RELATIONSHIPS BETWEEN CAREGIVER - CHILD BONDING, LOCUS OF CONTROL, COPING AND DEPRESSION IN ADOLESCENTS

KHOMDUEAN TOSIRI

A THESIS SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF NURSING SCIENCE
(MENTAL HEALTH AND PSYCHIATRIC NURSING)
FACULTY OF GRADUATE STUDIES
MAHIDOL UNIVERSITY
2007

Thesis
Entitled

RELATIONSHIPS BETWEEN CAREGIVER – CHILD BONDING, LOCUS OF CONTROL, COPING AND DEPRESSION IN ADOLESCENTS

Khomduean Tosiri.
Mrs. Khomduean Tosiri
Candidate

Atirat Wattanapailin
Asst. Prof. Atirat Wattanapailin, Ed.D.
(Curriculum Research & Development)
Major-Advisor

Yajai Sitthimongkol
Assoc. Prof. Yajai Sitthimongkol,
Ph.D. (Nursing)
Co-Advisor

Wannapa Suttiamnuaykul
Lect. Dr. Wannapa Suttiamnuaykul,
D.N.S.
Co-Advisor

Prof. M. R. Jisnuson Svasti, Ph.D.
Dean
Faculty of Graduate Studies

Pornsri Sriussadaporn.
Assoc. Prof. Pornsri Sriussadaporn,
M.Ed. (Education Research)
Chair
Master of Nursing Science
Faculty of Nursing

Thesis
Entitled

RELATIONSHIPS BETWEEN CAREGIVER – CHILD BONDING, LOCUS OF CONTROL, COPING AND DEPRESSION IN ADOLESCENTS

was submitted to the Faculty of Graduate Studies, Mahidol University
For the degree of Master of Nursing Science (Mental Health and Psychiatric Nursing)
on
30 May, 2007

Khomduean Tosiri.
.....
Mrs. Khomduean Tosiri
Candidate

.....
Lect. Dr. Wanlaya Thampanichawat,
Ph.D. (Nursing)
Chair

.....
Dr.Prayuk Serisathien,
MD. Diplomat, Thai Board of Psychiatry
Member

Atirat Wattanapailin.
.....
Asst. Prof. Atirat Wattanapailin, Ed.D.
(Curriculum Research & Development)
Member

.....
Lect. Dr. Wannapa Suttiamnuaykul,
D.N.S.
Member

.....
Assoc. Prof. Yajai Sitthimongkol,
Ph.D. (Nursing)
Member

.....
Prof. M. R. Jisnuson Svasti,
Ph.D.
Dean
Faculty of Graduate Studies
Mahidol University

.....
Assoc. Prof. Kobkul Phancharoenworakul ,
Ph.D. (Nursing)
Dean
Faculty of Nursing
Mahidol University

ACKNOWLEDGEMENTS

This thesis could not have been accomplished with out support, understanding, and assistance of many wonderful people; my committee, family, and friends. I am appreciative for the ongoing support, graciousness, encouragement, and supervision. I have received from my major advisor, Assist Prof. Atirat Wattanapailin, throughout my graduate study. I am sincerely thankful to Associate Professor Yajai Sitthimongkol, and Lect. Dr. Wannapa Suttiamnuaykul, my co-advisors, for their support, understanding, and valuable suggestions throughout the process of this study. Heartfelt thanks are extended to Lect. Dr. Wanlaya Thampanichawat, representative from the graduate program, Dr. Prayuk Serisathien, M.D., external examiners. All gave me valuable suggestions and comments to make this thesis successfully.

Furthermore, I wish to thank Dr. Prayuk Serisathien, Associate Professor Dr. Somporn Rungrueangkolakij, and Assist Prof Dr. Tassanee Prasopkittikun They all provided time and efforts to examine the validity of research instruments used in this study. Special thanks go to Lect. Dr. Atittaya Ponchaikate who performed back forth translation the research instrument. I wish to thank all students who participated in this study.

Finally, I especially wish to thank Mr. Kiat Kongkumkai (my lovely father), Mrs. Somboon Kongkumkai (my lovely mother), Dr. Visit Tosiri, M.D. my lovely husband, sons & daughter, and friends who shared their love, warm, support and encouragement which enabled me to accomplish my graduate study.

Khomduean Tosiri

RELATIONSHIPS BETWEEN CAREGIVER–CHILD BONDING, LOCUS OF CONTROL, COPING, AND DEPRESSION IN ADOLESCENTS

KHOMDUEAN TOSIRI 4637755 NSMH/M
M.N.S. (MENTAL HEALTH AND PSYCHIATRIC NURSING)

THESIS ADVISORS: ATIRAT WATTANAPAILIN, Ed. D., YAJAI SITTHIMONGKOL, Ph. D. (Nursing), WANNAPA SUTTIAMNUAYKUL, D.N.S.

Abstract

The present descriptive study aimed to investigated the relationships between caregiver - child bonding, locus of control, coping, and depression in adolescents based on the conceptual framework of Lazarus & Folkman (1984). Multistage sampling was used to recruit the subjects, which consisted of 568 Mathayomsuksa 2 students under the Department of General Education, Buriram Province, in the academic year 2006. Data were collected using a set of five questionnaires as follows: 1) The subjects' demographic characteristics questionnaire; 2) The Parent-Child Bonding Instrument (PBI) in the care aspect and the overprotection aspect; 3) The Locus of Control Scale for Children; 4) The Adolescent-Coping Orientation for Problem Experiences (A-COPE); and 5) The Children Depression Inventory (CDI).

The results revealed that there was a statistically significant negative relationship between caregiver-child bonding in the care aspect and depression of adolescents ($r = -.52$, $p < .01$), while caregiver-child bonding in the overprotection aspect was positively associated with depression of adolescents with statistical significance ($r = .33$, $p < .01$). In addition, it was found that locus of control was positively associated with depression in adolescents with statistical significance
($r = .47$, $p < .01$), whereas coping was negatively related to depression in adolescents with statistical significance ($r = -.23$, $p < .01$).

Healthcare teams should provide a psychological education program to caregivers and their adolescents to promote caregiver-child bonding in the care aspect, reduce the caregiver-child bonding in the overprotection aspect, as well as promote locus of control and coping, all of which could reduce depression in adolescents. In addition, depression in adolescents should be assessed and screened yearly for data base. Finally, the relationships between other variables as specified in the conceptual framework of Lazarus & Falkman should also be further investigated, and the items in the instruments to assess locus of control and depression in adolescents should be revised to suit adolescents who are not in the school system.

KEY WORDS: CAREGIVER–CHILD BONDING/ LOCUS OF CONTROL/ COPING/ DEPRESSION/ADOLESCENT

76 pp.

ความสัมพันธ์ระหว่างความผูกพันกับผู้ดูแล ความเชื่ออำนาจภายในตน การเผชิญความเครียด กับภาวะซึมเศร้าในเด็กวัยรุ่น(RELATIONSHIPS BETWEEN CAREGIVER–CHILD BONDING, LOCUS OF CONTROL, COPING, AND DEPRESSION IN ADOLESCENTS)

คมเดือน โตศิริ 4637755 NSMH/M

พย.ม. (การพยาบาลสุขภาพจิตและจิตเวช)

คณะกรรมการควบคุมวิทยานิพนธ์: อติรัตน์ วัฒนไพลิน, กศ. ด., ยาใจ สิทธิมงคล, Ph.D. (Nursing), วรรณภา สุทธิอำนวยกูล, D.N.S

บทคัดย่อ

การวิจัยเชิงบรรยายครั้งนี้มีวัตถุประสงค์ เพื่อศึกษาความสัมพันธ์ระหว่าง ความผูกพันกับผู้ดูแล ความเชื่ออำนาจภายในตน การเผชิญความเครียด กับภาวะซึมเศร้าในเด็กวัยรุ่น โดยใช้กรอบแนวคิดความเครียดและการเผชิญความเครียดของลาซารัสและโฟล์คแมน กลุ่มตัวอย่างได้จากการสุ่มหลายระดับ นักเรียนมัธยมศึกษาชั้นปีที่ 2 ในโรงเรียนมัธยมสังกัดกรมสามัญศึกษาทั้งหมดในจังหวัดบุรีรัมย์ ประจำปีการศึกษา 2549 จำนวน 568 คน เก็บรวบรวมข้อมูลด้วยตนเอง โดยใช้แบบสอบถามจำนวน 5 ชุด คือ 1). แบบบันทึกข้อมูลทั่วไป 2). แบบวัดความผูกพันกับบิดามารดา 3). แบบวัดความเชื่ออำนาจภายในตน 4). แบบวัดการเผชิญความเครียดของวัยรุ่น และ
5). แบบประเมินภาวะซึมเศร้าในเด็ก

ผลของการศึกษาโดยการโดยการทดสอบความสัมพันธ์พบว่า ความผูกพันของวัยรุ่นกับผู้ดูแลในองค์ประกอบการดูแลมีความสัมพันธ์ทางลบกับกับภาวะซึมเศร้าของวัยรุ่นอย่างมีนัยสำคัญทางสถิติ ($r = -.52$, $p < 0.01$) ความผูกพันของวัยรุ่นกับผู้ดูแลในองค์ประกอบของการปกป้องมากเกินไปมีความสัมพันธ์ทางบวกกับภาวะของซึมเศร้าของวัยรุ่นอย่างมีนัยสำคัญทางสถิติ ($r = .33$, $p < 0.01$) ความเชื่ออำนาจภายในตนมีความสัมพันธ์ทางบวกกับภาวะซึมเศร้าของวัยรุ่นอย่างมีนัยสำคัญทางสถิติ ($r = .47$, $p < 0.01$) และการเผชิญความเครียดมีความสัมพันธ์ทางลบกับภาวะซึมเศร้าของวัยรุ่นอย่างมีนัยสำคัญทางสถิติ($r = -.23, p < 0.01$)

ทีมบุคลากรทางสุขภาพจิตควรให้จิตศึกษาแก่ผู้ดูแลเกี่ยวกับการเลี้ยงดูเด็กและวัยรุ่นเพื่อเสริมสร้างความผูกพันกับผู้ดูแลในองค์ประกอบการดูแล ลดความผูกพันกับผู้ดูแลในองค์ประกอบการปกป้องมากเกินไป การส่งเสริมความเชื่ออำนาจภายในตนและความสามารถในการเผชิญความเครียดในวัยรุ่น ควรจัดให้มีการประเมินภาวะซึมเศร้าในวัยรุ่นเพื่อการคัดกรองทุกปี ศึกษาความสัมพันธ์ระหว่างตัวแปรอื่นตามกรอบแนวคิดของลาซารัสและโฟล์คแมน ปรับปรุงข้อคำถามในแบบวัดความเชื่ออำนาจภายในตนและศึกษาภาวะซึมเศร้าในเด็กวัยรุ่นที่ไม่อยู่ในระบบโรงเรียนต่อไป

76 หน้า

CONTENTS

CONTENTS (CONTINUED)

LIST OF TABLES

LIST OF FIGURES

CHAPTER I
INTRODUCTION

Background and Significance of the Study

Depression is an important mental health problem which is frequently found in adolescents (Rushton, Michelle, & Schectman, 2002; Stienberg, 1999), it is found to be a major cause of suicide among adolescents (Shives, 2005; Townsend, 1999). This is because depression or depressive symptoms affect individuals' daily living - physically, mentally, and socially. Individual with depression will develop insomnia or lack of sleep, sadness and gloominess, lethargy, indifference to the environment, lack of enthusiasm and satisfaction to activities, loss of appetite, hopelessness, low self-esteem, flightiness, and obsession. They may also have a suicidal idea (Carson, 2000; Lewis, 2000; Shives, 2005; Steinberg, 1999)

Depression affects individuals' ability to respond to their basic needs, which in turn affects their emotional expression, communication, and relationships with family members. Most of the adolescents who suffer from depression have poor academic achievement, behavioral problems, drug abuse problems, and possibly suicidal thoughts (Noble & McGrath, 2005). A study of the World Health Organization reported that during 1997 – 1998, American adolescents showed depressive symptoms more than adolescents living in other countries. It was also found that female adolescents aged between 11 and 15 years had five times more depressive symptoms than male adolescents (Rushton, Michelle, & Schectman, 2002). Moreover, the study findings also indicated that female adolescents with depression were more likely to commit a suicide than male adolescents with depression. In Thailand, Martrankasombat (1996) conducted a study to investigate depression among 1,246 adolescents and found that 40.8% of secondary school students aged 10 to 17 years had depression and 13.3% were sick with depressive symptoms. Furthermore, Tiamkeaw and colleague (2000) found that adolescents who were studying in a high school in Chiangmai Province could be categorized as having depression and 67.6%

needed medical intervention. According to a report on the incidence of depression, suicidal attempts, and committed suicides in 2004, there were 87,101 patients diagnosed with depression in the country, or 140.55 patients with depression /100,000 populations (Department of Mental Health, 2003). In Buriram Province, there were 3,183 patients diagnosed with depression, or 208.82 patients diagnosed with depression /100,000 populations. Of these, there were 176 who had suicide attempts, or 11.5545 patients diagnosed with depression /100,000 populations, while 83 patients had committed suicide or 5.45 patients /100,000 populations. This was close to the rate of committed suicide in Thailand which was 4,296 cases, or 6.93 individuals /100,000 populations (Department of Mental Health, 2003).

According to Lazarus & Folkman (1984), stress is an interaction between an individual and his or her environment. Individuals have to use cognitive appraisal to judge whether the situation is a danger, loss, or threat to their well-being or whether it is a challenge. They also have to consider how to use the available coping resources in coping. When individuals have stress, their physical, emotional, and cognitive beings are affected. They may try to continuously think and take action to deal with both their internal needs and their external needs in order to return the balanced and normal condition. In general, coping can be divided into two forms: 1.) Problem-focused coping is stress-coping which involves dealing with or solving problems which cause stress and 2) Emotional-focused coping which involves changing emotions in response to stress. Effective stress coping depends on adaptation outcome in various aspects including 1) Social functioning in family, peer group, and work 2) Subjective well-being with positive or negative emotional condition, with depression resulting from long-term failure to cope and 3) Somatic health (Lazarus & Folkman, 1984)

Stress during adolescence is developmental stress—physically, cognitively, emotionally, and socially-from childhood to puberty and from reliance on family members to self-reliance (Lewis, 2002; Stienberg, 1999). This includes stressful events such as loss of significant persons in life; parental divorce; conflicts with parents, teachers, or peers; low achievement in learning (Repetto, Caldwell, and Zimmerman, 2005) expectation and needs in learning; and occupation (Martin et al., 2005; William & Lisi, 2000). Adolescents have difficulty in adaptation to these

situations or events, which may eventually lead to depression (Kessler et al., cited in Reinherz et al., 2003). Stressful events in daily life, chronic illnesses, and physical and mental abuse are found to be related to depression, and adolescents with depression tend to show anxiety and have low self-esteem (Murberge, & Bru, 2005; Poulin, Hand, Boudreau, & Santor, 2005; Sund, Larsson, & Wichstrøm, 2003). In addition, studies have revealed that high stress is significantly associated with depression in both male and female adolescents (Berk, 2002; Franko et al., 2004; Hill, Pickles, Rollinson, Davies, & Byatt, 2004; Liu, Tein, & Zhao, 2004).

When adolescents encounter stress which results either from their age-appropriate development or from daily living situations or environment, they have to use cognitive appraisal to determine if such situation is a stress situation. Then, they need to use coping strategies to return to former balance. Adolescents' stress coping is complex (Liu, Tein, & Zhao, 2004), as they constantly try to change their thinking and behaviors to deal with the stressor, which can be either internal or external, including active coping/control coping, avoidant/passive coping, disengagement coping, distraction/accommodation coping, and support seeking coping. Stress which results from the relationship among close persons is an obstacle of coping and can lead to depression in female adolescents. Furthermore, avoidant stress coping is a predictor of an increase in depressive symptoms. Finally, it has been reported that problem-focused coping as well as search for available resources can reduce both anxiety and depressive symptoms, while avoidant coping results in a higher level of depression (Herman-Stahl, & Peterson, 1999).

The relationship between parents and children is related to depression in children and adolescents. It has been found that parents who have depressive symptoms are likely to cause depression in their children. In fact, mothers have the highest influence on prediction of depression during each developmental phase of children and adolescents, especially when there are other risk factors including deviation in family, psychological condition of family members, illegal acts of family, suppression or over control of children, as well as stressful events in daily living such as divorce, death of a parent, lack of a warm relationship in the family, lack of attention, lack of leadership or good role model, lack of problem-solving skills, and substance abuse (Jaffee et al., 2002; Lewinsohn et al., 1999). Shives (2005) conducted

a study and found that teenagers whose mother was unavailable, unresponsive, or unsupportive were more likely to develop depression. In addition, adolescents who were raised by overprotective parents, who came from a broken home, or who had to deal with divorce or mental health problems of parents were less able to adapt and function effectively in family, and this could lead to depression and suicide (Compton et al., 2005; Hill et al., 2004; Jaffee et al., 2002; Lewinsohn et al., 1999; Martin et al., 2004; Stein et al., 2000)

According to Lazarus & Folkman (1984), locus of control is an important resource of coping with stress. Rotter viewed that human behaviors result from each individual's learning and experience, and one major component of social learning is individuals' internal and external locus of control. Rotter divides locus of control into two types-external and internal locus of control. As for external locus of control, individuals believe or perceive that what has happened to them is a result of external influence which is beyond their control such as destiny, fate, coincidence, or other individuals. On the other hand, internal locus of control refers to individuals' beliefs or perceptions that have happened to them results from their own actions or capability. Such beliefs and perceptions bring about expectation in outcomes or rewards of new behaviors. Internal and external locus of control develops in childhood. Nowicki & Strickland (1973) points out that development of internal and external locus of control results from different factors including environment, childhood experience, and parents' socioeconomic status. It has been found that internal locus of control is positively related to age. That is, when children become older, they have a higher level of internal locus of control. It is also associated with learning achievement. Children who have a high level of learning achievement tend to have a higher level of internal locus of control when compared to children who have a lower level of internal locus of control (Nowicki & Duke, 1983). Furthermore, Fogas and colleagues (1992) found that internal locus of control is negatively associated with parental divorce and problem-solving of children, while external locus of control is related to depression and anxiety in children. In addition, studies have reported that adolescents who have a high level of external locus of control are more likely to abuse substances and commit suicide (Martin et al., 2005; Stahl & Petersen, 1999). Martin and colleague (2005) also found that students who have external locus of control are more likely to have a

suicidal idea. Kim (2003) discovered that there is a negative relationship between internal health locus of control and depression among adolescents.

