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PROTECTIVE FACTORS AND LEVEL OF SELF-ESTEEM IN ADOLESCENTS WITH ABSENCE OR PRESENCE OF DEPRESSION

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Abstract: Adolescence is a crucial stage in human development; It is a particular form of transition between childhood and adulthood where profound physical changes occur, including neuroendocrine growth and development, psychological changes, and social changes. **Objective:** Identify the Protective Factors and level of self-esteem in adolescents with the absence or presence of depression. **Methodology:** Cross-sectional, observational, descriptive study. The teachers, administrators and parents were informed about the objective of the study, they signed the informed consent authorizing the participation of their child in the study. **Results:** The depressive symptomatology through the Birlson scale, indicated that 21.9% present this symptomatology. Self-esteem evaluated with the Rosenberg scale, 17.6% with low self-esteem was observed. **Conclusions:** The observed prevalence is above that reported at the national level.

Keywords: Protective Factors, Self-esteem, Depression.

INTRODUCTION

Adolescence is a crucial stage in human development; It is a particular form of transition between childhood and adulthood where profound physical changes occur, including neuroendocrine growth and development, psychological changes (identity structuring) and social changes (integration of the adult world). And therefore the adolescent is susceptible to receiving the impact of the conflicts that originate around him (family, school, friends, economic, sociocultural and technological changes). Adolescents experience anxiety and depression in their lives just like adults, constituting a frequent problem that has increased in recent decades. Most adolescent depressive symptoms are characterized primarily by depressed mood and loss of interest or satisfaction in all or nearly

all activities over a period of at least two weeks, these being the key symptoms of adolescent depression. It has been found that individuals with histories of depression in adolescence present a high percentage of continuation of the depressive disorder in adulthood, due to this, the prevention of disorders and the promotion of adequate development are objectives whose achievement begins with the identification of risk factors, as well as protective factors of mental health.

Therefore, it is considered important to promote the development of protective factors that support the growth and healthy maturation of the adolescent, primarily focused on establishing and achieving adequate self-esteem, that gives adolescents the chances to face problems responsibly throughout their lives.

Adolescence must be understood as a non-transferable stage of personal crisis in the scheme of biopsychosocial development of every human being. It generally covers a long period of life, which usually ranges from 10 or 12 years of age to 22.

The WHO defines adolescence as “the stage that passes between 10 and 19 years, considering two phases: early adolescence, from 10 to 14 years, and late adolescence, from 15 to 19 years. Dulanto divides it into three main stages:

1) *Early adolescence*, that covers from 12 to 14 years and corresponds to the period of secondary education; 2) *Middle adolescence*, which covers from 15 years to 17 years, and is equivalent to the period of high school or upper secondary education; 3) *late adolescence* or phase of resolution of adolescence, includes from 18 to 21 years and corresponds almost completely to university education.

Although adolescence is characterized by being a stage of changes with its own characteristics, such as identification instability and emotional fluctuations, it

is susceptible to receiving the impact of conflicts that originate around it such as family, school, friends, economic changes, etc. sociocultural and technological. All this can act as triggers for the adolescent to suffer a state of vulnerability that easily leads to a state of depression.

Depression according to the DSM-IV defines it as the presence for a period of more than 2 weeks of symptoms such as: depressed or irritable mood most of the day, loss of interest or capacity for pleasure in all or most of of activities, insomnia or hypersomnia, fatigue or loss of energy, feelings of worthlessness or guilt, decreased ability to think or concentrate, agitation or psychomotor slowdown, weight loss or gain, decreased ability to concentrate and suicidal ideation, and according to the severity of the symptoms, depression can be: mild, moderate and severe. For a long time it was considered that depression did not exist in children and that it was normative in adolescence, but in the last 30 years it began to be recognized that major depression is a disorder that children and adolescents also suffer from. According to international studies, worldwide it is estimated that up to 25% of children and adolescents suffer from depression, and that only 3 or 4% require treatment.

