um decréscimo

(Kessler et al., 2007). Por estes motivos, alguns autores postulam se o surgimento de um episódio depressivo major não poderia ser prevenido ao reconhecer e tratar os sintomas iniciais, que não correspondem a qualquer diagnóstico (Fergusson et al., 2005).

Este estudo debruça-se na presença de sintomatologia depressiva, contudo, a literatura existente incide maioritariamente na depressão, motivo pelo qual se falará em depressão em vários momentos deste trabalho. Dito isto, apresentamos em seguida uma caracterização da perturbação depressiva.

A depressão é uma perturbação mental frequente, afetando mais de 264 milhões de pessoas no mundo inteiro. Esta perturbação caracteriza-se pela perda de interesse ou prazer e por uma tristeza permanente, podendo haver alterações de apetite e do sono, dificuldades de concentração e cansaço (WHO, 2020). Assim, além do desânimo e da diminuição de atividade, é habitual haver falta de motivação, diminuição da autoestima e autoconfiança, sentimentos de culpa e ideação suicida, assim como tentativas de suicídio (Pérez, 2010). Caracteriza-se ainda por um intenso pessimismo e crenças negativas relativamente a si próprio (Santos et al., 2012). Num estudo composto por uma amostra de estudantes universitários, com idades compreendidas entre os 16 e 35 anos, Quintero e colaboradores (2004) elaboraram uma caracterização da sintomatologia depressiva nos diversos graus de severidade com base na utilização do instrumento *Beck Depression Inventory*. Em seguida, apresentamos uma tabela síntese (Tabela 18) com os principais sintomas presentes (ou ausentes) no nível leve a moderado da depressão. Apenas fazemos referência ao nível leve a moderado uma vez que o objetivo deste estudo é avaliar sintomatologia depressiva com base no CES-D, que corresponde a níveis leves de sintomas depressivos.

Tabela 18

Caracterização dos Sintomas Depressivos a um Nível Leve a Moderado, nas suas Várias Dimensões (adaptado de Quintero et al., 2004)

Depressão Leve a Moderada	
Sintomas cognitivos	- Não se sentem castigados; - Não estão descontentes consigo próprios; - Autocrítica relativa às fraquezas ou erros; - Sem pensamentos suicidas; - Tomada de decisão sem alterações;

-
- Sem alterações significativas na autoestima;
 - Preocupação com problemas físicos (e.g., dores, indisposição);
 - Sem alterações na clareza do pensamento;
 - Na sua maioria, consideram agradável viver;
 - A crença de que seria melhor para os outros se o indivíduo morresse ocorre poucas vezes;
 - Por vezes, depositam confiança e esperança no futuro;
 - Apresentam facilidade na tomada de decisões;
 - Na sua maioria, consideram-se úteis e necessários para as pessoas.

Sintomas comportamentais

- Não desfrutam das coisas tanto como costumavam;
 - Alguns perderam o interesse pelos outros, outros não manifestam essa perda de interesse;
 - Não choram mais que o normal;
 - Maior esforço para iniciar algo do que o habitual;
 - Na sua maioria, desfrutam das mesmas coisas de antes;
 - Maioritariamente, não apresentam maior dificuldade para realizarem algo;
 - Em grande parte, beneficiam de ver, estar e conversar com homens ou mulheres;
 - Por vezes sentem-se menos tranquilos, mais agitados e não conseguem estar quietos.
-

Sintomas emocionais-afetivos	<ul style="list-style-type: none"> - A maioria apresenta mais irritabilidade que o habitual; - Sentem-se tristes; - Não manifestam particular desânimo face ao futuro; - Não existem sentimentos de fracasso; - Apresentam sentimentos de culpa em muitas circunstâncias; - Por vezes, sentem vontade de chorar e fazem-no; - Sentem-se deprimidos; - Sentem-se melhor de manhã do que no resto do dia.
Sintomas fisiológicos	<ul style="list-style-type: none"> - Na sua maioria, sem alterações significativas no sono; - Sentem mais cansaço do que antes; - Sem diminuição de apetite e perda de peso; - Sem alterações no interesse sexual; - Por vezes, sentem cansaço sem motivo para tal; - Poucos problemas relacionados com prisão de ventre; - Poucas alterações nos batimentos cardíacos (i.e., na sua maioria, não são acelerados).