According to the researcher's experience of providing mental health and psychiatric consultation to secondary students in Buriram Province, more than half of the students who sought consultation services had conflicts with their parents or caregivers because of discrepancy in ideas, feelings, needs, and values, especially those related to friends, studies, daily living activities, and riding motorcycles, etc. It was found that most of the adolescents used inappropriate problem-solving strategies. For example, they did not dare to express their opinions, and some of them suppressed their problems and feelings, thus adversely affecting their learning and adaptation. Even though sometimes advice had already been given to them but the problems still persisted. Some of the problems were serious or complex and affected the students' personality and mental health later on. In addition, it was frequently discovered that the problems stemmed from emotional or adaptation problems. Adolescents who lacked self-confidence and felt that they were inferior or inadequate may develop isolation behaviors, avoid socialization, and have fewer friends. These problems could result in mental and behavioral problems of adolescents, especially depression which was a major cause of suicide among adolescents.

As a psychiatric nurse whose responsibility was to promote mental health and prevent mental health problems, the researcher conducted an extensive search of literature review regarding depression among adolescents. The literature review revealed that there were numerous studies on different factors that affect depression in adolescents such as family conditions, problem coping, satisfaction in life, social support, self-pride, and adolescent suicide (Luangrtrakul, 2006). However, there was no study on the influence of caregiver - child bonding, locus of control, and coping and depression in Thai adolescents. Therefore, the objectives of the present study were to investigate the relationship among caregiver - child bonding, locus of control, and coping and depression in adolescents. It was anticipated that the findings of the study would be used as baseline data to promote the relationship between adolescents and their parents or caregivers, to arrange the environment in order to enhance development of locus of control, and to promote coping in order to reduce and prevent depression in adolescents.

Research Questions

1. Is caregiver – child bonding related to depression in adolescents?
2. Is locus of control related to depression in adolescents?
3. Is coping related to depression in adolescents?

Purposes of the Study

1. To investigate the relationship between caregiver – child bonding and depression in adolescents.
2. To investigate the relationship between locus of control and depression in adolescents.
3. To investigate the relationship between coping and depression in adolescents.

Hypotheses

1. The caregiver - child bonding in the care aspect is negatively correlated with depression in adolescents.
2. The caregiver - child bonding in the overprotection aspect is positively correlated with depression in adolescents.
3. Locus of control is negatively correlated with depression in adolescents.
4. Coping is negatively correlated with depression in adolescents.

Conceptual Framework of the Study

This study was a descriptive research which aimed to investigate the relationship between caregiver – child bonding, locus of control, coping and depression in adolescents. The stress and stress coping concept of Lazarus & Folkman (1984) was used as the conceptual framework of the study.

Adolescents face with complex stress situations due to developments in life. Examples of stress situations adolescents have to face and cope with are physical changes after entering puberty; the need to be emotionally independent from their parents; development of self-concept and identity (Rice & Dolkin, 2005) conflicts with family members, friends, teachers, and siblings; conflicts between parents; changes in parents' economic status; pressure in study; illness of family members; or death in the

family (Hamring & Pachler, 2005; Murberg, 2005; Walker, 2005). Studies have shown that stress situations in adolescents' life resulting from conflicts with loved ones, expectation in learning achievement, loss of significant persons, and physical and sexual abuse are associated with depression (Murberg, 2005; Repetto, 2004; Sund, 2003), and that these factors could predict depression in adolescents (Christine, 2005; Franco, 2004). Children who experience failure in learning may have a suicidal idea (Martin, 2005).

Vance (2002) conducted a study and found that adolescents who had a negative relationship with their parents had more risk behaviors and showed more depressive symptoms than those who had a positive relationship with their parents. In addition, adolescents who had a high level of family support had better self-protective skills and social skills, when compare those who had a poor relationship with their parents had a low or moderate level of depression with statistical significance. In short, adolescents who had different relationships with their parents had different levels of depression (Martin, Bergen, & Roeger, 2004). Furthermore, Wu (2004) found that adolescents whose mothers were unavailable, unresponsive, or unsupportive were more likely to develop depression. Shives (2005) also reported that adolescents who lived in a conflicting family, who had absence of limit setting, and who had bad experiences in the family were more likely to have depression. Besides, the components of family functioning (Crane, 2005), family structure, lack of good family adaptation, and low family bonding (Kaltiala-Heino, Rimpela, Rantanen, & Laippala, 2001) were all found to be related to depression in adolescents. Finally, poor parental care is another risk factor of depression in adulthood and suicidal thoughts (Compton, 2005; Hollis, 1996).

When dealing with stressful situations, adolescents may change their thinking and try to use behavioral changes to cope, based on available personal and environmental resources. Lazarus & Folkman (1984) pointed out that internal locus of control is a significant personal resource of individuals while relationship with their parents is an environmental resource that can be used in coping. Previous studies have shown that there was a positive relationship between adolescents' external locus of control and suicidal thoughts (Hillsman & Garber, 1995). Takakura & Sakihara (2001) also found a negative relation between internal locus of control and depression among Japanese adolescents.

According to Stahl & Patersen (1999) appropriate coping and search for coping resources can reduce individuals' anxiety and depressive symptoms. On the contrary, avoidance of problems results in a high level of depression. It has been found that adolescents who use problem solving (Ogul, 2003; Wilson, 2005), emotional modulation, acceptance, distraction, and positive thinking have less depression (Bonica, 2003). Moreover, there is a statistically significant relationship between adolescents who use aggression in their adaptation (Murberg, 2005) and avoidant coping and depression. Finally, substance abuse is found to be associated with increased depression (Poulin, 2005).

The conceptual framework of the present study was illustrated in Figure 1 below.

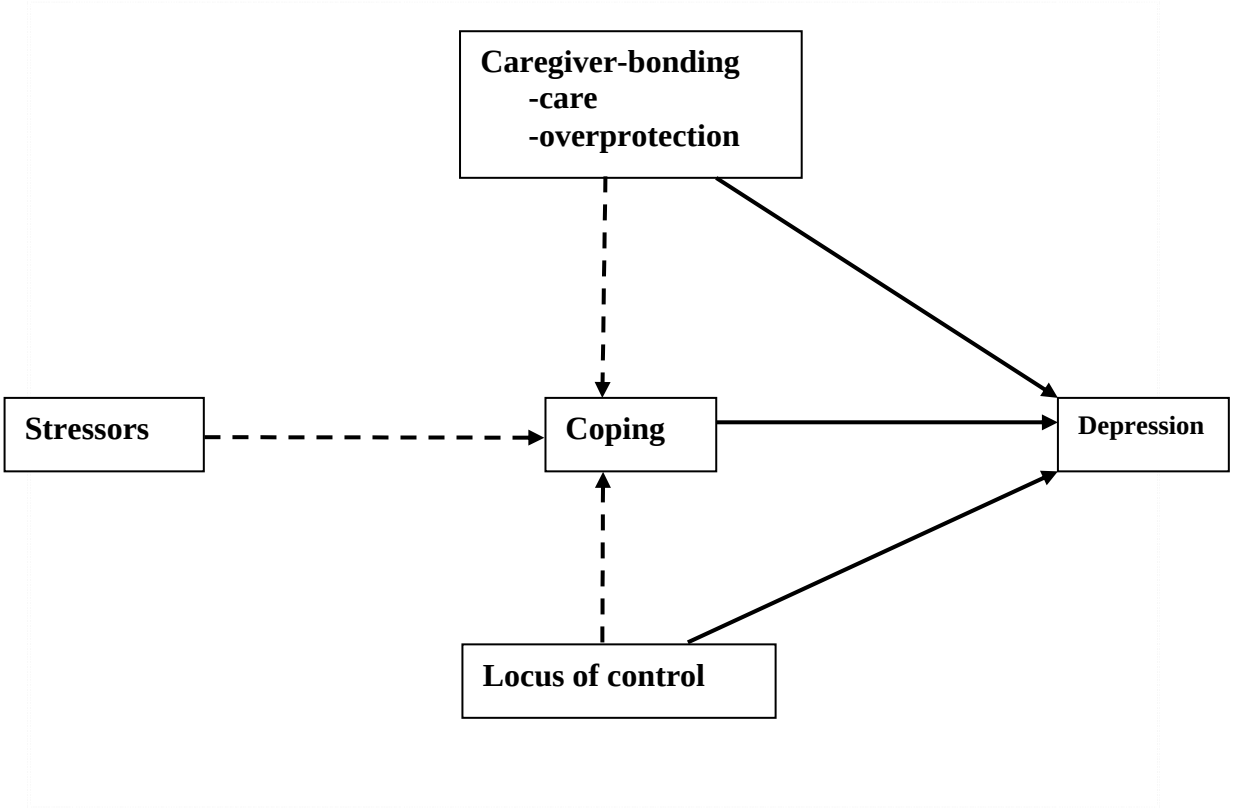

Figure 1: Conceptual Framework of the Study which describes the relationships between caregiver - child bonding, locus of control, coping, and depression in adolescents based on the conceptual framework of Lazarus & Folkman (1984).

Scope of the Study

The present descriptive study aimed to investigate the relationship between caregiver - child bonding, locus of control, coping, and depression in adolescents based on the conceptual framework of Lazarus & Folkman (1984). The subjects were Mathayomsuksa 2 students in the academic year 2006 in Buriram Province.

Expected Outcomes and Benefits

1. The findings of the study can be used as baseline data for psychiatric nurses and related personnel to promote locus of control in adolescents, caregiver - child bonding and appropriate coping in order to prevent depression in adolescents.

2. The findings can be use to construct guidelines for further research investigating various factors related to depression in adolescents due to locus of control, caregiver - child bonding, and coping in order to solve and prevent depression in adolescents.

Definition of Terms

1. Caregiver – child bonding refer to adolescents' perceptions of care, emotional attachment, family time, assistance, protection, and freedom in making decision and conducting which adolescents have received from their parents since they were born. This study assessed, caregiver - child bonding by using the Parent Bonding Instrument (PBI), which was developed by Parker and colleagues (1979, 1997) and translated into Thai by the researcher. The PBI consists of 25 items which measure caregiver – child bonding in two factors as follows:

1.1 Care refers to adolescent's perception of the affection, warm emotion, empathy, and closeness that child receive from their parents or caregiver. This also includes assistance when they need, freedom of ideas and actions, and loving kindness. There are12 items in this aspect, with high scores indicating positive relationship between caregiver and child filled with care, attention, affection, interest, and freedom of ideas and actions.

1.2 Overprotection refers to adolescent's perception of the care given by their caregiver. Overprotection involves too much concern, intrusion, excessive

contact, infantilization, and prevention of independent behaviors. There are 13 items in this aspect, with high scores reflecting caregiver's attempt to prevent child from becoming independent with excessive protection and control.

2. Locus of control refers to adolescents' beliefs in their own self-efficacy to control the situations and outcomes. In other words, it refers to their beliefs that everything that happened to them depended on their own action. In this study, locus of control was assessed by using the Nowicki-Strickland Locus of Control Scale for Children (CNSIE) developed by Nowicki & Strickland (1973) and translated into Thai by the researcher. The instrument consists of 40 items which assesses internal and external attribution style. High scores of locus of control meant individuals believe that different events in life are beyond their control and results from external factors or fate and vice versa.

3. Coping refers to different methods used by adolescents to deal with or to reduce their stress including ventilation, distraction, self-reliance, optimism, search for help, problem-solving, avoidance, search for spiritual support, spending time with close friends, search for help from professionals, doing other activities, using humors, and relaxation. In the present study, coping was assessed by using the Adolescent-Coping Orientation for Problem Experiences (A-COPE) constructed by Patterson & McCubbin (1995) and translated into Thai by the researcher. The instrument consists of 54 items regarding coping of adolescents.

4. Depression in adolescents refers to the feelings of sadness, gloominess, suffering, desperation, and loss experienced by adolescents. These feelings may occur with loss of satisfaction with regular activities, disruption of sleep, and loss of appetite and energy. This study assessed depression by using the Children's Depression Inventory (CDI) constructed by Kovacs & Goldston (1985) based on the Beck Depression Inventory (Beck, Rail, Rickels, 1974) and subsequently translated into Thai and adapted by Matrangkasombat and Likhanapichitkul (1996). The instrument composes of 27 items which elicited data regarding different aspects of depression found in child.

CHAPTER II
LITERATURE REVIEW

The present descriptive study aimed at investigated the relationships between caregiver – child bonding, locus of control, coping, and depression in adolescents based on the conceptual framework of Lazarus & Folkman (1984). In this chapter, related literature and research is reviewed in the following topics:

1. The conceptual framework of stress and stress coping of Lazarus & Folkman (1984)
2. Stress in adolescence
3. Depression in adolescence
4. Relationships between caregiver – child bonding and depression in adolescence.
5. Relationships between locus of control and depression in adolescence
6. Relationships between coping and depression in adolescence

1. The conceptual framework of stress and stress coping of Lazarus & Folkman (1984)

The conceptual framework of stress and stress coping proposed by Lazarus & Folkman (1984) explains the stress coping process which consists of cognitive appraisal, coping, and adaptation outcomes which can be described as follows:

1.1. Cognitive appraisal is a cognitive process in which individuals consider the significance of the arousal or the situation they are facing and select methods to deal with such situation. Cognitive appraisal can be divided into three following categories:

I) Primary appraisal is an appraisal about the outcomes of the situation on individuals as 1) irrelevant - the arousal does not have any effect on individuals'well-being, 2) benign positive - the arousal promotes and maintains individuals' well-being, and 3) stressful - the arousal causes tension and stress. The stressful arousal can further be categorized into three types - harm and loss, threat, and challenge.

II) Secondary appraisal is individuals' selection of the strategy to handle the stressful situation. There can be only one or more than one strategy to deal with the situation depending on the coping behavior of individuals.

III) Reappraisal is a repeated appraisal done after individuals have assessed the outcomes of the coping strategy they have already applied or after they have received additional information.

These three appraisal techniques are interactive, and they depend on individuals' amount and intensity of stress as well as emotional reactions. In general, these appraisals are under the influence of different factors as follows (Lazarus & Folkman, 1984):

1.1.1 Individual factors

1.1.1.1 Commitment—In a situation in which individuals have a high level of responsibility, they will experience considerable physical changes. It can also be a cause of physical weakness.

1.1.1.2 Beliefs—Beliefs help individuals understand the situation and explains the truth about individuals, which can be divided into three types:

1.1.1.2.1 Beliefs in locus of control of specific situations. Individuals who believe in internal locus of control feel that they are better able to handle the situation than those who have belief in external locus of control. They tend to participate and confidently express themselves in specific situations they believe they are able to control. At the same time, individuals are likely to fear and avoid situations they believe are beyond their control.

1.1.1.2.2 Beliefs in life and existence including belief in God, belief in nature, etc.

1.1.1.2.3 General beliefs and specific beliefs.

1.1.2. Situational factors

1.1.2.1 Novelty—New or unfamiliar situations or ambiguous situations make individuals uncertain about their meaning and significance, hence an increase in stress. However, individuals understand and interpret the meaning of situations from reading, listening, and transferring of knowledge from one situation to another. Sometimes individuals may understand the situation, but they do not know how to handle it, and this makes them feel more threatened.

1.1.2.2 Predictability—when individuals predict that there will be a situation that cause stress at a certain point in time, they can plan for adaptation in advance or calculate safe time before the situation arises.

1.1.2.3 Event uncertainty—Most of the situations in life tend to be ambiguous or come with insufficient information for understanding. This makes individuals interpret such situation as threatening to them and try to understand or give meaning to the situation.

1.1.2.4 The timing of stressful events in relation to the life cycle—when individuals predict that a situation will arise at a certain point in life, they will be better prepared to deal with it. If a stressful situation in life takes place unpredictably, it can lead to a great deal of stress because individuals lack preparation and support from others who have similar experience.

1.2 Coping

Coping is individuals' attempts, cognitively and behaviorally, to deal with their needs and specific conflicts, both internally and externally. Coping strategies can be divided into two categories as follows (Lazarus & Folkman, 1984):

1.2.1 Problem-focused coping is a strategy which requires the use of problem solving including identification of problems and causes, selection of available alternatives, consideration of advantages and disadvantages of each alternative, decision making, and expression of selected behaviors. Problem-focused coping aims at changing the situation to reduce the threat, assess obstacles, and search for support sources. It also involves learning new skills and new methods from the evaluation of the practice.

1.2.2 Emotion-focused coping is a stress coping strategy which aims at reducing unpleasant or unhappy emotions without changing the situation using a cognitive process or a mental mechanism as follows:

1.2.2.1 Changing the meaning of the situation is similar to cognitive reappraisal. It may mean giving the new meaning realistically but more positively, or it may involve denial of truth and self-denial.

1.2.2.2 Choosing to pay interest to only certain perspectives with the old meaning intact, or temporarily avoiding the situation.

1.2.2.3 Adapting behavioral strategies to reduce pain and suffering including exercising, hypnotizing, drinking alcohol, releasing anger, and seeking social support to cope with stress.

When individuals are facing stressful events, they may use either problem-focusing coping or emotion-focused coping or both (Lazarus & Folkman, 1984). Important factors that influence coping of individuals are individual resources and environmental resources and constraints.

I) Individual resources consist of the following:

- Health and energy: Healthy individuals are better able to cope with stress than those who are weak.

-Positive beliefs: Beliefs in positive outcomes, internal locus of control, beliefs in justice, religious beliefs, and hope enable individuals to better cope with stress.

- Problem-solving skills: Problem-solving skills are individuals' ability to analyze the stressful situations and search for alternatives to cope. They come from background knowledge and experience, intellectual ability, and ability to control behaviors to achieve desired outcomes.

- Social skills: Social skills are individuals' ability to communicate and live with others to initiate and maintain social support.

II) Environmental support consists of the following:

- Social support: Social support received from family network which benefit adaptation can be divided into: 1) emotional support which means provision of attachment, trust, and confidence, making individuals feel loved and cared for, 2) information support, which refers to provision of information and

advice in solving problems as well as feedbacks on individuals' actions, making them understand the stressful event and realize solutions to problems, and 3) tangible support which refers to assistance in the forms of money, materials, or services to help cope with stress, making individuals feel attended to and valued.

- Material resources refer to monetary resources including properties, money, or objects which can be used as resources to solve with problems, making individuals have more coping options. According to Downe-Wamboldt & Melanson (1991), material resources give individuals more alternatives to solve their problems.

1.3 Constraints

In general, even though individuals may have various support resources to cope with stressful situations, they may not be able to make full use of what are available to them due to individual constraints and/or environmental constraints.

Adaptation outcomes result from estimation of the situation, estimation and utilization of support resources, and effective stress coping of individuals, with both short-term and long-term outcomes taken into consideration in the following aspects: 1) working and living with family and society, 2) morale or satisfaction with life, and 3) somatic health. Encounter with severe stress or crises may lead some individuals to discovery of adaptation resources they have never known, hence strength and development from stress. Adaptation skills take place from learning in daily living, and when considering adaptation outcomes, three aspects need to be taken into consideration (Lazarus & Folkman, 1984):

1.3.1 Social function - this refers to individuals' ability to completely fulfill different roles as expected by society. Social function is influenced by different factors.