The WHO defines depression as the most common mental disorder, affecting around 340 million people worldwide. In the United States and Western Europe, the lifetime prevalence of major depressive disorder varies between 13.3% and 17.1% and in Mexico it is 12%, and it is estimated that the prevalence of psychiatric disorders ranges from 15% to 30% in the population under 18 years of age

Adolescents experience anxiety and depression in their lives just like adults, constituting a frequent problem that has increased in recent decades. Various international studies have shown that

diagnosed depression is present in 5% of adolescents at any given time, with a prevalence of 11.2% in women and 6.7% in men.

The causal factors of depression in adolescents are multiple, including genetics, being the child of people with affective disorders; Biological factors such as decreased dopamine, norepinephrine, and serotonin; individual factors such as emotional lability, formation of a new self-image, self-destructive attitude, lack of maturation and lack of academic achievement (deterioration of school performance); social factors such as family (effect of mother and father relationship), school, peers and social relationships that also play an important role in the genesis of adolescent depression. Stressors are also important, particularly the most common being the loss of a parent through death or divorce, child abuse, unstable attention span, lack of social skills, and chronic illness. Family conflicts have been associated with the externalization of problems such as aggressiveness and antisocial behavior, as well as their internalization, resulting in problems such as anxiety, depression, and low self-esteem.

It has been established that individuals with histories of depression in adolescence have presented a high percentage of continuation of the depressive disorder in adulthood.

For this reason, the opportune diagnosis of depressive disorder is imperative to avoid prolonged suffering and the possibility of suicide, since in Mexico it is estimated that suicide is the sixth cause of mortality, and the second cause between the ages of 14 to 49 years. The prevalence of suicide attempts in the Mexican adolescent population varies from 3.0 to 8.3%; and between 0.1 to 11% manage to commit suicide, being more common in the male gender, due to the fact that they present problems of impulsive, aggressive behavior

and an intense response to stress^(8, 19, 20)

If we consider the relevance of depressive disorder in adolescence as a serious pathology and as a critical period for the recognition of symptoms and early therapeutic establishment, it is important to have an instrument that can measure symptoms, quantify the intensity of depression and useful for therapeutic follow-up. Among the evaluation instruments is the Birleson Scale, translated into Spanish and validated in the Mexican adolescent population, which was designed to quantify the severity of depressive symptoms in children and adolescents that can be used to monitor response to treatment. It is a simple, self-applied Likert-type instrument that consists of 18 items with a cut-off point of 14 points for the detection of clinical depression.

And even though establishing a diagnosis of depression is important for timely treatment, prevention must be essential to avoid this problem and thus reinforce mental health in adolescence, which is defined as the state of balance between a person and their socio-cultural environment which guarantees their labor, intellectual and relationship participation to achieve well-being and respond to the ordinary demands of daily life. Therefore, prevention must be focused on favoring primarily protective factors and avoiding risk factors.

We understand risk behaviors to be actions, whether passive or active, that involve danger to the well-being of the individual or that have negative consequences for their health or compromise aspects of their development.^(7, 22)

A protective factor is defined as the set of circumstances and characteristics with which people improve their effectiveness to handle a potentially dangerous situation, these in turn offer a maximum degree of resistance, refraction or invulnerability, even under the most adverse conditions. The invulnerable or

refractory condition is defined as the ability to successfully cope with internal and external pressures that seek to violate a person. These factors play a beneficial or protective role in the health status of the individual, helping him to adapt to the physical and social environment. In turn, they reduce the probability of issuing risk behaviors or having negative consequences when they are involved in them, and likewise they favor the motivation to achieve the tasks typical of this stage of development and it has to do with the way they face situations. and life changes.

Studies, although insufficient, allow us to suggest that protective processes include:

- Those that reduce the repercussions of risk, by virtue of their effects on the risk itself, or by modifying the exposure or participation in it.
- Those that reduce the probability of a negative chain reaction resulting from the encounter with risk.
- Those that promote self-esteem and efficiency through personal relationships that provide security and support, or through success in completing tasks.
- Those who create opportunities.

In this regard, special attention needs to be paid to the fundamental mechanisms of developmental processes that enhance people's ability to cope effectively with future stress and adversity, and those that enable them to overcome the sequelae of past psychosocial risks. protective factors can be **personal** (self-esteem, autonomy and social projection), **family** (cohesion, warmth and low level of discord) and **social** (adequate stimuli and recognition of adaptation attempts).