Adicionalmente, importa referir um modo de classificação deste quadro clínico, elaborado em função da relação existente ou não existente entre a perturbação e outras doenças. Daqui decorrem as depressões secundárias, que estão associadas a outras doenças médicas ou psiquiátricas, sendo importante detetar a perturbação que provocou a sintomatologia ansiosa.

Por sua vez, temos as depressões primárias, sendo estas as que não se encontram associadas a qualquer tipo de alteração psiquiátrica ou médica, surgindo autonomamente assim que se geram os sintomas anteriormente referidos (Riveros et al., 2007).

A depressão pode afetar indivíduos de qualquer idade, interferindo com a sua vida a um nível social, laboral e familiar (Brandtner & Bardagi, 2009), sendo que as suas consequências podem prolongar-se e influenciar significativamente o funcionamento do indivíduo e a sua capacidade de viver uma vida satisfatória (WHO, 2020). Contudo, apenas uma pequena fração dos indivíduos recebem o diagnóstico de depressão, seja porque os pacientes não possuem conhecimento dos sintomas, seja porque os profissionais de saúde não estão capacitados para realizar o diagnóstico (Rodas et al., 2010).

A prevalência de depressão é maior em estudantes universitários comparativamente à presença da perturbação na população geral (Bolsoni-Silva & Loureiro, 2016; Brondani et al., 2019).

1.1.1. Fatores de Risco

Num estudo de Brandtner e Bardagi (2009), embora os investigadores não tivessem conseguido determinar se a sintomatologia depressiva é despoletada por fatores pessoais, familiares e académicos, os autores afirmam que estes exercem influência em todas as áreas de vida do estudante. Com efeito, a literatura aponta para a existência de uma associação entre a perturbação depressiva em estudantes universitários e diversos fatores, nomeadamente ao nível social, familiar e afetivo, além da violência, consumo de substâncias, entre outros (Rodas et al., 2010).

Na literatura, são ainda definidos outros fatores como o planeamento ou a intenção suicida (Quintero et al., 2004; Carneiro & Baptista, 2012), antecedentes familiares ou pessoais de depressão e experiências críticas de vida (Quintero et al., 2004), cuja exposição poderá conduzir a sentimentos de desesperança, que são também um fator de risco (Lamis et al., 2016). Outro elemento associado à sintomatologia depressiva em estudantes é a presença de sintomas de *stress* pós-traumático (Peltzer et al., 2013).

Por fim, outros fatores de risco também referidos consistem numa baixa autoestima e na incapacidade de lidar com acontecimentos de vida *stressantes* (Pérez, 2010), além da presença de sintomas psicossomáticos e desconfiança de si próprio (Carneiro & Baptista, 2012). Por outro lado, é possível que muitos estudantes tenham de trabalhar para suportarem os seus estudos, o que poderá constituir um risco (Brondani et al., 2019).

Outros aspetos específicos da experiência universitária dizem respeito à possível deslocação para outra cidade e à saída da casa dos pais (Pérez, 2010; Lovell et al., 2015), à escassez de relacionamentos interpessoais significativos, à comunicação pobre ou insuficiente com professores e às exigências do ensino superior (Pérez, 2010), sendo que esta fase se caracteriza sobretudo por um aumento da autonomia e independência, resultando em novas dificuldades,

escolhas e pressões. Contudo, muitos destes fatores não podem ser modificados, ou não são modificados tão facilmente (Lovell et al., 2015).

1.1.2. Consequências

Além das consequências anteriormente referidas no enquadramento teórico, a depressão pode afetar de forma negativa o percurso pessoal e académico do estudante universitário, uma vez que os efeitos psicofisiológicos que lhe estão subjacentes vão levar à falta de energia, dificuldades de concentração, problemas de comunicação e menor rendimento, além do absentismo e do abandono escolar (Pérez, 2010). Efetivamente, esta perturbação pode levar à dificuldade na resolução das tarefas de desenvolvimento, como terminar os estudos e criar ou manter laços de intimidade (Santos et al., 2012).