1.3.2 Morale or satisfaction - this means individuals' feeling that life is filled with happiness, satisfaction, and comfort. Short-term morale or satisfaction refers to positive and negative motions that occur during the adaptation process including satisfaction or dissatisfaction, happiness or unhappiness, hopefulness or fear, challenge or threat, and confidence or doubt. Emotion - focused coping can help reduce suffering emotions and increase happiness, while problem - focused coping

makes individuals satisfied with their successful actions. The emotional status which results from each adaptation will accumulate and become a basis for long-term happiness and morale including goals in life.

1.3.3 Somatic health - Somatic health refers to individuals' attempt to cope with stressful situations which result in positive or negative effects on health in two ways. First, negative changes of emotion resulting from inappropriate control of stress may obstruct individuals' realistic specification of the problem, making them unable to solve the problem and suffer from long-term stress which can eventually bring about physical sickness. Second, increased amount of coping also increases risks for sickness and death such as drinking alcohol, abusing substances, or smoking. However, there are some forms of stress coping which result in positive effects on health such as exercising and taking care of health.

2. Stress in adolescence

Adolescence is a transition period when children enter adulthood with complete physical, intellectual, emotional, and social development. Adolescence can be divided into three phases of early adolescence (10 – 13 years of age), middle adolescence (14 – 16 years of age), and late adolescence (17 – 21 years of age) (Neinstein, 1996). Adolescents undergo rapid physical changes and their reproductive system becomes completely developed, making them ready to reproduce. Such physical changes are influenced by heredity and environment. In addition, adolescents begin to develop creativity and are capable of more abstract and logical thinking. They better understand social relationships and change from being totally dependent on family members to being self-reliant (Santrock, 2001). Therefore, adolescents have developmental tasks including accepting physical changes, developing self-identity, and developing meaning relationships with other individuals, becoming emotionally independent, and have responsible behaviors toward society (Rice & Dolgin, 2005).

Based on physical, intellectual, emotional, and social development of adolescents, their psychosocial development can be divided into three phases as follows (Neinstein, 1996):

2.1 Early adolescence

Early adolescents are between 10 and 13 years of age. During this phase, there is a rapid change in hormonal production, making adolescents grow quickly and undergo considerable physical changes, especially sexual functions. Male adolescents are able to ejaculate and experience sexual orgasm, while female adolescents have menstruation and developed breasts and thighs. Moreover, there are emotional changes which result from physical changes. For instance, some adolescents may feel that there are abnormalities in their body, and they become irritated or dissatisfied with their shape. Besides, early adolescents undergo social changes, and they like to be with and be accepted by their peer groups. They are likely to imitate postures, clothes, hairstyle, and language of their peers to ensure acceptance.

2.2 Middle adolescence

Middle adolescence is between 14 and 16 years of age. During this phase, adolescents begin to accept their mature body. They are now capable of ideal thinking, and they seek to establish their identity while trying to overcome bonding with or reliance on their parents. Furthermore, middle adolescents learn to accept their sexual identity and give tremendous significance to their peers. However, some may rely so much on their peer groups that they develop conflicts with their family.

2.3 Late adolescence

Late adolescence is between 17 and 21 years of age. During this phase, adolescents reach full physical maturity and become full-grown adults. Their body weight and height increase, and their bone structure is large and strong. Late adolescents tend to perform self-search to discover their potential, strengths, and weaknesses for improvement and for making decision about their way of life.

According to Lazarus & Folkman (1984), stress is defined as an assessment that a situation is beyond individuals' ability or available resources and can cause harm, challenge, or threat, or can lead to loss of well-being in life. Stress may result from assessment of changing situations regarding individual factors and environmental factors.

Selye (1956) defines stress as a group of symptoms which results when the body have reactions toward threats, causing structural and chemical changes in the body to resist such threats, hence a reaction to stress.

A review of literature on stress in adolescence reveals that most of the stress of adolescents results from intellectual, emotional, and social changes, coupled with rapid changes in educational, economical, socio-cultural, and environmental opportunities (Ayelet, 2001; Kesornubol, 2001; Samutsane, 2000; Walker, 2005). Thus, it can be concluded that stress in adolescents generally results from the adolescents themselves and their environment including family, peer, and educational system which affects their cognitive appraisal. If adolescents are unable to adapt or they adapt themselves inappropriately, they may develop inappropriate behaviors which can be categorized as follows:

2.4 Personal factors

Stress that results from adolescents themselves comes from transition from childhood to adulthood, and from dependency on family members to self-reliance (Lewis, 2002 ; Neistein, 1996; Steinberg, 1999; WHO, 1997). Developmental changes of adolescents are as follows:

2.4.1 Biological processes

Adolescents begin to have physical changes including sexual and hormonal functions to enter puberty. For male adolescents, their height increases, and they develop body muscles. Also, their voice becomes harsh, and they have more body hair including moustache and beard. In terms of sexual reproduction, their body begins to produce sperm, and they may have ejaculation while they are sleeping at night. As for female adolescents, their breasts become fully developed, and their menstruation starts. In general, adolescents may easily develop irritation and sensitivity to changes. Since adolescents have a high level of sexual energy, they may become interested in sexual activities and may try out some sexual acts to serve their curiosity and to release their sexual energy (Hamburg, 1998; Santrock, 2001). According to Rice (2005), most of the American adolescents lose their virginity before their 17^{th} birthday.

In summary, adolescents can be characterized by changes when entering puberty, as well as social expectation of adolescents' behaviors, roles, and responsibilities toward self, family, peer, and society, as follows:

1. Acceptance of physical appearances and care of own physical development
2. Development of mature relations with friends of similar age, both of the same sex and of the opposite sex
3. Adopting gender-appropriate roles
4. Preparation for future career
5. Preparation for marriage and family life
6. Development of socially responsible behaviors
7. Development of ethical values as behavioral guidance (Rice & Dolgin, 2005).

2.4.2 Cognitive processes

Adolescents are more capable of abstract and logical thinking. They like to learn by 'trials and errors' and are eager to search for and discover new things. They like to express their opinions, listen to others' opinions, and adapt themselves to become ethical and independent adults (Santrock, 2001; Hamburg, 1998; Sriruan Kaewsangwan, 1997).

2.4.3 Socio-emotional processes

Adolescents pay a great deal of attention to development of relationships with peer groups. They like to compare themselves to their peer and tend to imitate their peers' behaviors. They need acceptance from their peers, and they try to be more independent from their family as well (Hamburg, 1998). According to the psychosocial theory of Erickson (1986), adolescence is a period of socio-emotional development in terms of identity and identity confusion. This is the time when adolescents search for their identity and have anxiety about their appearance. They also experience role conflicts. Adolescents who are unable to solve their internal conflicts tend to develop mental problems. They may experience moodiness, anxiety, depression, impaired decision making, and eventually develop problematic behaviors such as abusing substances (Jaffe et al., 2002; Lewinsohn et al., 1998).

2.5 Environmental factors

According to an extensive review of literature, there are a number of environmental factors that can cause stress in adolescents including parents' marital status, relationship with peer, expectation from society and family, and educational system in school, which can be explained as follows (Rice & Dolgin, 2005):

2.5.1 Parental marital status

Parents are an important source of social support that enables individual to cope with stress. At the same time, adolescents' relationship with their parents or family may cause stress. Both positive and negative changes in the family can be the cause of stress in adolescents (Suwat Mahatnirankul, Wanida Poompaisal, & Pimmas Tapanya, 1997). The causes of adolescents' stress are the nature of adolescents' relationship with parents, including parents' strict control over adolescents, parents' refusal to give adolescents independence, parents' lack of understanding, and conflicts with parents (Department of Mental Health, 2001; Martin, 2000; Williams & McGillicuddy-De-Lisi, 2000). Other sources of stress include negative life events such as loss of loved ones, loss of relationship with close persons, or life-changing events (Dumas & Nilsen, 2003; Franko et al., 2004; Monroe, 1999; Wiener & Dulcan, 2004) including physical abuse (Beck, 2002) or sexual abuse (Hill et al., 2004).

2.5.2 Relationship with peer groups

Peers are very important to adolescents as they can provide encouragement and spiritual support when adolescents have problems or sufferings, and peers can give beneficial advice. In general, adolescents feel that they belong to their peers, and they willingly share faith, beliefs, values, and interests when they are together. Having peers make adolescents feel warm, and they sometimes dare to defy adults if they feel that they are unfairly treated. On the other hand, peers can also be a bad influence in adolescents' life. Sometimes they may quarrel or fight with each other, and conflicts with peers cause adolescents stress (Martin, 2000; Williams & McGillicuddy-De-Lisi, 2000). In short, relationship with peer can be a source of stress for adolescents. Walker (2002) points out that breaking up with friends, arguments, problems with siblings in the family, and problems with classmates in school all cause stress in adolescents. Moreover, Ayelet (2001) conducted a study and

found that inability to establish a relationship with friends and society has an effect on adaptation of adolescents and causes them a high level of stress.

2.5.3 Expectation from society and family

When adolescents become physically mature and look like adults, they are expected to have more adult-like behaviors. If they are not emotionally ready, adolescents can find themselves under a great deal of pressure. Major missions society generally expect adolescents to fulfill include the following: 1) being able to accept their physical changes, 2) having development necessary for adulthood, 3) becoming emotionally independent, 4) being financially reliable, 5) developing relationship with people of the same age, 6) being able to form identity, and 7) becoming more responsible (Berk, 2002; Doyle, 1998). In addition, adolescents are expected by family to succeed in studying and choosing an occupation. If adolescents have personal desires that do not match the desires of the family, or reality, they may experience failure and sense of insufficiency (Department of Mental Health, 2001).

2.5.4 Learning system in school

The current technologically advanced society requires members who are highly capable and skillful. Schools are responsible for producing graduates who are able to contribute to society. As such, modern schools are regarded as an 'industrial factory' whose main function is to produce 'children' in their production line who are programmed to be the products desired by society. Thus, schools try to give as much knowledge to students as possible instead of allowing age-appropriate development. In particular, adolescents in secondary and high schools tend to have a high level of competition. They have to try to be successful both in school and in entering the university. If they are unable to be admitted to a university, they will have to suffer from loss of self-pride. Also, they may feel embarrassed with friends and teachers and find themselves under pressure from their parents (Kaewkangwan, 1997). This can definitely bring about stress and depression. Previous studies have shown that adolescents who have low academic achievements are more likely to suffer from depression (Ayelet, 2001; Kaewin, 2002; Poulin et al., 2005). Lack of academic achievement has also been found to be related with suicidal thoughts in adolescents (Martin, 2005), as well as conflicts with teachers, pressure in studying, and academic and occupational expectations (Martin, 2005; Williams & McGillicuddy-De-Lisi,

2000). These factors can increase stress in adolescents and negatively affects their study (Repetto, 2005). A study of Ayelet (2001) on stress in 173 adolescents studying in grade 9 found that the cause of a high level of stress among these adolescents was academic competition. In Thailand, Arunee Kesornubol (2001) investigated stress among 404 students under the Department of General Education in Nontaburi Province and found that major causes of stress were changes in school, education, and university entrance examination. Likewise, Wongpan Malarat (2000) found that major causes of stress among high school students in Chiangmai Province were anxiety about academic achievement and poor performance in class.

Adolescence is a critical period in which individuals learn to develop problem-solving skills. They may also have to deal with negative events in life such as loss of loved ones, changes in relationship in school, changes in family, their own mental well-being, physical development, chronic illnesses, as well as possible physical and emotional abuse. These factors are found to have a high correlation with stress among both male and female adolescents, and the degree of correlation depends on behavioral risks or emotional problems of adolescents (Berk, 2002; Franko et al., 2004; Hill et al., 2004; Lui et al., 2000; Williamson et al., 1995; Schraedley & Hayward, 1999). Besides, stressful events in daily living are associated with depression in adolescents, and adolescents who have depression tend to show symptoms of anxiety and low self-esteem (Christine, 2005; Murberg, 2005; Sund, 2003). All of these factors can cause difficulty in physical adaptation and bring about depression (Kaewkangwan, 1997; Kessler et al., cited in Reinherz et al., 2003). Thus, stress coping skills and self-concept should help shed light on causes of depression in adolescents and lead to effective measures to prevent and solve depression in adolescents.

3. Depression in adolescence

According to the conceptual framework of Lazarus & Folkman (1984), stress in adolescents' life results from a number of stress stimuli including personal factors, such as age-appropriate physical, intellectual, emotional, and social development, as well as environmental factors, such as parental marital status, relationship with peer groups, expectation from society and family, and educational system in school. If

adolescents assess these factors as overwhelming or beyond their available resources and as harms, challenges, or threats, they may be unable to appropriately cope with stress, hence a loss of well-being in life and eventually the onset of depression.

Depression in adolescence has received increasing attention. Depression can be found in both children and adolescents, and it can be diagnosed with the same criteria used with adults, even though some symptoms may be different due to age and developmental stages. Studies conducted in the United States have shown that depression can be found in one to 50% of adolescent population depending on the study population and data collection methods (Trangkasombat & Likhanapichitkul, 1996). The findings of Sarafolean (2000) have revealed that the prevalence rate of depression among adolescents was equal to 9%, with the severity of depression at moderate and high levels. Initial findings indicated a higher prevalence rate of depression due to the female gender factor, increased age, and ethnicity. Similarly, Lewinsohn, Rhode, & Seely 1998, cited in Hauenstein, 2003) found that the prevalence rate of depression in adolescents ranged from 0.4 to 8.3%, and it was twice as high among female adolescents. In Thailand, it has been reported that the prevalence rate of depression in adolescents ranges from 10.2% to 34.5% (Boonprakob, cited in Trangkasombat & Likhanapichitkul, 1996).

Different scholars and researchers have defined depression differently. Depression in adolescents is generally characterized by too much sleep, social isolation, expression of violence or destruction, sense of despair (Sarafolean, 2000), change in appetite, change in sleep pattern, body weight change, fatigue, decreased libido, difficulty concentrating, and feeling of worthlessness. Similar definitions are given by Berk (2002) who explains that depression in adolescents is characterized by feelings of sadness, confusion, and despair in life, which are expressed in the forms of indifference in doing activities, insomnia, loss of appetite, and lack of concentration and energy, which are commonly found in depressive adolescents. Finally, (Beck, 1976 cited in Lewinsohn, Thomas, & Rhode, 2001) characterizes depression in adolescence as sadness, suicidality, low energy, apathy, psychomotor retardation, sleep disturbance, and poor concentration.

4. Relationships between caregiver - child bonding and depression in adolescence

Parents constitute an important source of social support which enables individuals to cope with stress. At the same time, adolescents' relationship with parents and family members can be a cause of stress. Both positive and negative changes in the family can cause stress (Mahatnirankul, Poompaisan, & Tapanya, 1997), as well as changes in other families such as siblings, which have an effect on independence and self-confidence of adolescents, which in turn, influence other behaviors of adolescents.

Coopersmith (1967) contends that one of the most important factors that affect development of sense of self-esteem in adolescents is the relationship between parents and adolescents under the following conditions:

-Parents completely or almost completely accepting ideas and values of children

-Parents clearly specifying boundary for children's actions and paying attention to children's actions to instill sense of stability and security

-Parents respecting children and giving them freedom within the set boundary while emphasizing rewards more than punishments

Field et al. (1995) conducted a study and found that closeness between parents and adolescents is positively related to adolescents' sense of self-esteem. In other words, adolescents who have high self-esteem have a close relationship with their parents, while those who have depression and suicidal thoughts are not so close to their parents.

Vance et al. (2002) also report that adolescents with a history of aggression and negative parent-child relationships were more likely to have worse behaviors in a one-year follow-up, just like lower IQ. In contrast, positive behaviors at one-year follow-up could be predicted by a consistent parent employment, positive parent-child relationships, and high levels of current family support, etc.

According to Shives (2005), adolescents whose mothers are unavailable, unresponsive, or unsupportive are more likely to develop depression. In addition, adolescents who are raised with overprotection, in a broken family, in a family with absence of limit setting, with bad family experiences, and with a parental divorce tend to be less capable of adaptation and functioning, leading to depression and possible

suicide (Compton et al., 2005; Hammen et al., 2004; Hill et al., 2004; Hollis, 1996; Jaffe et al., 2002; Lewinsohn et al., 1998; Martin et al., 2004; Stein, 2000; Wu, 2004).

Besides, there is a relationship between parents' mental status and depression in adolescents. Parents who are depressive tend to lead their children to depression. It has also been found that the mother has the highest level of influence on depression in each developmental stage of children and adolescents. Other risk factors are variation in family patterns, mental well-being of family members, illegal activities of the family, and strictness of parents (Jaffe et al., 2002; Lewinsohn et al., 1998).

Family functioning (Crane, 2005) and family structure (Kaltiala-Heino, Rimpela, Rantanen, & Laippala, 2001) also have an effect on depression in adolescents. If there is a lack of a warm family relationship, lack of attention, or lack of guidance, adolescents can easily develop depression. Furthermore, substance abuse in the family, as well as current stressful situations like parental divorce or death of a family member, can lead to depression in adolescents. Compton (2005) points out those adolescents who live in a family with poor adaptation entertain more suicidal thoughts than those who live in a family with good adaptation.

5. Relationships between locus of control and depression in adolescents

Lazarus & Folkman (1984) explain internal and external locus of control as follows:

Internal locus of control is a resource of adolescents as explained in the concept of Lazarus & Folkman (1984) which was developed based on the Social Learning Theory of an American psychologist named Rotter. It has been observed that human behaviors result from individual learning and experiences. One important component of the Social Learning Theory is internal and external locus of control of individuals. According to Rotter, internal and external locus of control of individuals can be divided into two characteristics as follows:

1. External locus of control of individuals refers to individuals' beliefs or perceptions that the events or things around them result from external power beyond their control such as fate, destiny, coincidence, or other individuals' influences.
2. Internal locus of control of individuals refers to individuals' beliefs or

perceptions that events or things that happen in their life result from their own action or capability.

Rotter explains internal and external locus of control in a step-by-step manner. An outcome from individuals' action brings about an expectation to receive similar outcomes from similar actions. If their expectation is fulfilled, it will be increased. However, if they are disappointed, their expectation will decrease. Put another way, a decrease or increase in individuals' expectation results from a certain behavior before expanding to cover other similar or relevant behaviors, which will eventually become individuals' major personality. If such experiences are frequently reinforced, individuals will tend to believe that they result from their own skills or capability. This is called internal locus of control. On the other hand, if such experiences are not frequently reinforced, individuals will begin to think that they are not outcomes of their own action, but they result from fate, destiny, coincidence, or environmental factors. This is called external locus of control. Such beliefs or perceptions lead individuals back to expectation of outcomes from new behaviors, as illustrated below.