METHOD DESCRIPTION

An observational, cross-sectional, comparative study was carried out to identify protective factors in adolescents, the presence

of depression in adolescents enrolled in secondary school. For this purpose, the Birlésón scale was used to identify depression and the Rosenberg scale to assess self-esteem. Both scales are validated and used in the Mexican adolescent population. For the protective factors, a data collection survey designed expressly for this project was used, for which the risk and protective factors of the published studies were first identified, since in none of them did we identify a scale, in each of these only they mention the aspects they explored and some questions are mentioned. A list of possible questions of the aspects to be explored was made and in a round of experts that included psychologists, pediatricians and social workers; The first version was created and the terms were modified for a better understanding in the adolescent population, with mixed questions. A second round was carried out to integrate the survey in a fine way, later a pilot test was carried out to verify if the questions are understandable, adaptation to idioms and the adolescent's own language, it was applied in three different populations of adolescents at different times to verify comprehension. of the questions and the answer options, until conforming the final version.

The permit was managed in the secondary school and the authorization by the local investigation committee, after these efforts, we proceeded to identify how many rooms and students per room

Prior agreement with the school authorities, a meeting was scheduled with all the teachers to inform them of the research project and a general discussion of the subject, later a meeting was held with the parents about how the research work was carried out, the best strategy for signing informed consent was identified, which was after the talk.

FINAL COMMENTS

SUMMARY OF RESULTS

The population that participated in the study was 466 students, 39.1% corresponded to the male gender and 60.9% to the female gender, the average age was 14 years with a minimum age of 12 and a maximum of 17 years. The school grade to which they corresponded was 44.2% for first grade, 27.3% for second grade, and 28.5% for third grade; 57.5% were from the morning shift and 42.5% from the evening shift. With an average grade of 86.1 for all participating students. The religion to which they belong was Catholic with 72.7%, Christian with 13.5%, Jehovah's Witness with 3.4% and none with 2.8%.

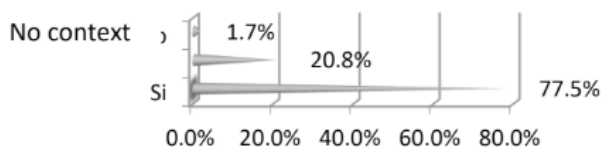
When evaluating the depressive symptoms through the Birleson scale, it was found that 21.9% present this symptomatology. (Graph 1)

In relation to the self-esteem evaluated with the Rosenberg scale, 17.6% with low self-esteem was observed, 19.5 with medium self-esteem, 59.7% with high self-esteem and 3.2% did not respond to this scale. (Graph 2)

One of the protective factors evaluated was the goals they have for the future, in the first goal, 90.1% responded and academic goals predominated with 46.0%, followed by professional ones with 27.9%; In the second goal, 80.7% of the students responded and professional and academic goals predominated with 20.2% each, followed by work goals with 17.6% and personal goals with 17.3%; in the third goal there was a response of 65.5% and personal goals predominated with 20.0%. In the fourth goal, 45.5% responded and family goals predominated; for the fifth goal there was a response of 29.4% and personal goals predominated; in the sixth goal, 14.2% responded and the personal ones predominated.

Another factor evaluated in the adolescent

population identified as a protector for depression and low self-esteem is the performance of some sport and it was observed that 77.5% of them do so. (Graph 3)



Graph 3. Distribution of students who do sports

32.0% with depressive symptoms do not perform this physical activity. (Table 1)

	Do sport	
	Yeah	No
Depressive symptomatology	68.0%	32.0%
Without depressive symptoms	81.8%	18.2%

Table 1. Depressive symptomatology in relation to doing some sport

Similarly, 27.2% with low self-esteem do not practice any sport. (Table 2)

	Do sport	
	Yeah	No
Low self-esteem	72.8%	27.2%
Average self-esteem	75.8%	24.2%
High self-esteem	81.6%	18.4%