1.1.3. Fatores de Proteção

Apesar de poder ser um fator de risco, o suporte social também pode constituir-se como um fator de proteção, sendo que este tem especial destaque nos estudantes universitários dado que estes, frequentemente, vivem e trabalham juntos num meio comunitário (Lamis et al., 2016). Como tal, aquando a sua transição do ensino secundário para o ensino superior, as redes sociais sofrem modificações, sendo esperado que os alunos formem novos relacionamentos exteriores ao contexto de “vigilância” parental (Arnett, 2000, cit in Lamis et al., 2016). Assim, a capacidade de criar laços e desenvolver ligações saudáveis pode servir como amortecedor para sentimentos de solidão ou tristeza (Lamis et al., 2016), existindo evidências de que uma maior adaptação social se encontra associada a menor nível de sintomatologia depressiva (Horgan et al., 2016). Por outro lado, a ausência ou pobreza de redes sociais de suporte pode agravar os sentimentos depressivos, e até mesmo os sentimentos de desesperança ou pensamentos suicidas (Lamis et al., 2016; Vergara et al., 2013).

Outro fator de proteção relaciona-se com a capacidade de adaptação, uma vez que Horgan et al. (2016) constataram que uma alta pontuação nesta dimensão se associava com um menor nível de sintomatologia depressiva.

Adicionalmente, podemos referir a esperança como um fator que pode contribuir para o evitamento ou redução de sintomatologia depressiva, sendo composta por uma dimensão afetiva e uma dimensão cognitiva (Cohen et al., 2019). A esperança constitui-se como um atributo que torna o indivíduo ativo e competente, fazendo com que este encare o futuro positivamente e possua motivação para atingir os seus objetivos pessoais (Pacico & Bastianello, 2014, cit in Cohen et al., 2019). Assim, podemos pensá-la como um mecanismo protetivo face a acontecimentos negativos e sintomatologia depressiva (Visser et al., 2013).

A satisfação com a carreira também tem sido considerada como um fator protetivo face à depressão, pois o modo como o estudante vai alcançando, com êxito, as suas expectativas

personais e académicas face à sua carreira aumenta a sua autoestima, autoconceito e autoeficácia, favorecendo assim um estado de ânimo saudável (Medina et al., 2003).

1.2. Iniciativa de Crescimento Pessoal

Além do que já foi referido na introdução, importa notar que os aspetos que motivam o crescimento podem suportar-se na cultura do indivíduo e, portanto, divergir consoante a cultura (Robitschek, 2003; Robitschek et al., 2009).

No que diz respeito ao bem-estar psicológico, o crescimento pessoal intencional apresenta uma associação positiva e significativa com esta dimensão. Por outro lado, o crescimento pessoal consciente mas não intencional (i.e., capacidade de identificar eventos que levaram à mudança, porém esta não ocorreu por meio de crescimento intencional), ou o crescimento pessoal inconsciente (i.e., não há qualquer ideia de como a mudança ocorreu) apresentam uma associação significativa e negativa com o bem-estar psicológico (Robitschek, 1999, cit in Robitschek et al., 2012). Isto pode ocorrer porque os indivíduos com maiores pontuações de iniciativa de crescimento pessoal (ICP) têm uma maior consciência dos efeitos do planeamento intencional da sua mudança do que aqueles cujo crescimento tenha ocorrido de forma não intencional ou não planeada (Klockner & Hicks, 2008).

Adicionalmente, importa referir que, como qualquer conjunto de competências, o grau de ICP surge num contínuo que vai de baixo a elevado (Robitschek et al., 2009).