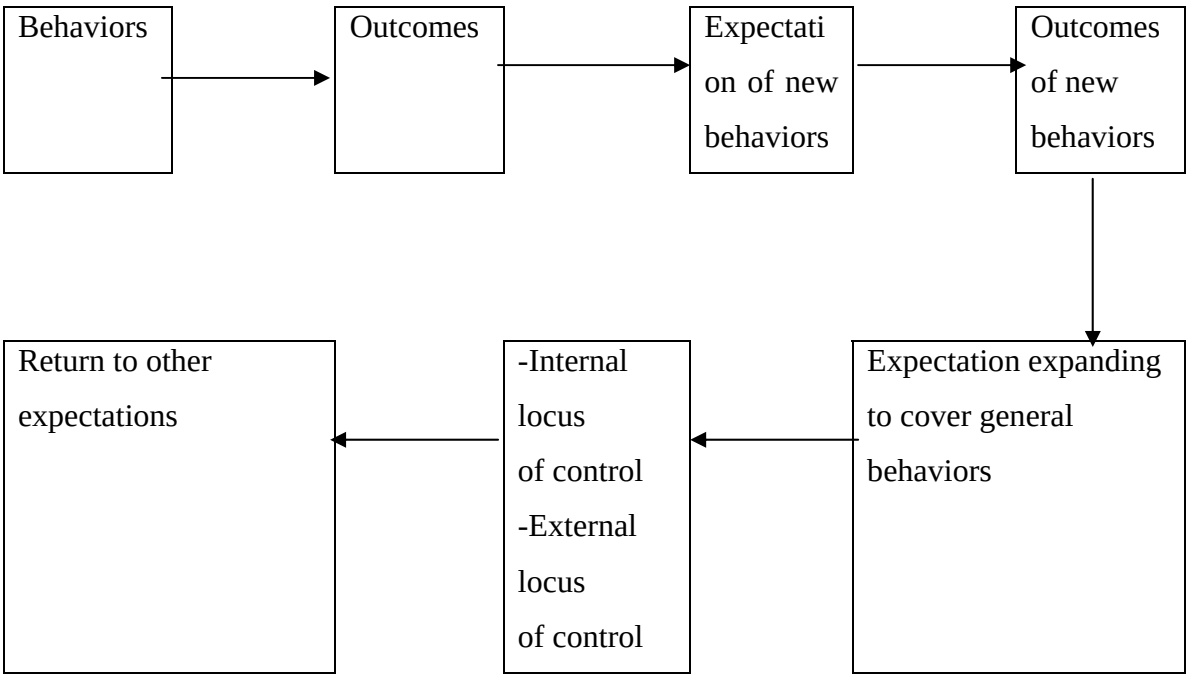

Figure 2: Developmental pattern of internal and external locus of control

Development of internal and external locus of control during childhood depends on age. According to Nowicki & Strickland (1973), children will have increased internal locus of control when they grow older. Development of internal and external locus of control results from various factors including childhood environment and experience, as well as socioeconomic status of parents.

There is a positive relationship between internal locus of control and age. When children grow older, their internal locus of control increases. Internal locus of control is also associated with learning achievement as children who have high learning achievement have more internal locus of control when compared to those with low learning achievement (Nowicki & Strickland, 1983).

Fogas (1992) studied locus of control as a mediator for negative divorce-related events and adjustment problems in children and found that locus of control is related to anxiety and depression.

Moreover, studies have also reported that adolescents' self-concept is associated with depression. That is, adolescents with a low sense of self-esteem tend to develop negative self-images, pessimism, and low locus of control, all of which are highly related to depression, substance abuse, and suicide (Martin, 2005; Sadock & Sadock, 2003; Shaffer & Craft, 1999; Stahl & Petersen, 1999). Likewise, Kim (2003) found that there is a relationship between internal locus of control and depression in adolescents. In addition, Martin (2005) carried out a study and reported that external locus of control of students were statistically significantly related to suicidality as students with a high score of LOC (locus of control) had a high level of suicidal thoughts. Also, adolescents who feel that they have little control over their learning tend to have a high level of depression (Hillsman & Garber, 1995). Finally, internal locus of control of Japanese adolescents is negatively related to depression (Takakura & Sakihara, 2001).

Therefore, it could be concluded that development of internal and external locus of control of adolescents will lead to appropriate coping, which, in turn, can help reduce mental problems and behavioral problems of adolescents.

6. Relationships between coping and depression in adolescence

Stress is an event which can usually take place in daily living of individuals. It is difficult for any individual to avoid stress. It can be said that individuals have to constantly live with stress. A review of literature has revealed that coping has been defined differently by different scholars and researchers as follows:

Trakulsarit (2001) defines coping as a process in which individuals make an attempt to adjust themselves when facing problems, difficulties, tension, sufferings, or stress, to enable them to continue living happily in the environment.

Kojakrai (2001) defines coping as a process which individuals use to deal with what they perceive as harm or threat, which are expressed in the forms of different behavioral patterns with an aim to stop, relieve, or eliminate such harm or threat.

According to Lazarus & Folkman (1984), coping is thinking or behavioral attempt of individuals to deal with specific needs or conflicts, both internally and externally, which are appraised as taxing and exceeding individual resources. Stress coping is a process that is constantly changing depending on individuals' cognitive appraisal and balance between demand and resources available.

Based on these definitions, it can be summarized that coping is a cognitive process in which individuals perceive and express different behaviors to deal with stress or problems they are facing to serve and maintain internal and external needs.

When adolescents face developmental stress, stress in daily living, and environmental stress, and when they use cognitive appraisal to judge the situation as stressful, they need to attempt to use coping to maintain their balance. Coping strategies of adolescents are complex (Liu, Tein, & Zhao, 2004), and they tend to change their thinking and behaviors constantly to deal with internal and external sources of stress. Coping strategies of adolescents include active coping/control coping, avoidant/passive coping/disengagement coping, distraction/accommodation coping, and support seeking coping (Ayelet et al., 1996; Cornor-Smith et al., 2000; Cornor-Smith & Campas, 2002; Gonzales et al., 2001).

The study findings of Arbeau & Ruth (2002) showed that high school students who had good problem-solving skills were more likely to feel that they were able to overcome their problems and to be less vulnerable to the problems. In addition, Chang (2002) found that there is a negative relationship between problem-solving skills and

stress and suicidality. In other words, adolescents who have good problem-solving skills have less tress and less suicidal thought. These research findings indicate that problem-solving skills are necessary and beneficial for adolescents. They enable adolescents to cope with stress and reduce suicidal thoughts, making adolescents able to maintain good mental health.

Gonzales et al. (2001) conducted a study and found that obstacles in appropriate adaptation to stress caused by close persons could cause depression in female adolescents, and that avoidance of confrontation with problems resulted in an increase in stress. It was also discovered that appropriate coping and support seeking helped decrease anxiety and depressive symptoms. On the contrary, avoidance of problems could increase the level of anxiety (Stahl & Petersen, 1999). Depressive symptoms generally include changes in sleeping pattern, loss of appetite, feeling of hopelessness, low self-esteem, apathy, loss of motivation to do activities, diversion in thinking, and suicidal thoughts (Carson, 2000; Oesterheld, Shader, Parmelee, & Sood, 2003; Shives, 2005).

As coping of adolescents is rather complex (Compas et al., 2001), it requires a number of factors to analyze or predict behaviors that will follow such as problem confrontation, problem avoidance, coping adaptation, coping control, and support seeking (Ayelet et al., 1996; Cornor-Smith et al., 2000; Cornor-Smith & Campas, 2002; Gonzales et al., 2001). Previous studies have suggested that adolescents who use problem solving (Ogul, 2003; Wilson, 2005), emotional modulation, acceptance, distraction, and positive thinking tend to have a low level of depression (Bonica, 2003), whereas adolescents who opt for aggressive adaptation (Murberg, 2005), avoidant coping, or substance abuse (Christiane, 2005) are more likely to suffer from depression.

CHAPTER III
METHODOLOGY

The present descriptive study aimed to investigate the relationships between caregiver – child bonding, locus of control, coping, and depression in adolescents.

Research Design

This was a descriptive study.

Population and Sampling

The population of the present study was adolescents who were studying in Mathayomsuksa 2 in the academic year 2006 in Buriram Province.

The sample size was obtained using power analysis (Cohen, 1992) with the statistically significant level (α) set at 0.05, power of test at 0.80, and small effect sized at 0.20. The result of the power analysis was 547 subjects.

Multi-stage random sampling was employed to select Mathayomsuksa 2 students studying in schools under the Department of General Education, Ministry of Education, in Buriram Province as follows:

First, the random sampling was used to select one school from 13 large –size schools, two schools from 29 medium-size schools, and the other two schools from small schools. The results were Burirampittayakom School, Romburipittayakomratchamakala- pisek School and Huayrajpittayakom School, Sawaijeekpittayakom School and Kanoksilppittayakom School respectively.

Second, Mathayomsuksa 2 classes were randomly selected from these schools as follows:

Four classrooms were randomly selected from Burirampittayakom School, There were 200 students participated to this study.

Three classrooms were randomly selected from Romburipittayakomratchamakala-pisek School, There were 100 students participated to this study.

Three classrooms were randomly selected from Huayrajpittayakom School, There were 107 students participated to this study.

Two classrooms were randomly selected from Sawaijeekpittayakom School, There were 80 students participated to this study.

Two classrooms were randomly selected from Kanoksilppittayakom School, There were 81 students participated to this study.

The descriptions of the sampling method of this study are the diagram as follow;

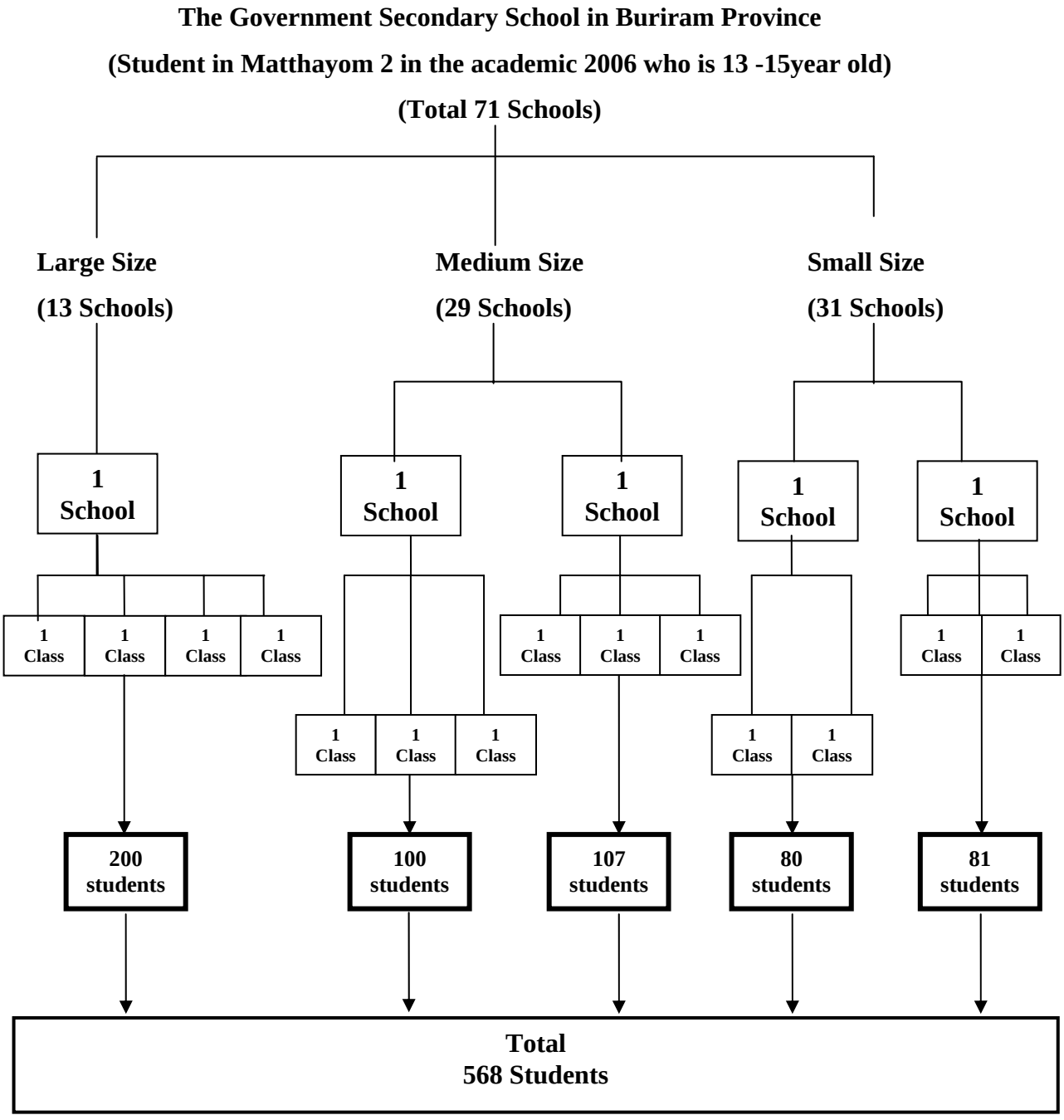

Figure 3 Diagram of Sample sampling of the study

Settings

The research setting for this study was Buriram Province. Five schools under the Department of General Education, Ministry of Education which offered classes in Mathayomsuksa 2 level were sampled. They were Burirampittayakom School,

Romburipittayakomratchamakala-pisek School, Sawaijeekpittayakom School, Kanok-silppittayakom School, and Huayrajpittayakom School.

Research Instrumentation

There are 5 instruments used to collect data in this present study as follows:

1. The Demographic Characteristics Questionnaire was designed to elicit data regarding demographic characteristics of the subjects including gender, age, number of family members, parental marital status, parents' educational background, and parents' occupation. There are ten items.

2. The Children's Depression Inventory (CDI) was the Thai version translated from the original version of Kovacs (1991) by Trangkasombat and colleagues in 1997. This instrument was adapted from the Beck Depression Inventory (Beck, Rial, & Rickels, 1974). This instrument consisted of 27 items regarding different depression symptoms which found in child. The respondents were required to assess themselves in the past two weeks by choosing the response which best represented what their self-report. The scores for each of the 27 items in the questionnaire were three choices which ranged from 0 to 2 as follows: The total scores ranges from 0 to 54 points. As for interpretation of scoring, the cut-off point with clinical significance is 15 points. However, the cut-off point for epidemiological screening is either 19 or 21 points. The Depression Inventory (CDI) consists of 5 subscales of depression symptom and the items that require reversal before summing are marked with an asterisk in the right hand column of the following table. (Department of Mental Health, www.dmh.go.th/test/cesd/)

1. Negative Mood; Item 1, 6, 8, 10, 11, and 13
2. Interpersonal Problem; Item number 5, 12, 26, and 27
3. Ineffectiveness; Item number 3, 15, 23, and 14
4. Anhedonia; Item number 4, 16, 17, 18, 19, 20, 21, and 22
5. Negative Self-esteem; Item number 2, 7, 9, 14, and 25

Item number; 1, 3,4,6,9,12,14,17,19,20,22,23,26,27	Few = 0 Often =1 Always = 2
Item number; 2,5,7,8,10,11,13,15,16,18,21,24,25	Few = 2 Often = 1 Always = 0

The reliability of the Thai version of the Children's Depression Inventory (CDI) is 0.83 (Trangkasombat et al., 1997). In this study, the instrument was tried out with a group of Mathayomsuksa 2 students who shared similar characteristics with the subjects of the main study. Cronbach's Alpha was equal to 0.765. The reliability of the instrument when used with the subjects of the study was 0.83.

3. The Parent Bonding Instrument (PBI), developed by Parker et al. (1979), is a questionnaire which elicited adolescents' perceptions of parents' behaviors and attitudes expressed towards them in the following domains: care, love, attention, cooperation, access, household rules and regulations, control and punishment, protection, promotion of independence, and adolescents' self-reliance. The instrument was back and forth translated into the Thai language. It consists of 25 items arranged in a four-point rating scale to represent the expression of parents or caregivers of adolescents. The response format is 'very like = 3,' 'moderately like = 2,' 'moderately unlike = 1,' and 'very unlike = 0' in positive question and it was inverse response format in negative question. The total score ranged from 0 – 75 points. The questionnaires consist of two aspects in caregiver – child bonding. They are as follows.

3.1 *Care*: The care aspect consists of 12 items. Six of items were positive question these were number 1, 5, 6, 11, 12, and 17. Six of items were negative question which were number 2, 4, 14, 16, 18, and 24. It regards adolescents' perceptions of their relationship with parents or caregivers which could be classified as either 'care/involvement' or 'indifference/rejection'. High scores in this aspect

reflected the caregiver-child bonding which could be characterized by care, affection, attentiveness, and freedom of thinking and actions.

The reliability of the care aspect of the Parent Bonding Instrument (PBI) ranges from 0.77 to 0.83 (Parker, 1998). In this study, the instrument was tried out with 36 students who had similar characteristics with those of the subjects of this study. Cronbach's alpha was 0.89. Because of reliability coefficient value which is over 0.70 are considered satisfactory. The Parent Bonding Instrument (PBI) had an appropriate Cronbach's alpha. Therefore, the care subscale measured the same characteristics within care subscale. Cronbach's alpha of the instrument when used with 568 subjects of the study was .74.

3.2 *Overprotection*: The protection aspect consists of 13 items. Seven of items were positive question which were number 8, 9, 10, 13, 19, 20, and 23. Six of items were negative question which were number 3, 7, 15, 21, 22, and 25. It regards adolescents' perceptions of their relationship with parents or caregivers which could be classified as either 'control/overprotection/intrusion' or 'encouragement of autonomy and independence.' High scores of this domain reflected the parental-adolescent bonding which could be characterized by protection, control, and attempt to make adolescents inadequate and reliant.

The reliability of the protection aspect of the Parent Bonding Instrument (PBI) ranges from 0.83 to 0.86 (Parker, 1998). In this study, the instrument was tried out with 36 students who had similar characteristics to the characteristics of the subjects of this study. Because of reliability coefficient value which is over 0.70 are considered satisfactory, the Parent Bonding Instrument (PBI) had an appropriate Cronbach's alpha. Therefore, the care subscale measured the same characteristics within care subscale. Cronbach's alpha of the instrument when used with 568 subjects of the study was 0.70.