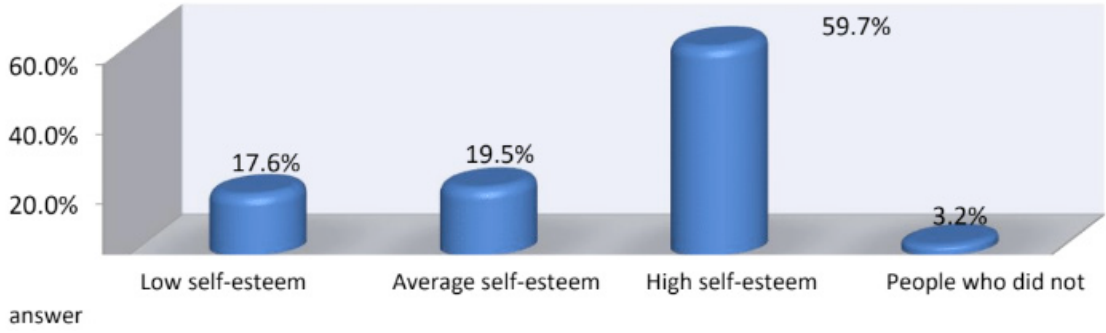
Table 2. Degree of self-esteem in relation to doing some sport

The coexistence that occurs with parents



■ Depressive symptomatology ■ Without depressive symptoms

Graph 1. Frequency of depressive symptoms



Graph 2. Distribution of the degrees of self-esteem in the study population

is walking with 28.6%, talking with 19.5%, sharing mealtimes with 11.0% and 5.9% reported that they do not carry out any coexistence activity. It is important to note that, for this question, 15.9% did not respond. Being related or making friends is another factor that is related to the presence or absence of depression or low self-esteem and it was observed that in the students surveyed, 35.1% find it difficult to make friends and 5.8% did not answer this item. In relation to what they do to feel good when they are sad, 72.6% do one activity, 8.9% two activities, 8.7% three and 1.1% none. 91.6% have a trusted family member to talk to ^{Graph 8} and 60.9% have someone they trust to talk to who is not from the family.

CONCLUSIONS

The population that participated in the study was 466 students, 39.1% corresponded to the male gender and 60.9% to the female gender, the average age was 14 years with a minimum age of 12 and a maximum of 17 years.

The school grade to which they corresponded was 44.2% for first grade, 27.3% for second grade, and 28.5% for third grade; 57.5% were from the morning shift and 42.5% from the evening shift. With an average grade of 86.1 for all participating students. The religion to which they belong was Catholic with 72.7%, Christian with 13.5%, Jehovah's Witness with 3.4% and none with 2.8%.

When evaluating the depressive symptoms through the Birleson scale, it was found that 21.9% present this symptomatology. In relation to the self-esteem evaluated with the Rosenberg scale, 17.6% with low self-esteem was observed, 19.5 with medium self-esteem, 59.7% with high self-esteem and 3.2% did not respond to this scale.

One of the protective factors evaluated

was the goals they have for the future, in the first goal, 90.1% responded and academic goals predominated with 46.0%, followed by professional ones with 27.9%; In the second goal, 80.7% of the students responded and professional and academic goals predominated with 20.2% each, followed by work goals with 17.6% and personal goals with 17.3%; in the third goal there was a response of 65.5% and personal goals predominated with 20.0%. In the fourth goal, 45.5% responded and family goals predominated; for the fifth goal there was a response of 29.4% and personal goals predominated; in the sixth goal, 14.2% responded and the personal ones predominated. Another factor evaluated in the adolescent population identified as a protector for depression and low self-esteem is the performance of some sport and it was observed that 77.5% of them do do it, 32.0% with depressive symptoms do not perform this physical activity, in the same way the 27.2% with low self-esteem do not practice any sport.

The coexistence that occurs with parents is walking with 28.6%, talking with 19.5%, sharing mealtimes with 11.0% and 5.9% reported that they do not carry out any coexistence activity. It is important to note that, for this question, 15.9% did not respond. Being related or making friends is another factor that is related to the presence or absence of depression or low self-esteem and it was observed that in the students surveyed, 35.1% find it difficult to make friends and 5.8% did not answer this item. In relation to what they do to feel good when they are sad, 72.6% do one activity, 8.9% two activities, 8.7% three and 1.1% none. Graph 7 91.6% have a trusted family member to talk to ^{Graph 8} and 60.9% have someone they trust to talk to who is not from the family.

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