Quando falamos de ICP, torna-se inevitável referir um dos instrumentos que a avalia: a Escala de Iniciativa de Crescimento Pessoal-II (EICP-II). Esta é composta por quatro subescalas, desenvolvidas com base na ICP enquanto teoria e que refletem as dimensões cognitivas e comportamentais da ICP. Assim, as dimensões cognitivas são a Prontidão para a Mudança e o Planeamento. A primeira reflete a prontidão do indivíduo para executar mudanças concretas em si próprio, e a segunda diz respeito ao planeamento da evolução do crescimento pessoal. Por outro lado, as dimensões comportamentais são o Comportamento Intencional e a Utilização de Recursos. O Comportamento Intencional relaciona-se com a tomada de atitudes dirigidas à mudança, sendo de facto visto como um processo atitudinal, em oposição a um processo ativo. Por fim, a Utilização de Recursos concerne o uso de recursos externos como meio auxiliar no processo de crescimento pessoal. A Utilização de Recursos distingue-se das restantes subescalas ao tratar de mecanismos exteriores ao *self*, em oposição às operações maioritariamente internas medidas nas outras subescalas (Robitschek et al., 2012). No geral, pode afirmar-se que as dimensões cognitivas englobam saber como executar a mudança em diversos domínios de vida, enquanto as dimensões comportamentais envolvem o começo da mudança propriamente dito (Yalcin & Malkoc, 2013).

A literatura tem mostrado que indivíduos que apresentam competências associadas à ICP melhor desenvolvidas poderão persistir mais no processo de exploração do meio, bem como na

busca por oportunidades para o crescimento pessoal (Yakunina et al., 2013a, cit in Freitas et al., 2018).

No que diz respeito a diferenças relativamente ao género, se os homens apresentam pontuações significativamente menores na Utilização de Recursos comparativamente às mulheres, isso corroboraria pesquisa prévia de género na procura de ajuda (Addis & Mahalik, 2003, cit in Robitschek et al., 2012), constituindo, potencialmente, uma expressão do estereótipo masculino de que homens não devem solicitar ajuda. Contudo, também é plausível que homens tenham pontuações maiores no item da subescala que descreve concretamente “recursos” em vez de “ajuda”, possivelmente decorrente de ativação reduzida de auto-estigma ou medos de dependência ao ler ou ouvir a palavra “ajuda” (Addis & Mahalik, 2003, cit in Robitschek et al., 2012; Hammer & Vogel, 2010, cit in Robitschek et al., 2012).

A ICP é uma dimensão que pode ser trabalhada, sendo que Thoen e Robitschek (2013) desenvolveram um programa para o treino do crescimento pessoal intencional, verificando que determinados aspetos são cruciais para progredir nos níveis de ICP. Por exemplo, as autoras constataram que o envolvimento numa tarefa com o simples objetivo de aumentar o crescimento pessoal parece contribuir, efetivamente, para o aumento do crescimento pessoal. Adicionalmente, vivenciar (e ultrapassar) a sensação de desconforto associada à realização de algo desafiante, com a única finalidade de crescer como pessoa, parece levar a um aumento nos níveis de ICP.

1.3. ICP e Saúde Mental, Depressão e Sintomatologia Depressiva

Espera-se que a ICP, como construto, atue diretamente na prevenção de *distress* psicológico por meio de um mecanismo cognitivo que consiste em percecionar os *stressores* como chances de crescer como pessoa. Ao terem esta perceção, os indivíduos vêem-se como aptos para se aperfeiçoarem a si mesmos e mostram-se otimistas, acreditando que uma mudança positiva irá ocorrer (Robitschek et al., 2012).

De facto, altos níveis de ICP estão associados a maiores níveis de afeto positivo e, portanto, a menores níveis de afeto negativo e de *stress* (Hardin et al., 2007, cit in Freitas et al., 2016; Yang & Chang, 2014) e *distress* psicológico (Ayub & Iqbal, 2012). Adicionalmente, a ICP está positiva e significativamente associada à auto-compaixão (Neff et al., 2007), a maiores níveis de autoestima (Shigemoto et al., 2017) e a estilos de enfrentamento mais saudáveis (Robitschek et al., 2012). Indivíduos com maiores níveis de ICP apresentam ainda maior probabilidade de procurar apoio psicossocial (Klockner & Hicks, 2008). Para além disso, a ICP está positivamente associada à autoeficácia, saúde mental e comportamentos associados com correr riscos (Ogunyemi & Mabekoje, 2007).