4. The Locus of Control Scale was adapted from the Nowicki-Strickland Locus of Control Scale for Children (CNSIE) which developed by Nowicki & Strickland (1973) to assess perception of child who was 9-18 year old about the internal and external locus of control. They are 40 close-ended items which required the answer to respond with a 'yes' or 'no'. The positive question which answer 'yes = 1' and 'No = 0' were item number 1, 3, 5, 7, 8, 10, 11, 12, 14, 16, 17, 18, 19, 21, 23, 24, 27, 29, 31,

33, 35, 36, 37, 38, and 39. The negative question which answer 'No = 1' and 'yes = 0' were item number 2, 4, 6, 9, 13, 15, 20, 22, 25, 26, 28, 30, 32, 34, and 40. The total scores ranges from 0 to 40. High scores of the Locus of Control Scale indicate that adolescents believed that different events in life are beyond their control and they are determines situation by external factors or destiny. On the contrary, low scores of the scale meant that adolescents believe that different events in life resulted from their own actions. However, the scale had never been used or calculated for norms of scoring in Thai adolescents.

The reliability of The Locus of Control Scale when it was used with Grades 3 and 4 students was 0.63, Grades 6, 7, and 8 students was 0.68, Grades 9, 10, and 11 students was 0.74, and Grade 12 students was 0.81 (Nowicki & Strickland, 1973). The questionnaire was back and forth translated into Thai. The instrument was then tried out with 36 students who had similar characteristics with the subjects of the study; Cronbach's Alpha was 0.55 (n=36). The reliability of the instrument when used with the subjects of the study was 0.63 (n=568). Because of the Locus of Control Scale was the first translation in Thai language which was different culture and context from the western country. So the scales lower than the previous study.

5. The Adolescent-Coping Orientation for Problem Experiences (A-COPE) was constructed by Patterson & McCubbin (1995) to elicit information regarding problem-solving of adolescents. The questionnaire was translated into Thai by the researcher. It was composed of 54 items which are arranged in a five-point rating scale which represented frequency of different methods adolescents used to solve problems. The scores for each of the responses were as follows: 1 = Never, 2 = Hardly ever, 3 = Sometimes, 4 = Often, 5 = Most of the time. The total scores ranges from 54 to 270 points. The nine negative items must be reversing (7, 8, 19, 24, 26, 28, 42, 46 and 46). High score refer to the adolescents use multi-coping strategies and low score refer to the adolescents did not use multi- coping strategies with the stressful event in their life.

The reliability of The Adolescent-Coping Orientation for Problem Experiences (A-COPE) was tried out with 36 students who had similar characteristics to the characteristics of the subjects of this study Cronbach's alpha was 0.83. Because of reliability coefficient value which is over 0.70 are considered satisfactory, the

Adolescent-Coping Orientation for Problem Experiences (A-COPE) had an appropriate Cronbach's alpha. Therefore, A-COPE subscale measured the same characteristics within care aspect. The reliability of instrument when used with 568 subjects of the study was 0.84.

Validity of the Instruments

The Parent Bonding Instrument, The Locus of Control Scale, and The Adolescent-Coping Orientation for Problem Experiences were examined by a panel of three experts to ensure content validity and language appropriateness. These clinical experts included one psychiatric nurse, one psychiatrist, and one psychologist. The instruments were then revised and improved based on the experts' comments and suggestions.

Data Collection

A letter from the Graduate School of Mahidol University was submitted to the directors of the schools to ask for permission to collect data from high school students. The researcher met the directors of the schools, heads of student affairs, and heads of student counseling of Burirampittayakom School, Romburipittayakomratchamakala-pisek School, Sawaijeekpittayakom School, Kanoksilppittayakom School, and Huayrajpittayakom School to explain the research objectives, data collection procedures and asked for consent to participate in the study from the parents or caregivers and Mathayomsuksa 2 students. After consent forms were granted, the researcher distributed and collected all five questionnaires to the students. It took approximately 45 – 60 to complete all five questionnaires. Data collection took place from June 19 to June 30, 2006, from 8:00 a.m. to 4:00 p.m. The data obtained from the study sample were statistically analyzed.

Human Subjects Protection

The Committee on Human Rights Related to Human Experimentation of Mahidol University approved the protocol for this study on May 25, 2006.

The researcher proceeded with data collection with full awareness and respect of the human rights of the study sample. The researcher clearly explained the research

objectives, data collection procedures, and expected outcomes and benefits to the subjects and their parents. The subjects and their parents were given the opportunity to ask questions, and they were asked to sign the informed consent forms before data collection took place.

During data collection, the subjects completed the questionnaires by themselves. If they did not understand any of the items or have questions, the researcher would explain and review the items before letting them respond freely. The researcher was careful not to ask leading questions. Participation in this research was completely voluntary. There were no risks to being in the study. The subjects were assured that they could withdraw from the study at any time if they wished, without having to give any reasons to the researcher, and their withdrawal would not affect them or their study in any way. Participants' name and the other identified information were not linked to the questionnaires. To ensure confidentiality, the demographic questionnaires and self-report instruments were not identified by name but by code number.

Data Analysis

The data gathered from the study sample were analyzed using the SPSS for Windows Program. Descriptive statistics were used to analyze demographic characteristics of the subjects in terms of frequency, mean, percentage, and standard deviation. Data regarding locus of control, caregiver-child bonding, coping, and depression among adolescents were analyzed in terms of mean and standard deviation. Data regarding locus of control, caregiver-child bonding, and coping were analyzed to determine the relationship between these factors and depression among adolescents using Pearson's Produce Moment Correlation Coefficient.

CHAPTER IV
RESULTS

The present study aimed to investigate the relationships between caregiver - child bonding, locus of control, coping, and depression in adolescents. The sample of the study consisted of 568 Mathayomsuksa 2 students in Buriram Province in the academic year 2006. The research settings were Burirampittayakom School, Rom-buripittayakomrajamankalapisek School, Sawaijeekpittayakom School, Kanoksilp-pittayakom School, and Huayrajpittayakom School.

In this chapter, the study findings are presented in the form of tables with descriptions in two parts as follows.

Part I: Demographic characteristics of the subjects

Part II: Relationships between caregiver-child bonding, locus of control, coping, and depression in adolescents

Part I Demographic characteristics of the subjects

Table 1. Demographic characteristics of the subjects classified by gender, Grade Point Average, and chronic illness

Demographic characteristics	Mean (SD)	Number (n=568)	Percentage (%)
Gender			
Male		212	37.3
Female		356	62.7
Age			
(range 13 – 15 years)	13.30 (0.51)		
Grade Point Average	2.926 (0.73)		
1.00 – 1.99		65	11.4
2.00 – 2.99		201	35.4
3.00 – 4.00		302	53.2
Chronic illness			
Not having		553	97.4
Having		15	2.6
-Allergy		10	1.8
-Musculoskeletal diseases		2	0.4
-Peptic ulcer		1	0.2
-Epilepsy		1	0.2
Living with			
Single Parent		81	14.3
Father and mother		413	72.7
Grandparent		54	9.5
Others (Aunt/Uncle)		20	3.5

According to Table 1, the sample was compose of 356 female (62.7%) and 212 ranging in age from 13 to 15 years with a mean age of 13.30. Most of the sample (302 persons or 53.2%) had a good to excellent GPA (grade point averages ranging from

3.00 to 4.00). Almost all, or 97.4%, did not have a chronic illness that required continuous treatment.

Table 2. Demographic characteristics of caregiver of the subjects classified by living with, caregiver marital status, caregiver educational background, and caregiver occupation

Demographic characteristics	Number (n = 568)	Percentage (%)
Caregiver marital status		
Separated/Divorced/Widowed	90	15.8
Married	478	84.2
Caregiver educational background		
No formal education	36	6.3
Elementary education	255	44.9
Secondary education	112	19.7
Certificate or diploma	27	4.8
Undergraduate or higher	138	24.3
Caregiver occupation		
Unemployment	36	6.3
Agriculture	203	35.7
Employment	132	23.2
Government	118	20.8
Merchant	85	15.0

Table 2 shows that close to three-fourths of the subjects (413 individual or 72.7%) were living with their father and mother, and (478 individual or 84.2%) parents who were living together as a family. Furthermore, the largest group of caregivers (255 individual or 44.9%) completed elementary education. Most of the caregivers were agriculturists (203 individuals or 35.7%)

Table 3. Mean, Standard Deviation, Actual Range, and Possible Range of the Caregiver - child bonding, Locus of control, Coping, and Depression of the subjects

Variables	Mean	SD	Actual Range	Possible Range
Caregiver - child bonding				
- Care	24.21	6.006	1 – 36	0 - 39
- Overprotection	16.32	4.852	1 – 32	0 - 36
LOC (Locus of Control)	16.20	3.819	7 – 27	0 - 40
A-COPE (Coping)	173.16	17.99	94 – 233	54 - 270
CDI (Depression)	12.20	6.528	0 – 39	0 – 54

Note: SD = Standard Deviation,

As illustrated in Table 3, the mean score of the care aspect of caregiver-bonding was 24.21 out of the total score of 36, while the mean score of the overprotection aspect of caregiver-bonding was 16.32 out of the total score of 32. Moreover, the mean score of the LOC was 16.20 out of the total score of 40, the mean score of the A-COPE was 173.16 out of the total score of 270, and the mean score of the CDI (depression) was 12.20 out of the total score of 54.

The subjects who have depression score upper than 15 points =151 students about 26.6% and it refer to they have depression symptoms. The subjects who have no depression score lower than 15 points = 417 students about 73.4 % and it refer to they have no depression symptoms.

Part II: Relationships between caregiver - child bonding, locus of control, coping, and depression in adolescents

Table 4 Relationships between caregiver - child bonding, locus of control, coping, and depression of the subjects.

Variables	Caregiver – Child bonding (Care aspect)	Caregiver – Child bonding (Over protection aspect)	Locus of Control	Coping	Depression
Caregiver–Child bonding					
- Care aspect	1.00				
- Overprotection aspect	-.494**	1.00			
Locus of Control	-.476**	.33**	1.00		
Coping	.444**	-..282**	-.216**	1.00	
Depression	-.520**	.329**	.473**	-.234**	1.00

**** P ‹ .01**

According to Table 4, the score of the care aspect of the caregiver-child bonding was negatively correlated with the score of depression with statistical significance ($r = -.520$, $p < .01$). On the other hand, the score of the overprotection aspect of the caregiver-child bonding was positively correlated with the score of depression with statistical significance ($r = .329$, $p < .01$). Besides, the score of the locus of control was positively correlated with the score of depression with statistical significance ($r = .473$, $p < .01$), whereas the score of coping was negatively correlated with the score of depression with statistical significance ($r = -.234$, $p < .01$)

CHAPTER V
DISCUSSION

The present study aimed at investigated the relationships between caregiver-child bonding, locus of control, coping, and depression in adolescents based on the conceptual framework of Lazarus & Folkman (1984). In this chapter, the study findings are discussed according to the research hypotheses as follows:

1. Relationship between caregiver-child bonding and depression in adolescents

The caregiver-child bonding could be divided into two aspects—the care aspect and the overprotection aspect. As for the former, high scores in the care aspect indicated that parents or caregivers raised their child with love, care, affection, and emotional warmth. They paid attention to child's feelings and thinking. As regards the latter, high scores in the overprotection aspect indicated that the parents or caregivers were overprotective of their child. In other words, they controlled the child too much and did not allow their child to take care of themselves or to be self-reliant. The relationship between caregiver-child bonding and depression in adolescents could be explained as follows:

1.1 The care aspect of caregiver-child bonding was negatively related to depression in adolescents with statistically significance ($r = -.520$, $p < .01$) (Table4). This finding supported the hypothesis of this study. The explanation is that if child received appropriate care from their parents or caregivers, they would not have a depression. On the other hand, if the parents or caregiver did not have much care or attention for their child, their child would have a depression.

2. The overprotection aspect of caregiver-child bonding was positively related to depression in adolescents with statistically significance ($r = .329$, $p < .01$) (Table 4). This finding supported the hypothesis of this study. This could be explained that if parents or caregivers were overprotective of their child and did not allow them to appropriately develop a self-reliance or independence, they would have the depression.

By contrast, if parents or caregivers did not overprotect their child, the child would not have the depression.

In fact, adolescents have to deal with different stressful situations in their life. They are in the transition period when they are leaving childhood and entering adulthood, and they need to learn to accept both physical changes and maturity changes. Development stages of the adolescents consist of becoming emotionally independent from their parents or caregivers, learning to be socially responsible and socially accepted values as norms, studying in school to ensure cognitive and intellectual development, and establishing relationships with close friends and peer - groups (Rice & Dolgin, 2005). All of these situations can lead the adolescents to stress in their life. On the other hand, adolescents have to live with possible conflicts between their friends and their teachers, studying pressure, conflicting parenting styles, socioeconomic changes of the family, distraction caused by gambling and substance abuse in the society (Murberg, 2005), as well as family conflicts, parents' divorce, or death of their parent (Hamrin & Pachler, 2005), all of which can be a source of stress in adolescents' life as well.

According to Lazarus & Folkman (1984), social interaction can be either a cause of stress or a valuable resource for individuals. It can be a significant source of social support which makes individuals feels that they are cared for and valued by others, thus assisting them in prevention of stress and subsequent sickness. It also helps with individuals' coping as it makes them feel that they are loved and trusted by others, and this can bring about the sense of self-pride of individuals. Individuals also feel that they are able to utilize resource and support to deal with stress. On the other hand, family interaction can also be seen as a cause of stress of individuals. This is because when there are conflicts in the family, with destructive interaction pattern or pathogenic interaction pattern, or divorce, individuals can become under considerable stress.

In this study, adolescents who perceived the care of their parents, as shown by high scores in the care aspect of the caregiver bonding, received reinforcing factors which enabled them to become emotionally and behaviorally independent, develop self-control, and become confidence in the relationship and bonding they shared with their parents or caregivers. They could more easily develop perceived self-efficacy,

which is an important resource that makes individuals effectively deal with stress and avoid depression. On the contrary, if the adolescents perceived that their parents were overprotective, they would experience intrusion and interference, making them feels distrusted and lack sense of self-pride. If the condition persisted, adolescents may have to live with chronic stress and become unable to make use of both external and internal resources to cope with stress. As a consequence, these adolescents will eventually suffer from depression (Rice & Dolgin, 2005).

The findings of the present study were consistent with the findings of a number of previous studies on caregiver bonding, family functioning, and depression in adolescents. That is, changes in life experiences leading to stress and depression in adolescents were associated with perceived caregiver bonding. Put another way, adolescents who felt that their parents did not care for them, that they did not receive assistance from parents, that their parents were too protective (Hill, 2004; Kaltiala-Heino, Rimpela, Rantanen, & Laippala, 2001; Kim & Ermolina, 1998; Martin et al., 2005; Parker, 1994; Stein et al., 2000), and that their mothers were unavailable, unresponsive, or unsupportive (Shives, 2005) were more likely to develop and suffer from depression. In addition, there is a relationship between parents' lack of understanding of adolescents' problems and difficulties and parents' aggressive or violent behaviors and adolescents' depression and suicidal behaviors (Hollis, 1996). In contrast, happiness, lack of depression, or a low risk of depression was found to be associated with positive family relationship (Herman-Stahl, 1999). Finally, depression in adolescents was also found to be related to low levels of family cohesion and support (Kim & Ermolina, 1998), poor family functioning, and family conflicts and dysfunctional interaction pattern (McCubbin, et al., 1997).

2. Relationship between locus of control and depression in adolescents

According to the study findings, the locus of control was a positively related to depression in adolescents with statistically significance ($r = .47$, $p < .01$) (Table 4). This finding supported the hypothesis of this study. This can be explained that adolescents who had a high score of locus of control, believing that stressful situations in their life were beyond their controlling as they resulted from external factors or fate and then they would have a depression. On the contrary, adolescents who had a low

score of locus of control believed that the stressful situations in their life resulted from their own actions and they can control it by themselves and then they would not have a depression.

According to the aforementioned stressful situations, adolescents had to make great efforts to adapt themselves and maintain balance and well-being in life. Lazarus & Folkman (1984) point out that individuals' locus of control is individuals' appraisal of stress situations and their coping resources. As such, individuals with locus of control will assess ambiguous situations as controllable and they will encounter stress situations with self-confidence and perceived self-efficacy to control the outcomes. In addition, they will try to be patient and use perseverance to cope with stress. They are more likely to employ more problem-focused coping and task-related coping behaviors than those who have a high level of external locus of control (Lazarus & Folkman, 1984). A study has reported that the use of problem-focused coping is related to reduction in depression in adolescents.

Besides, the present study also found that adolescents who had internal locus of control that made them believe that their action may make others like or dislike them or hard work always paid off were more likely to make good planning and struggle to accomplish their goals. Thus, they would have a lower level of depression. Likewise, Kim (2003) found that the locus of control related to the depression in Korean adolescents. Similar findings were reported by studies which conducted in Japan, it revealed that the locus of control was negatively related to the depression and the helplessness in Japanese adolescents as well (Takakura & Sakihara, 2001; Takakura & Sakihara, 2002). These findings agreed with the findings of Martin, et al. (2005) and Herman-Stahl (1999) that adolescents with a high level of internal locus of control, believing that they had the capability to control situations in life, had a low risk to develop depression or entertain a suicidal thought.

3. Relationship between coping and depression in adolescents

According to the study findings, the coping was a negatively related to the depression in adolescents with statistically significance ($r = .23$, $p < .01$) (Table 4). This finding supported the hypothesis of this study. This could be explained that adolescents who used different coping strategies had a low or no level of depression.

On the contrary, adolescents who had limited coping strategies were more likely to obtain a high score of depression and have depressive symptoms.

Lazarus & Folkman (1984) contend that coping is individuals' attempt to continuously change their thinking and behaviors depending on the situations which are assessed as stressful. Individuals may make use of either problem-focused coping or emotion-focused coping. In fact, different strategies can be used simultaneously to achieve positive adaptation outcomes including social functioning, somatic health, well-being, morale, and life satisfaction. In contrast, depression is seen as a negative adaptation outcome which results from the feeling of helplessness.

Generally, adolescents have to face various stressful situations in their life. They are in the transition period when they are no longer child and are becoming adults. During this important transition period, they need to learn to accept both physical changes and maturity, become emotionally independent from their parents or caregivers, learn to be socially responsible and socially accepted values as a norms, establishing and maintenance a relationship with their peer groups (Rice & Dolgin, 2005), handle pressure in their school, deal with conflicts with their teachers or friends, live with possible conflicts between their parents, tolerate attraction and distraction from gambling and substance abuse in the environment (Murberg, 2005), and live with parents' divorce or death (Hamrin & Pachler, 2005).

In the present study, it was discovered that use of various coping strategies was negatively associated with depression. In other words, adolescents who knew how to use different strategies to cope with stress were less likely to suffer from depressive symptoms. Similar findings were reported by Stienberg (1999) who found that adolescents with different coping strategies had a lower level of depression when compared to those who had a limited number of coping strategies.

According to Lazarus & Folkman (1984), when individuals assess a situation as stressful events and believe that it affects their well-being, they will draw on both inner and outer resources to reduce or eliminate such stress. If individuals have various coping strategies, including problem-focus coping and emotion-focused form of coping, they are likely to be able to adapt themselves and maintain their well-being. Therefore, the findings of the present study were consistent with the concepts of stress and stress coping of Lazarus & Folkman (1984), as adolescents who had high scores of coping had a low level of depression.

CHAPTER VI
CONCLUSION

Summary of the Study

The present descriptive study investigated the relationships between caregiver – child bonding, locus of control, coping, and depression in adolescents based on the conceptual framework of Lazarus & Folkman (1984).

The sample of the study consisted of 568 Mathayomsuksa2 students in the academic year 2006 in Buriram Province. The sample size was obtained by using power analysis (Cohen, 1992) with the statistically significant level (α) set at 0.05, power of test at 0.80, and small effect sized at 0.20. The result of the power analysis was 547 subjects. Multi-stage random sampling was employed to select five schools under the Department of General Education, Ministry of Education, in Buriram Province. They were Burirampittayakom School, Romburiratchamakala-pisek School, Sawaijeekpittayakom School, Kanoksilppittayakom School, and Huayrajpittayakom School. Then, four classrooms were randomly selected from Burirampittayakom School, resulting in 200 subjects; three classrooms were randomly selected from Romburiratchamakala-pisek School, resulting in 100 subjects; three classrooms were randomly selected from Huayrajpittayakom School, resulting in 107 subjects; two classrooms were randomly selected from Sawaijeekpittayakom School, resulting in 80 subjects, and two classrooms were randomly selected from Kanoksilppittayakom School, resulting in 81 subjects. The total number of subjects in this study was 568 subjects.

There were five questionnaires that were used to collect data in this study. First, demographic questionnaire consisted of 10 items. Second, the Thai version of the Child Depression Inventory (CDI) consisted of 27 items. Third, the Parents – Child Bonding Instrument (PBI) involving two aspects which were care aspect and overprotection aspect. It was 25 items which consist of care aspect about 13 items and overprotection aspect about 12 items. Fourth, the Locus of Control Scale composed of 40 items. The fifth instrument was the Adolescent-Coping Orientation for Problem

Experiences (A-COPE) which composed of 54 items. The Parents - Child Bonding Scale, The Locus of Control Scale, and The Adolescent-Coping Orientation for Problem Experiences which were back-forth translated into the Thai language were examined by a panel of three experts to ensure content validity and language appropriateness.

The Parents - Child Bonding Scale (PBI), The Locus of Control Scale (LOC), The Adolescent-Coping Orientation for Problem Experiences (A-COPE), and The Thai version of the Child Depression Inventory (CDI) were tried out with 36 Mathayomsuksa2 students of Phatraborpit School who similar with characteristics of the subjects and the reliability were as follow; Cronbach's Alpha of PBI car aspect was 0.89, Cronbach's Alpha of PBI overprotection aspect was 0.73, Cronbach's Alpha of LOC was 0.55, Cronbach's Alpha of A-COPE was 0.83, and Cronbach's Alpha of CDI was 0.76 respectively. And the reliability of four questionnaires in the study (n = 568) were as follow; Cronbach's Alpha of PBI in car aspect was 0.74, Cronbach's Alpha of PBI overprotection aspect was 0.70, Cronbach's Alpha of LOC was 0.63, Cronbach's Alpha of A-COPE was 0.84, and Cronbach's Alpha of CDI was 0.83, respectively.

After approval was granted from The Committee on Human Rights Related to Human Experimentation of Mahidol University on May 25, 2006, data collection is initiated on June 19 to June 30, 2006.

Summary of the Findings

1. Demographic characteristics of the subjects were that the majority of the subjects was female (62.7%), and more than half of the subject had a good to excellent GPA (grade point average ranging from 3.00 to 4.00) (53.2%). In addition, almost the entire subject did not have any chronic disease that required continuous treatment (97.4%). Close to three-quarters of all subjects lived with their father and mother (72.7%), and most of them had parents who lived as a family together (84.2%). Finally, 44.9% of the caregivers completed at elementary education, and 35.7% of the caregivers were agriculture (Table 1 and 2).

2. For the first hypothesis tested whether the caregivers - child bonding score in the care aspect is negatively related to depression score in adolescents with

statistical significance which supported this research hypothesis ($r = -.52$, $p<.01$) (Table 4).

3. For the second hypothesis tested whether the caregivers-child bonding score in the overprotection aspect was positively related to depression scores in adolescents with statistical significance which supported this research hypothesis ($r = .33$, $p<.01$) (Table 4).

4. For the third hypothesis tested whether locus of control score is negatively related to depression score in adolescents with statistical significance which supported this research hypothesis ($r = .47$, $p<.01$) (Table 4).

5. For the forth hypothesis tested whether coping score is negatively related to depression score in adolescents with statistical significance which supported this research hypothesis ($r = -.23$, $p<0.01$) (Table 4).

Implications and Recommendation

Implications for Nursing Practice

The result of this study have important implications for understanding important factors that are essential for prevention or reducing depression in adolescents, The implication for nursing practice base on these finding were presented as follow;

1. Psychiatric care team could develop the education program to instruct the adolescents and their teachers in schools about the factors which related to depression symptoms in adolescents about the caregiver – child bonding in the care aspect, caregiver – child bonding in the overprotection aspect, locus of control, and coping.

2. Psychiatric care team, psychiatric nurse, and school could use The CDI to assess

the depression symptoms in adolescents as screening test at least one time/year.

3. The factors which related to depression symptoms in adolescents were the caregiver – child bonding in the care aspect, caregiver – child bonding in the overprotection aspect, locus of control, and coping. Therefore psychiatric care team could develop the psychosocial education program to treat the depression symptoms in adolescents who had depression symptoms.

4. Psychiatric nurses can use these results to develop Adolescents Counseling Clinic about depression by coordinating responsibility of psychiatric nurses,

psychiatrists, psychiatric doctor and their schools in order to manage, primary treat, follow-up, record data, and referral .

Recommendations for future research

1. The further studies should more extensively investigate variables which related to depression in adolescents such as stressful- situations, self-esteem, social support etc.

2. This study was conducted only in adolescents who were in school system, therefore the further study should be conducted in adolescent who were in community.

3. The further study should be conducted to explore the factors that can predict the depressive symptoms in adolescents.

Limitations of the Study

The limitation of this study was as follow;

1. The Locus of Control Scale (LOC) was first translated into Thai language which was different culture and context from the western country. Then the reliability of The Parents - Child Bonding Scale (PBI) and The Locus of Control Scale (LOC) were lower than the previous study.

2. The Locus of Control Scale (LOC) did not have cut-off point to differentiate to external or internal locus of control in Thailand.

3. The subjects were adolescents in Buriram Province of Thailand, therefore the results could not be used or represent in generalize of all adolescent in Thailand.

REFERENCES

Ayelet, T. (2001). *Challenges and social support during the transition to high school.* Retrived October 5, 2005, from http://www.il.proquest.com/hp/product/ dissertation.html.

Bal, S., Crombez, G., Oost, P.V., & Debourdeaudhuij, I. (2003). The role of social support in well-being and coping with self-reported stressful events in adolescents. *Child Abuse & Neglect, 27,* 1377-1395.

Beck, A.T., Rail, W.Y., & Rickels, K. (1974). Short form of depression inventory: cross-validation. *Psychol. Rep, 34,* 1184-1186.

Berk, L. E. (2002). *Infants, children, and adolescents (4th ed).*New York: Allyn & Bacon.

Birmaher, B., Ryan, N.D., Williamson, D.E., Brent, D.A., & Kaufman, J. (1996). Children and adolescent depression: a review of the past 10 years part II. *Journal of American Academy Child and Adolescent Psychiatry, 35*(12), 1575-1583.

Bonica, C., & Daniel, J.H. (2003). Helping adolescents cope with stress during stressful times. *Pediatrics, 15,* 385-390.

Carson, V. B. (2000). *Mental health nursing: The nurse- patient journey (2nd ed).* Philadelphia: W. B. Saunder.

Child Development Institute. (2005). *Depression in children and adolescents,* Retrieved September 3, 2005, from http://www.depression%20in%20children%20and %20adolescents.htm.

Clarke, G. N., Lewinsohn, P. M., & Hops, H. (1990). Cognitive- behavioral group treatment of depression in adolescents. *Behavior Therapy, 21,* 385-401.

Clarke, G.N., Hawkins, W., Murphy, M., Sheeber, L.B., Lewinsohn, P.M.,& Seeley, J.R. (1995). Target prevention of unipolar depressive disorder in an at-risk sample of high school adolescents: a randomized trial of a group cognitive intervention. *Journal of American Academy Child and Adolescent Psychiatry, 34*(3), 312-321.

Cohen, J. (1992). A Power primer. *Psychological Bull*etin, *112*(1) 155-159

Coleman, J.C., & Hendry, L.B. (1999). *The nature of adolescence (3rd ed.).* London: Routledge.

Compton, M. T., Thompson N. J., & Kaslow N. J.(2005). Social environment factors associated with suicide attempt among low- income African Americans: The protective role of family relationships and social support. *Social Psychiatry Psychiatric Epidemiology, 40*(3), 175-185.

Constance, H., Brennan, P., & Shih, J.H. (2004). Family discord and stress predictors of depression and other disorders in adolescent children of depressed and nondepressed women. *Journal of American Academic of child and Adolescent Psychiatry,43*(8), 994–1002.

Cox, B.J., Enns, M.W., & Clara, I.P. (2000). The parental bonding instrument: Confirmatory evidence for a three-factor model in a psychiatric clinical sample and in the national comorbidity survey. *Soc Psychiatry Psychiatr Epidemiol, 35*, 353-357.

Department of Mental Health. (2001). Retrieved December 1, 2004, from www.dmh.go.th/test/cesd/

Dumas, J.E.,& Nilsen, W. (2003). *Abnormal child and adolescent psychology.* Boston: Pearson Education, Inc.

Franko, D.L., Moore, R. H. , Brown, K. M., Barton, B.A., McMahon, R. P., Schreiber, G. B., Crawford, P. B., et al. (2004). Expanding our understanding of the relationship between negative life events and depressive symptoms in black and white adolescent girls. *Psychological Medicine, 34*, 1319-1330.

Fogas, B.S., Wolchick, S.A., Braver, S.L., Freedom, D.S., & Bay, C. (1992). Locus of control; as a mediator of negative divorce-related events and adjustment problemsin children. *American Journal of Orthopsychiatry, 62*, 589-598.

Geldard, K., & Geldard, D. (1999). *Counseling adolescents: the pre-active approach* London: SAGE.

Haine, R.A., et al., (2003). Control and self-esteem in bereaved children. *Psychological Medicine, 34*, 620-640.

Hammen, C., Brennan, P.A., & Shih, J.H. (2004). Family discord and stress predictors of depression and other disorders in adolescent children of depressed and nondepressed women. *Journal of American Academy Child and Adolescent Psychiatry43*,(8); 994-1002.

Hamrin, V., & Pachler, M. C. (2005). Child & Adolescent depression:Review of the latest evidence. *Journal of Psychosocial Nursing, 43*(1), 54-63.

Hauenstein, E. J. (2003). Depression in adolescence. *JOGNN, 32*(2), 239-248.

Herman-Stahl, M., & Peterson, A.C. (1999). Depressive symptoms during adolescence:Direct and stress-buffering effects of coping, control beliefs, and family relationships. *Journal of Applied Developmental Psychology, 20*(1), 45-62.

Hill, J., Pickles, A., Rollinson, L., Davies, R., & Byatt, M. (2004). Juvenile- versus adult- onset depression: Multiple differences imply different pathways. *Psychological Medicine, 34*, 1483-1493.

Ho-Cheung, W.L., & Lopez, V. (2004). Chinese translation and validation of the Nowiki-Strickland locus of control scale for children. *International Journal of Nursing Studies, 41*, 463-469.

Holliss, C. (1996). Depression, family environment, and adolescent suicidal behavior. *Journal of American Academy Child and Adolescent Psychiatry, 41*(2),199-214.

Jaffee, S.R., Moffitt, T.E., Caspi, A., Fonbonne, E., Paulton, R., & Martin, J. (2002). Differences in early childhood risk factors for juvenile-onset depression. *Archives of General Psychiatry, 179*, 104-109.

Jaycox, L.H., Reivich, K.J., Gillham, J.& Seligman, E.P.(1994) Prevention of depressive symptoms in school children. *Behavior Research Therapy, 32*(8),801-816.

Kaltiala-Heino, R., Rimpelä, M., Rantanen, P., & Laippala, P. (2001). Adolescent depression: The role of discontinuities in life course and social support. *Journal of Affective Disorders, 64*, 155-166.

Kazdin, A.E. (1993). Adolescent mental health: prevention and treatment programs. *Am Psychol, 48*(2), 127-141.

Kim, L. & Ermolina, L. (1998). *Family dysfunction and depression among adolescents (cross-cultural study).* Posters Presentation on September 22, 1998. Moscow Research Institute of Psychiatry, Moscow, Russia.

Kim, Y.H. (2003). Correlation of mental health problems with psychological constructs in adolescence: Final results from a 2-year study. *International Journal of Nursing Studies, 40,* 115-124.

Kosunen, E., Kaltiala-Heino, R., Rimpelä§, M., & Laippala, P. (2003). Risk-taking sexual behaviour and self-reported depression in middle adolescence-a school-based survey. *Child: Care, health & development, 29*(5), 337-344.

Kovacs, M., & Goldston, D. (1991). Cognitive and social cognitive development of depressed children and adolescents. *Journal of American Academy Child and Adolescent Psychiatry,30*(3), 388-392.

Lazarus & Folkman, (1984). *Stress appraisal and coping.* New York: McGraw-Hill.

Lewis, M. (2002). *Child and adolescent psychiatry: A comprehensive textbook (3rd ed).* Philadelphia: Lippincott Williams & Wilkins.

Lewinsohn, P.M. & Clarke, G.N. (1999). Psychosocial treatments for adolescent depression. *Clinical Psychology Review, 19*(3), 329-342.

Lewinsohn, P.M., & Joiner Jr., T.E. (2001). Evaluation of cognitive diathesis-stress model in predicting major depressive disorder in adolescents. *Journal of Abnormal Psychology, 110*(2), 203-215.

Liu, X., Tein, J.Y., & Zhao, Z. (2004). Coping strategies and behavioral/emotional problems among Chinese adolescents. *Psychiatry Research, 126,* 275-285.

Lôôksmart. (1997). *Parental bonding and mental health in adolescence,* Retrieved March 25, 2005, from http://www.looksmart.com.

Lopis, E.J., Hosman, C., Jenkins, R.& Anderson, P. (2003). Predictor of efficacy in depression prevention programs: Meta- analysis. *The British Journal of Psychiatry, 183,* 384-397.

Martin, G., Richardson, A.S., Bergen, H.A., Roeger, L., & Allison, S. (2005). Perceived academic performance, self-esteem and locus of control as predicators of need for assessment of adolescent suicide risk: Implications for teachers. *Journal of Adolescence, 28,* 75-87.

Martin, G., Bergen, H.A., Roeger, L., & Allison, S. (2004). Depression in young adolescents investigations using 2 and 3 factor version of the parental bonding instrument. *The Journal of Nervous and Mental Disease, 192*, 650-657.

McCubbin, H.I., McCubbin, M.A., Thompson, A.I. (1996). *Family assessment: Resiliency, coping and adaptation inventories for research and practice.* Madison: University of Wisconsin.

McCubbin, H.I., McCubbin, M.A., Thompson, A.I., Han, S.Y., and Chad, T. (1997). Families under stress: What makes them resilient. *American Association of Family and Consumer Sciences Commemorative Lecture.* Washington, D.C.: June 22, 1997.

Meijer, S.A., Sinnema, G., Bijstra, J.O., & Mellenbergh, G.J. (2002). Coping styles and locus of control as predictors for psychological adjustment of adolescents with a chronic illness. *Social Science & Medicine, 54*, 1453-1461.

Merry, S., McDowell, H., Hetrick, S., Bir, J., & Muller, N. (2004). Psychological and/or educational interventions for the preventions of depression in children and adolescents. *The Cochrane Database of Systematic Reviews, Issue 2.*

Millet, P. & Sandberg, K.W. (2003). Locus of control and its relationship with vocational rehabilitation of unemployed sick leaves in Sweden. *Journal of Vocational Rehabilitation, 19*, 59-66.

Millin, R., Walker, S., & Chow,J. (2003). Major depressive disorder in adolescence: A brief review of the treatment literature. *The Canadian Journal of Psychiatry, 48*, 600-606.

Monroe, S. M., Rohde, P., Seeley, J.R., & Lewinsohn, P.M. (1999). Life event and depression in adolescence: Relationship loss as a prospective risk factor for first onset of major depressive disorder. *Journal of Abnormal Psychology,108*(4), 606-614.

Moos, R.H. (2001). Life stressors, social resources, and coping skills in youth: Applications to adolescents with chronic disorders. *Journal of Adolescent Health,30*(45), 22-29.

Murberge, T., & Bru, E. (2005). The role of coping styles as predictors of depressive symptoms among adolescents: A prospective study. *Scandinavian Journal of Psychology, 46*, 385-393.

Neinstein, L.S. (1996). *Adolescent health care: A practice guide (3rd ed).* Los Angeles: Williams & Wilkins.

Noble, T., & McGrath, H. (2005). Emotional growth: Helping children and families "bounce back". *Australian Family Physician, 34*(9), 749 – 752.

Nowicki, S., & Duke, M.P. (1983). The Nowicki–Strickland internal–external control scale: construct validation. In H.M. Lefcourt (ed.). *Research with the locus of control construct: Development and social problem.* New York: Academic press.

Nowicki, S., & Strickland, R. (1973). A locus of control scale for children. *Journal of Consulting and Clinical Psychology, 40*(1), 148-154.

Okon, D.M., Greene, A.L., & Smith, E. (2002). Family interactions predict intraindividual symptom variation for adolescents with Bulimia. *Int J Eat Disord,34*, 450-457.

O`Halloran, M., et al., (2002) Psychological profile of sexually abusive adolescents in Ireland. *Child Abuse & Neglect, 26*, 349-370.

Parker, G. et al., (1994). Defining melancholia: properties of a refined sign-based measure. *British Journal of psychiatry, 164*, 316-326.

Patterson, J.M. (1995). Promoting resilience in families experiencing stress. *Pediatric Clinics of North America, 42*, 47-63.

Peterson, J. M., & McCubbin, H.I. (1995) Promoting resilience in families experiencing stress. *Pediatric Clinics of North America, 42*, 47-63.

Pine, D.S., Cohen, E., Cohen, P., & Brook, J. (1999). Adolescent depressive symptoms as predictors of adult depression: Moodiness or mood disorder? *American Journal of Psychiatry, 156,* 133-135

Poulin, C., Hand, D., Boudreau, B., & Santor, D. (2005). Gender differences in the association between substance use and elevated depressive symptoms in a general adolescent population. *Addiction, 100*(4), 525-535.

Reinherz, H.Z., Paradis, A.D., Giaconia, R.M., Stashwick, C.K., & Fitzmaurice, G. (2003). Childhood and adolescent predictors of major depression in the transition to adulthood. *American Journal Psychiatry, 160*(12), December, 2141-2147.

Repetto, P.B., Caldwell, C.H., & Zimmerman, M.A. (2003). Trajectories of depressive symptoms among high risk African-American adolescents. *Journal of Adolescent Health, 35*, 468-477.

Rice, F.P., & Dolgin, K.G. (2005). *The adolescent development, relationships, and culture (11th ed.).* Boston: Pearson education, Inc.

Rushton, J. L., Michelle, F., & Schectman, R. M. (2002). Epidemiology of depressive symptoms in the national longitudinal study of adolescent health. *Journal of American Academy Child and Adolescent Psychiatry,41*(2),199-214.

Sarafolean, M.H. (2000). Depression in school-age children and adolescents: Characteristics, assessment and prevention. *A Pediatric Perspective, 9*(4), 10-12.

Santrock, J. W. (2003). *Adolescence (9th ed).* New York: McGraw-Hill.

Scabini, E., & Galimberti, C. (1995). Adolescents and young adults: A transition in the family. *Journal of Adolescence, 18*, 593-606.

Seiffge-Krenke, I. (2000). Causal links between stressful events, coping style, and adolescent symptomatology. *Journal of Adolescence, 23*, 675-691.

Stienberg, L. (1999)**.** *Adolescence (5th ed)***.** New York: McGraw-Hill.

Shives, L. R. (2005). *Basic concepts of psychiatric- mental health nursing (6th ed).* Philadelphia: Lippincott Williams & Wilkins.

Stein, D. et al., (2000). Parent-child bonding and family functioning in depressed children and children at high risk and low risk for future depression. *Journal of American Academy Child and Adolescent Psychiatry, 39*(11), 1387 – 1395.

Stevens, E. A. & Prinstein, M. J. (2005). Peer cognition of depress organic attribution styles among adolescents: A longitudinal study. *Journal of Abnormal Child Psychology, 33*(1), 25-37.

Sund, A.M., Larsson, B., & Wichstrøm, L. (2003). Psychosocial correlates of depressive symptoms among 12-14-year-old Norwegian adolescents. *Journal of Child Psychology and Psychiatry, 44*(4), 588-597.

Takakura, M., & Sakihara, S. (2001). Psychosocial correlates of depressive symptoms among Japanese high school students. *Journal of Adolescent Health, 28*, 82-89.

Tamplin, A., & Goodyer, I.M. (2001). Family functioning in adolescents at high and low risk for major depressive disorder. *European Child & Adolescent Psychiatry, 10*, 170 - 179.

Tatar, M. (1995). Parental views of popularity and stress among adolescents. *Journal of Adolescence, 18*, 679-686.

Timbremont, B., & Braet, C. (2003). Cognitive vulnerability in remitted depressed children and adolescents. *Behaviour Research and Therapy, 42*, 423-437.

Townsend, M. C. (1999). *Essential of psychiatric/mental health nursing.* Philadelphia: F. A. David.

Vance, J.E., Bowen, N. K., Fffernandez, G., & Thompson, S. (2002). Risk and protective factors as predictors of outcome in adolescents with psychiatric disorder and aggression. *Journal of American Academy Child and Adolescent Psychiatry,41*(1), 36-43.

Varcarolis, E. M. (1998). *Foundations of psychiatric mental health nursing (3rd ed)* Philadelphia: W. B. Saunder.

Wagner, E.F., Myers, M.G., & Mcininch, J.L. (1999). Stress-coping and temptation-coping as predictors of adolescent substance use. *Addictive Behaviors, 24*(6), 769-779.

Walker, J. (2005). Teens in distress series adolescent stress and depression; adolescent stress and depression. *Journal of Adolescence, 25*, 450-455.

William, K. & Lisi, A.M. (2000). Coping strategies in adolescents. *Journal of Applied Developmental Psychology, 20*(4), 537-549.

กรมสุขภาพจิต. (2546). (Department of Mental Health, 2003). *สถิติสาธารณสุข พ.ศ. 2546.* กรุงเทพฯ: องค์การสงเคราะห์ทหารผ่านศึก.

กัลญา แก้วอินทร์. (2545). (Kaewin, K., 2002). *ภาวะซึมเศร้าและปัญหาพฤติกรรมในเด็กวัยรุ่นชั้นมัธยมต้น โรงเรียนขยายโอกาสทางการศึกษา สังกัดสำนักงานการประถมศึกษาจังหวัดสิงห์บุรี*. วิทยานิพนธ์ ปริญญาวิทยาศาสตรมหาบัณฑิต, จุฬาลงกรณ์มหาวิทยาลัย.

กิตติวรรณ เทียมแก้ว, ปพิชญา แสงเอื้ออังกูร และวนิดา พุ่มไพศาลชัย. (2543). (Tiamkeow, K., Sangueaakkul, P., & Pumphaisarn, W., 2000).*การคิดฆ่าตัวตายและภาวะอารมณ์เศร้าของเด็กวัยรุ่นไทย.* เชียงใหม่:โรงพยาบาลสวนปรุง.

จุลจราพร ศรีเพชร. (2546). (Sriphet, J., 2003). *ปัจจัยที่มีอิทธิพลต่อภาวะซึมเศร้าในวัยรุ่น.* วิทยานิพนธ์ปริญญา พยาบาลศาสตรมหาบัณฑิต, มหาวิทยาลัยมหิดล.

ดวงใจ กสานติกุล. (2542). (Kasarntikul, D., 1999). *โรคซึมเศร้าและโรคอารมณ์ผิดปกติ รักษาหายได้.* กรุงเทพฯ: นำอักษรการพิมพ์.

พิสมัย เต็งพงศธร. (2533). (Tengphongsatorn, P., 1990). *การศึกษาระดับความซึมเศร้าของเด็กและเยาวชนจากสถานสงเคราะห์ในจังหวัดกรุงเทพมหานครและนนทบุรี.*วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต, มหาวิทยาลัยมหิดล.

เพ็ญพรรณ์ ชิตวร. (2546). (Chitaworn, P., 2003). *ผลของโปรแกรมพฤติกรรมบำบัดแบบพิจารณาเหตุผล อารมณ์ต่อภาวะซึมเศร้าในวัยรุ่น.* วิทยานิพนธ์ปริญญาพยาบาลศาสตรมหาบัณฑิต, มหาวิทยาลัยมหิดล

ไพรินทร์ สมุทรเสน. (2543). (Samutsane, P., 2000). *การศึกษาภาวะสุขภาพจิตนักเรียนระดับมัธยมศึกษาตอนต้นและตอนปลายจังหวัดระยอง.* รายงานการวิจัย งานสุขภาพจิตสำนักงานสาธารณสุขจังหวัดระยอง.

วงศ์พรรณ์ มาลารัตน์. (2543). (Malarat, W., 2000).*ความเครียดและพฤติกรรมการแก้ปัญหาความเครียดของนักเรียนชั้นมัธยมศึกษาตอนปลายในจังหวัดเชียงใหม่* การค้นคว้าอิสระหลักสูตรปริญญามหาบัณฑิต ศึกษาศาสตร์มหาบัณฑิต สาขาวิทยาการศึกษาและการแนะแนว บัณฑิตวิทยาลัย มหาวิทยาลัยเชียงใหม่.

รัชนก คชไกร. (2541).(Kojakrai, R., 1998). *ความเครียด บุคลิกภาพแบบเข้มแข็ง แรงสนับสนุนทางสังคมกับพฤติกรรมการเผชิญปัญหาของวัยรุ่น: นักเรียนชั้นมัธยมศึกษาปีที่ 5 สังกัดกรมสามัญศึกษา กรุงเทพมหานคร.* วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต สาธารณสุขศาสตร์ สาขาอนามัยครอบครัว. บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.

วราภรณ์ ตระกูลสฤษดิ์. (2544). (Trakulsarit, W., 2001). *จิตวิทยาการปรับตัว.* กรุงเทพฯ: ศูนย์ส่งเสริมวิชาการ.

สมภพ เรืองตระกูล. (2543). (Ruangrtrakul, S., 2000). *โรคซึมเศร้าและการฆ่าตัวตาย.* กรุงเทพฯ: เรือนแก้วการพิมพ์.

สมโภชน์ เอี่ยมสุภาษิต. (2543). (Aeumsuphasit, S., 2000). *ทฤษฎีและเทคนิคการปรับพฤติกรรม. พิมพ์ครั้งที่ 4.* กรุงเทพฯ: จุฬาลงกรณ์มหาวิทยาลัย.

หน่วยศึกษานิเทศก์ กรมสามัญศึกษา กระทรวงศึกษาธิการ. (2544). (Supervise Unit of the General Education Division, 2001). *ระบบการดูแลช่วยเหลือนักเรียนในโรงเรียนสังกัดกรมสามัญศึกษา.* ราชบุรี: โรงเรียนราชโบริกานุเคราะห์.

อัญชลี ฉัตรแก้ว. (2546). (Chatkeaw, U., 2003). *ผลของการบำบัดทางปัญญาต่อภาวะซึมเศร้าในเยาวชนหญิงในสถานสงเคราะห์ จังหวัดเชียงใหม่.* วิทยานิพนธ์ปริญญาพยาบาลศาสตรมหาบัณฑิต, มหาวิทยาลัยเชียงใหม่.

อุมาพร ตรังคสมบัติ และดุสิต ลิขนะพิชิตกุล. (2539). (Trangkasombat, U., & Likhanapichitkul, D., 1996). อาการซึมเศร้าในเด็ก: การศึกษาโดยใช้ Children's Depression Inventory. *วารสารสมาคมจิตแพทย์แห่งประเทศไทย, 41*(4), 222-234.

อุมาพร ตรังคสมบัติ และดุสิต ลิขนะพิชิตกุล. (2539). (Trangkasombat, U., & Likhanapi-chitkul, D., 1996). ภาวะซึมเศร้าในเด็กนักเรียนนมัธยมต้นในเขต กรุงเทพมหานคร. *วารสารสมาคมจิตแพทย์แห่งประเทศไทย, 41*(3),162-173.

APPENDIX

APPENDIX A

LIST OF CONTENT VALIDATORS

The content validity of the questionnaires was determined by three consulting experts as follows:

1. Dr. Prayuk Serisathien, M.D., M.P.H
   Director of the 1st Mental Health Center
   Department of Mental Health
   Ministry of Public Health

2. Asst. Prof. Somporn Rungrueangkolakij Ph.D. (Nursing)
   Department of Mental Health and Psychiatric Nursing,
   Faculty of Nursing,
   Khonkhane University

3. Asst. Prof. Tassanee Prasopkittikun Ph.D. (Nursing)
   Department of Pediatric Nursing,
   Faculty of Nursing,
   Mahidol University

APPENDIX B

Data Collection Instruments

แบบสอบถาม

ความสัมพันธ์ระหว่างความเชื่ออำนาจภายในตน ความสัมพันธ์กับผู้เลี้ยงดู
การเผชิญความเครียด กับภาวะซึมเศร้าในวัยรุ่น

หมายเลขแบบสอบถาม

คำชี้แจง : แบบสัมภาษณ์นี้ประกอบด้วย 5 ส่วน ได้แก่

ส่วนที่ 1 แบบบันทึกข้อมูลส่วนบุคคล จำนวน 10 ข้อ
ส่วนที่ 2 แบบประเมินภาวะซึมเศร้าในเด็ก จำนวน 27 ข้อ
ส่วนที่ 3 แบบวัดความเชื่ออำนาจภายในตนของวัยรุ่น จำนวน 40 ข้อ
ส่วนที่ 4 แบบวัดความสัมพันธ์กับบิดามารดาของวัยรุ่น จำนวน 25 ข้อ
ส่วนที่ 5 แบบวัดการเผชิญความเครียดของวัยรุ่น จำนวน 54 ข้อ

ส่วนที่ 1 แบบบันทึกข้อมูลส่วนบุคคล

คำชี้แจง : แบบสอบถามนี้ไม่ใช่แบบทดสอบ จึงไม่มีคำตอบถูกหรือผิด คำตอบที่ได้จะถูกเก็บรักษาไว้เป็นความลับและไม่มีผลใดๆต่อผู้ตอบ กรุณาตอบแบบสอบถามโดยทำเครื่องหมาย ✘ ลงใน **O** หน้าข้อความที่ตรงกับนักเรียน หรือเติมข้อความลงในช่องว่าง

1. เพศ O 0) หญิง O 1) ชาย
2. อายุ O 9 ปี O 10 ปี O 11 ปี O 12 ปี
   O 13 ปี O 14 ปี O 15 ปี O 16 ปี
   O 17 ปี
3. ผลการเรียน (เกรดเฉลี่ยสะสมในชั้นมัธยม) .....
4. ป่วยเป็นโรคที่ต้องใช้ระยะเวลาในการรักษาต่อเนื่อง
   O 0) ไม่เป็น O 1) เป็นโรคที่เป็นคือ.....
5. เคยดื่มแอลกอฮอล์หรือไม่
   O 0) ไม่เคย O 1) เคย ดื่มครั้งละ.....แก้ว

O บุรีรัมย์พิทยาคม
O รมย์บุรีรัชมังคลาภิเษก
O ห้วยราชพิทยาคม
O สวายจีกพิทยาคม
O กนกศิลป์พิทยาคม

วันที่ตอบแบบสอบถาม ...../...../.....

6. เคยสูบบุหรี่หรือไม่

O 0) ไม่สูบ O 1) สูบ ปัจจุบันสูบจำนวน..... มวน/วัน

7. ปัจจุบันนักเรียนอาศัยอยู่กับ

O 1) บิดา O 2) มารดา O 3) บิดา–มารดา O 4) ปู่ - ย่า, ตา – ยาย

O 5) อื่น ๆ ระบุ.....

8. ผู้ที่นักเรียนอาศัยอยู่ด้วยมีการศึกษาระดับ

O 1) ไม่ได้เรียน O 2) ประถมศึกษา O 3) มัธยมศึกษา

O 4) อนุปริญญา O 5) ปริญญาตรี/เทียบเท่า O 6) สูงกว่าปริญญาตรี

9. พ่อ-แม่ ของนักเรียนอยู่ด้วยกันหรือไม่

O 1) อยู่ด้วยกัน O 0) แยกกันอยู่

10. ผู้ที่นักเรียนอาศัยอยู่ด้วยประกอบอาชีพอะไร

O 0) ไม่ได้ประกอบอาชีพ O 1) เกษตรกร O 2) รับจ้าง

O 3) ประกอบธุรกิจส่วนตัว O 4) รับราชการ/พนักงานรัฐวิสาหกิจ

ส่วนที่ 2 แบบประเมินภาวะซึมเศร้าในเด็ก

<u>คำชี้แจง</u> : ให้นักเรียนเลือกประโยคที่ตรงกับ ความรู้สึกหรือความคิด ของนักเรียนมากที่สุดในระยะ 2 สัปดาห์ที่ผ่านมา โดยทำเครื่องหมาย ✖ ลงใน ☐

1	☐	ฉันรู้สึกเศร้า นานๆ ครั้ง	10	☐	ฉันรู้สึกอยากร้องไห้ทุกวัน
	☐	ฉันรู้สึกเศร้า บ่อยครั้ง		☐	ฉันรู้สึกอยากร้องไห้บ่อยครั้ง
	☐	ฉันรู้สึกเศร้าตลอดเวลา		☐	ฉันรู้สึกอยากร้องไห้นานๆ ครั้ง
2	.....		11	☐	.....

23 ☐ การเรียนของฉันอยู่ในขั้นใช้ได้ดี

☐ การเรียนของฉันไม่ค่อยดีเหมือนเมื่อก่อน

☐ การเรียนของฉันแย่ลงมาก

ส่วนที่ 3 แบบวัดความเชื่ออำนาจภายในตนของวัยรุ่น

<u>คำชี้แจง</u> : แบบสอบถามนี้มีวัตถุประสงค์เพื่อ ประเมินรูปแบบความเชื่ออำนาจภายในตน และความเชื่ออำนาจภายนอกตนของท่าน

โปรดพิจารณาข้อความก่อนตอบโดยการเลือกทำเครื่องหมาย ✖ ลงใน ☐ ที่ท่านเห็นว่าตรงกับความเป็นจริงมากที่สุด

ข้อความ	ใช่	ไม่ใช่
1. ท่านมีความเชื่อว่าปัญหาส่วนใหญ่สามารถแก้ไขได้ด้วยตัวของมันเอง ถ้า เราไม่เข้าไปทำให้ปัญหามันยุ่งยากเสียเอง	☐	☐
2. …….	☐	☐
3. ท่านคิดว่าคนเรามีความฉลาดดีกว่าความโชคดี	☐	☐

ส่วนที่ 4 แบบวัดความสัมพันธ์กับ บิดามารดา/ผู้เลี้ยงดู ของวัยรุ่น

<u>คำชี้แจง</u> : แบบสอบถามนี้มีวัตถุประสงค์เพื่อ ประเมินพฤติกรรมและทัศนคติที่ พ่อแม่ หรือ ผู้เลี้ยงดู ปฏิบัติต่อท่าน (นับตั้งแต่เกิดจนถึงปัจจุบัน) กรุณาทำเครื่องหมาย ✖ ลงใน ☐ ที่ท่านเห็นว่าตรงกับความเป็นจริงมากที่สุด หลังข้อความที่แสดงถึงทัศนคติและพฤติกรรมต่างๆ ของ พ่อแม่หรือผู้เลี้ยงดู ที่มีต่อท่าน

ทัศนคติและพฤติกรรมต่างๆ ของพ่อ/แม่ที่มีต่อท่าน	ตรงมากที่สุด	ตรง	ไม่ตรง	ไม่ตรงมากที่สุด
1. พูดคุยกับฉันด้วยสำเนียงที่อบอุ่นและเป็นมิตร	☐	☐	☐	☐
2. ……..	☐	☐	☐	☐
25. ปล่อยให้ฉันได้แต่งตัวในแบบที่ฉันพอใจ	☐	☐	☐	☐

ส่วนที่ 5 แบบวัดการเผชิญความเครียดของวัยรุ่น

คำชี้แจง : - กรุณาทำเครื่องหมาย ✘ ลงใน ☐ ที่ท่านเห็นว่าตรงกับพฤติกรรมที่นักเรียนกระทำเมื่อมี**ความไม่สบายใจ**หรือ**เครียด**ตามความเป็นจริงมากที่สุด

เมื่อนักเรียนมี**ความไม่สบายใจ**หรือ**เครียด**เนื่องจากความยุ่งยากในชีวิต เช่น -ความคาดหวังจากพ่อแม่ อาจารย์ -ความขัดแย้งกับพ่อแม่/ผู้เลี้ยงดู อาจารย์หรือเพื่อน -สูญเสียบุคคลสำคัญในชีวิต -ไม่พอใจผลการเรียน -การเจ็บป่วยเรื้อรัง นักเรียนทำสิ่งต่อไปนี้บ่อยแค่ไหน	ไม่เคย	แทบจะไม่เคย	เป็นบางครั้ง	บ่อยครั้ง	ตลอดเวลา	ไม่มีสถานการณ์
1. ทำตามกฎและคำขอร้องของพ่อแม่	☐	☐	☐	☐	☐	☐
2. ……	☐	☐	☐	☐	☐	☐
54.ทำกิจกรรมต่างๆ ที่ทำให้ร่างกายแข็งแรง (วิ่ง, ปั่นจักรยาน ฯลฯ)	☐	☐	☐	☐	☐	☐

APPENDIX C

Consent Form

คำอธิบายโครงการวิจัยก่อนลงนามยินยอมร่วมการวิจัย

1. หัวเรื่องที่จะทำการวิจัย

ความสัมพันธ์ระหว่างความสัมพันธ์กับผู้ดูแล ความเชื่ออำนาจภายในตน การเผชิญความเครียด กับภาวะซึมเศร้าในวัยรุ่น

2. วัตถุประสงค์และวิธีการวิจัย

การวิจัยครั้งนี้มีวัตถุประสงค์เพื่อศึกษาความสัมพันธ์ระหว่างความสัมพันธ์กับผู้ดูแล ความเชื่ออำนาจภายในตน การเผชิญความเครียด กับภาวะซึมเศร้าในวัยรุ่น โดยการวิจัยครั้งนี้เป็นการวิจัยเชิงบรรยายซึ่งนักเรียนได้รับเชิญเข้าร่วมการตอบแบบสอบถาม

3. เหตุผลที่เชิญชวนผู้ยินยอมตนให้เข้าทำการวิจัยในโครงการวิจัย

นำข้อมูลที่ได้จากการตอบแบบสอบถามเกี่ยวกับข้อมูลส่วนบุคคล การประเมินความสัมพันธ์กับผู้ดูแล การประเมินความเชื่ออำนาจภายในตน การเผชิญความเครียด และการประเมินภาวะซึมเศร้าในวัยรุ่น มาใช้เป็นแนวทางในการป้องกันและช่วยลดภาวะซึมเศร้าในเด็กวัยรุ่นตอนต้นต่อไป

4. ระยะเวลาที่ต้องทำการทดสอบในผู้ยินยอมให้ทำการวิจัย

ผู้วิจัยจะขอให้นักเรียนตอบแบบสอบถามจำนวน 5 ฉบับ ได้แก่แบบสอบถามเกี่ยวกับข้อมูลส่วนบุคคล จำนวน 10 ข้อ แบบวัดความเชื่ออำนาจภายในตน จำนวน 40 ข้อ แบบวัดความสัมพันธ์กับผู้ดูแล จำนวน 25 ข้อ แบบวัดการเผชิญความเครียดของวัยรุ่น จำนวน 54 ข้อและแบบวัดประเมินภาวะซึมเศร้าในเด็ก จำนวน 27 ข้อ รวมทั้งหมด 156 ข้อ โดยใช้เวลาในการตอบแบบสอบถามทั้งหมดประมาณ 45-60 นาที

5.ประโยชน์ที่คาดว่าจะเกิดขึ้นทั้งต่อผู้ยินยอมตนให้ทำการวิจัยและต่อผู้อื่น

ประโยชน์ที่คาดว่าจะเกิดขึ้นต่อผู้ยินยอมตนในการวิจัยครั้งนี้จะได้รับการประเมินภาวะซึมเศร้า หากนักเรียนคนใดมีภาวะซึมเศร้าอยู่ในเกณฑ์ที่ต้องได้รับความช่วยเหลือจากผู้วิจัยจะดำเนินการติดต่อและประสานงานให้ได้รับการตรวจจากแพทย์ผู้มีความชำนาญต่อไป ประโยชน์ที่คาดว่าจะเกิดขึ้นต่อผู้อื่นคือ บุคคลกรที่เกี่ยวข้องในการดูแลนักเรียนวัยรุ่น และฝ่ายแนะแนวของ

โรงเรียน จะได้ทราบสถานการณ์ของภาวะซึมเศร้าและจะได้มีแนวทางในการป้องกันและลดภาวะซึมเศร้าในวัยรุ่นต่อไป

6. ความเสี่ยงหรือความไม่สบายใจที่คาดว่าอาจจะเกิดขึ้นกับผู้ยินยอมให้ทำการวิจัยในการเข้าร่วมโครงการวิจัย

การวิจัยนี้มีความเสี่ยงน้อยมาก เนื่องจากเป็นการตอบแบบสอบถามเท่านั้น ไม่ได้มีการรักษาหรือตรวจวินิจฉัยใดๆ

7. การเตรียมผลิตภัณฑ์ หรือกระบวนการรักษาที่พิสูจน์จากการวิจัยแล้วว่าปลอดภัยและมีประสิทธิ-ผลไว้ให้ผู้ยินยอมตนให้ทำการวิจัยอย่างไร

เป็นเพียงการตอบแบบสอบถามเท่านั้น

8. ทางเลือกในการรักษาหรือวิธีการตรวจวินิจฉัยอื่น ที่อาจเป็นประโยชน์แก่ผู้ยินยอมตนให้ทำการวิจัย

ในการวิจัยในครั้งนี้เป็นการตอบแบบสอบถามเท่านั้น ไม่ได้มีการรักษา หรือการตรวจวินิจฉัยใดๆ อย่างไรก็ตาม หากพบว่าขณะที่เข้าร่วมโครงการวิจัยนักเรียนมีภาวะซึมเศร้าในระดับรุนแรง ผู้วิจัยจะประสานงานกับฝ่ายแนะแนวของโรงเรียนและผู้ปกครองของนักเรียนเพื่อให้นักเรียนได้รับการดูแลช่วยเหลือจากจิตแพทย์ผู้เชี่ยวชาญโดยเร็วที่สุด โดยไม่เสียค่าใช้จ่ายใดๆ

9. ขอบเขตการรักษาความลับของข้อมูลต่างๆ ของผู้ยินยอมตนให้ทำการวิจัย

ข้อมูลต่างๆที่ได้จากการวิจัย จะเก็บรักษาเป็นความลับ ไม่มีการเปิดเผยชื่อนามสกุลของนักเรียน และจะนำเสนอผลการวิจัยในภาพรวมเท่านั้น

10. การดูและรักษาผู้วิจัยจัดไว้ให้

ในการวิจัยในครั้งนี้เป็นเพียงการตอบแบบสอบถามเท่านั้น ไม่ได้มีการรักษา หรือการตรวจวินิจฉัยใดๆ หากพบว่าขณะที่เข้าร่วมโครงการวิจัยนักเรียนมีภาวะซึมเศร้าในระดับรุนแรง ผู้วิจัยจะประสานงานกับฝ่ายแนะแนวของโรงเรียนและผู้ปกครองของนักเรียนเพื่อให้นักเรียนได้รับการดูแลช่วยเหลือจากจิตแพทย์ผู้เชี่ยวชาญโดยเร็วที่สุด โดยไม่เสียค่าใช้จ่ายใดๆ

11. กรณีเกิดอันตรายหรือผลไม่พึงประสงค์จากการศึกษาวิจัยผู้ยินยอมให้ทำการวิจัยจะได้รับการดูแลรักษาโดยไม่เสียค่าใช้จ่ายอย่างใดบ้าง

เป็นเพียงการตอบแบบสอบถามเท่านั้น

12. ในกรณีเกิดอันตราย จากการวิจัยถึงขั้นพิการหรือเสียชีวิต หรือทายาทจะได้รับการชดเชยอย่างไร

ในการวิจัยในครั้งนี้เป็นเพียงการตอบแบบสอบถามเท่านั้นไม่ก่อให้เกิดอันตรายจนถึงขั้นพิการหรือเสียชีวิต

13. ผู้ยินยอมตนให้ทำการวิจัยจะถอนตัวออกจากโครงการวิจัยทุกเมื่อ โดยไม่กระทบต่อการดูแลรักษาที่พึงได้รับตามปกติ

นักเรียนมีสิทธิ์ที่จะถอนตัวหรือบอกเลิกการเข้าร่วมโครงการวิจัยเมื่อใดก็ได้ โดยไม่มีผลกระทบใดๆ ทั้งผลต่อการเรียนหรือการใช้ชีวิตในโรงเรียน

14. ชื่อที่อยู่ และเบอร์โทรศัพท์ที่ผู้ยินยอมตนให้ทำการวิจัยสามารถติดต่อได้สะดวกทั้งในและนอกเวลาราชการ กรณีมีเหตุจำเป็นและฉุกเฉิน

นาง คมเดือน โตศิริ
โรงพยาบาลบุรีรัมย์ อ.เมือง จ. บุรีรัมย์ 31000
เบอร์โทรศัพท์ที่สามารถติดต่อได้ 0-8138-98211

คมเดือน โตศิริ

ใบยินยอมให้ทำการวิจัยโดยได้รับการบอกกล่าวและเต็มใจ (Inform Consent Form)

(สำหรับนักเรียน)

การวิจัยเรื่อง ความสัมพันธ์ระหว่างความสัมพันธ์กับผู้เลี้ยงดู ความเชื่ออำนาจภายในตน การเผชิญความเครียด กับภาวะซึมเศร้าในวัยรุ่น

วันให้คำยินยอม วันที่.....เดือน.....พ.ศ. .....

ก่อนที่จะลงนามในใบยินยอมให้ทำการวิจัยนี้ ข้าพเจ้าได้รับการอธิบายจากผู้วิจัยถึงวัตถุประสงค์ของการวิจัย วิธีการวิจัย รวมทั้งประโยชน์ที่จะเกิดขึ้นจากการวิจัยอย่างละเอียดและมีความเข้าใจดีแล้ว

ผู้วิจัยรับรองว่าจะตอบคำถามต่างๆ ที่ข้าพเจ้าสงสัยด้วยความเต็มใจ ไม่ปิดบัง ซ่อนเร้น จนข้าพเจ้าพอใจ

ข้าพเจ้ามีสิทธิ์ที่จะบอกเลิกการเข้าร่วมในโครงการนี้เมื่อไดก็ได้ และเข้าร่วมโครงการวิจัยนี้โดยสมัครใจ และการบอกเลิกการเข้าร่วมวิจัยนี้จะไม่มีผลต่อการเรียนหรือการดำเนินชีวิตในโรงเรียนของข้าพเจ้าแต่อย่างใด

ผู้วิจัยรับรองว่าจะเก็บข้อมูลเฉพาะเกี่ยวกับข้าพเจ้าเป็นความลับ และจะเปิดเผยได้เฉพาะในรูปที่เป็นผลสรุปการวิจัย การเปิดเผยข้อมูลเกี่ยวกับตัวข้าพเจ้าต่อหน่วยงานต่างๆ ที่เกี่ยวข้อง กระทำได้เฉพาะกรณีจำเป็นด้วยเหตุผลทางวิชาการเท่านั้น

ผู้วิจัยรับรองว่าหากมีข้อมูลเพิ่มเติมที่ส่งผลกระทบต่อการวิจัย ข้าพเจ้าจะได้รับการแจ้งให้ทราบโดยไม่ปิดบังซ่อนเร้น

ข้าพเจ้าได้อ่านข้อความข้างต้นแล้ว และมีความเข้าใจดีทุกประการ และได้ลงนามในใบยินยอมนี้ด้วยความเต็มใจ

ลงนาม.....ผู้ยินยอม

ลงนาม.....พยาน

ลงนาม.....พยาน

ในกรณีที่ผู้ยินยอมตนให้ทำการวิจัยยังไม่บรรลุนิติภาวะ จะต้องได้รับการยินยอมจากผู้ปกครองหรือผู้อุปการะโดยชอบด้วยกฎหมาย

ลงนาม.....ผู้ปกครอง/ผู้อุปการะ
โดยชอบด้วยกฎหมาย

ลงนาม.....พยาน

ลงนาม.....พยาน

ใบยินยอมให้ทำการวิจัยโดยได้รับการบอกกล่าวและเต็มใจ (Inform Consent Form)

(สำหรับผู้ปกครองนักเรียน)

การวิจัยเรื่อง ความสัมพันธ์ระหว่างความสัมพันธ์กับผู้เลี้ยงดู ความเชื่ออำนาจภายในตน การเผชิญความเครียด กับภาวะซึมเศร้าในวัยรุ่น

วันให้คำยินยอม วันที่.....เดือน.....พ.ศ.....

ก่อนที่จะลงนามในใบยินยอมให้ทำการวิจัยนี้ ข้าพเจ้าได้รับการอธิบายจากผู้วิจัยถึงวัตถุประสงค์ของการวิจัย วิธีการวิจัย รวมทั้งประโยชน์ที่จะเกิดขึ้นจากการวิจัยอย่างละเอียดและมีความเข้าใจดีแล้ว

ผู้วิจัยรับรองว่าจะตอบคำถามต่างๆ ที่ข้าพเจ้าสงสัยด้วยความเต็มใจ ไม่ปิดบัง ซ่อนเร้น จนข้าพเจ้าพอใจ

ข้าพเจ้ามีสิทธิ์ที่จะบอกเลิกการเข้าร่วมในโครงการนี้เมื่อไดก็ได้ และเข้าร่วมโครงการวิจัยนี้โดยสมัครใจ และการบอกเลิกการเข้าร่วมวิจัยนี้จะไม่มีผลต่อการเรียนหรือการดำเนินชีวิตในโรงเรียนของนักเรียนในปกครองของข้าพเจ้าแต่อย่างใด

ผู้วิจัยรับรองว่าจะเก็บข้อมูลเฉพาะเกี่ยวกับตัวนักเรียนในปกครองของข้าพเจ้าเป็นความลับ และจะเปิดเผยได้เฉพาะในรูปที่เป็นผลสรุปการวิจัย การเปิดเผยข้อมูลเกี่ยวกับตัวนักเรียนในปกครองของข้าพเจ้าต่อหน่วยงานต่างๆ ที่เกี่ยวข้อง กระทำได้เฉพาะกรณีจำเป็นด้วยเหตุผลทางวิชาการเท่านั้น

ผู้วิจัยรับรองว่าหากมีข้อมูลเพิ่มเติมที่ส่งผลกระทบต่อการวิจัย ข้าพเจ้าจะได้รับการแจ้งให้ทราบโดยไม่ปิดบังซ่อนเร้น

ข้าพเจ้าได้อ่านข้อความข้างต้นแล้ว และมีความเข้าใจดีทุกประการ และได้ลงนามในใบยินยอมนี้ด้วยความเต็มใจ

ลงนาม.....ผู้ยินยอม

ลงนาม.....พยาน

ลงนาม.....พยาน

APPENDIX D

Permission letters for data collection

No. MU 2006-080

Documentary Proof of Ethical Clearance
The Committee on Human Rights Related to
Human Experimentation
Mahidol University, Bangkok

Title of Project: Relationships among Internal Locus of Control, Caregivers-Child Bonding, Coping, and Depression in Adolescents
(Thesis for Master Degree)

Principle Investigator: Mrs. Khomdoen Tosiri

Name of Institution: Faculty of Nursing

Approved by the Committee on Human Rights Related to Human Experimentation

Signature of Chairman: .....
(Professor Dr.Srisin Khusmith)

Signature of Head of the Institute: .....
(Professor Dr.Pornchai Matangkasombut)

Date of Approval: 18 MAY 2006

Date of Expiration: 17 MAY 2007

บันทึกข้อความ

ส่วนราชการ มหาวิทยาลัยมหิดล กองบริหารงานวิจัย โทร. ๐-๒๘๔๙-๖๒๔๖ โทรสาร ๐-๒๘๔๙-๖๒๔๗
ที่ ศธ ๐๕๑๗.๐๑๖/๒๔๙(๑) วันที่ ๒๕ พฤษภาคม ๒๕๔๙
เรื่อง หนังสือรับรองโครงการวิจัยของคณะกรรมการสิทธิมนุษยชนเกี่ยวกับการทดลองในมนุษย์ของมหาวิทยาลัยมหิดล

เรียน ผู้ช่วยศาสตราจารย์ ดร. อติรัตน์ วัฒนไพลิน

ตามที่ นางคมเดือน โตศิริ นักศึกษาปริญญาโท สาขาวิชาการพยาบาลสุขภาพจิตและจิตเวช คณะพยาบาลศาสตร์ ได้เสนอโครงการวิจัยเรื่อง "Relationships among Internal Locus of Control, Caregivers-Child Bonding, Coping, and Depression in Adolescents" มาเพื่อขอหนังสือรับรองจากคณะกรรมการสิทธิมนุษยชนเกี่ยวกับการทดลองในมนุษย์ของมหาวิทยาลัยมหิดล

บัดนี้ โครงการวิจัยเรื่องดังกล่าวได้รับการรับรองจากคณะกรรมการสิทธิมนุษยชนเกี่ยวกับการทดลองในมนุษย์ของมหาวิทยาลัยมหิดลแล้ว กองบริหารงานวิจัย จึงขอส่งหนังสือรับรองโครงการวิจัยตามที่แนบมาพร้อมนี้เพื่อโปรดทราบ และแจ้งนักศึกษาต่อไปด้วย จักขอบพระคุณยิ่ง

(นางรัตนา เพ็ชรอุไร)
ผู้อำนวยการกองบริหารงานวิจัย
กรรมการและเลขานุการฯ

สำเนาเรียน คณบดีบัณฑิตวิทยาลัย

BIOGRAPHY

NAME Mrs.Khomduean Tosiri

DATE OF BIRTH 15 April 1965

PLACE OF BIRTH Nakhon Rajchasima, Thailand

INSTITUTION ATTENDED Boromarajonani College of Nursing,
1986-1989: Bachelor of Nursing
Mahidol University, 2003 - 2007
Master of Nursing Science
(Mental Health and Psychiatric Nursing)

POSITION&OFFICE Buriram Hospital
Buriram, Thailand
Position: Registerd Nurse
Tel. 0 – 4461 - 5002
E-mail; khomduean@hotmail.com

HOME ADDRESS 166/9 Nhasathanee Road
Muang distric
Buriram Provinc, Thailand
Tel. 0 – 4461 - 7764