



### *Original Contribution*

## **SELF-ESTEEM AND DEPRESSION IN ADOLESCENTS**

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### **ABSTRACT**

**PURPOSE.** The article looks at self-esteem and depression during adolescence. It is a theoretical study of the relationship between depression and self-esteem. There are types of self-esteem, self-esteem by gender and age. The theories of depression in adolescence, as well as the factors leading to depression, are examined. Several scales for assessing depression are presented. In view of the application of the main features of self-esteem and depression, their intersections in practical context are examined.

**Key words:** self-esteem, adolescence, depression, interrelation

### **SELF-ESTEEM IN ADOLESCENTS**

One of the many challenges that clinical psychologists face in modern society is the understanding of the correlation between self-esteem and depressive symptoms in adolescents.

The period of life characterized by transition from adolescence to adulthood is of a paramount importance for human development both because of the physiological changes and due to the fact that the adolescent has to acquire, in extremely tight time limits, all necessary cognitive, social and emotional skills that will allow him to respond adequately to the future demands of society.

An important condition for adequate assisting adolescents in their transition to maturity is the knowledge of the dynamics in the development of personality traits and of the prerequisites for the occurrence of mental problems in high school students. Depressive symptoms among Bulgarian high school students are becoming increasingly widespread.

Last stage of adolescence is the time of confrontation with unfulfilled tasks from previous periods and, in this sense, it gives a chance for overcoming the difficulties associated with creating adolescents' self-

identity and outlining the path to individuation process. The upper secondary school age plays a key role in shaping a number of personality and interpersonal communication features, in stabilizing the general psychophysiological state and in making important decisions about future life realization.

Self-esteem is the adolescent's attitude and overall evaluation of their own worth, or evaluation of given traits, position in the group, their own activities and relationships with others. Self-esteem is the degree to which the adolescents value and accept themselves; it is the sense of personal worth and competence. This is the value that they attribute to themselves (the belief that the self has for their own worth); it is one's love for oneself – emotions, care and devotion that the adolescent gives to him. (1).

Adolescent's relationships with environment require different qualities that are being manifested in different degrees, which, in turn, lead to different results. Depending on the relationship of these qualities with a given aspect of environment, the following types of self-esteem may be defined (2).

- **Self-esteem, related to adolescent's health and physical fitness** – assessment of physical endurance, health, strength, agility, speed, sharpness of vision and hearing, etc. They are important for a number of physical activities and especially for sports. In adolescence this

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type of self-esteem plays an important role in the process of boys' assertion among peers.

- **Self-esteem, related to appearance and physical attractiveness** – Besides self-evaluation of personal physical beauty here are also included assessments of manners and behavior, possession of good taste in dressing, maintenance of personal hygiene, neatness and orderliness. This type of self-esteem has a decisive role in the regulation of gender relations.

- **Self-esteem, related to habits, skills and abilities** – By content and scope that is the largest type of self-assessment, related to adolescents' abilities to effectively influence the external environment and achieve the goals set. They are important in defining ego identity and developing motivation for achievement.

- **Self-esteem, related to the qualities needed for interpersonal relationships** – they can be divided into two sub-groups – skills and abilities to communicate and maintain interpersonal relationships and moral qualities. **Self-appraisals**, regardless of their type, have **three main characteristics**.

The first one is the level of self-esteem. The subjective interpretation of the intensity of a given quality as insufficient, within the limits of the norm, or above the average, characterizes the level of self-appraisal, which is said to be low, medium or high. W. James (3) sees self-esteem as a ratio of success compared to pretensions and offers the following formula:

$$\text{Self-esteem} = \frac{\text{Success}}{\text{Pretensions}}$$

It is clear from this formula that, by reducing the level of pretensions, even modest success can be sufficient to maintain high self-esteem, while even significant success may prove to be insufficient if pretensions are too high. In some cases pretensions are set by the requirements of social environment for holding a certain position and then, to maintain high self-esteem, it is imperative to develop and improve personal potential which must go beyond the external requirements.

The second characteristic of self-esteem is **its significance**. It coincides with the subjective importance.

The third characteristic of self-esteem is **its adequacy**. It is known in psychology that the subjective perception of one's qualities does

not often correspond to their objective level. When there is such a discrepancy we define self-esteem as inadequate. Depending on the direction of discrepancy between self-appraisal and objective capabilities the self-esteem may be defined as inadequately low, or inadequately high.

**Inadequately low self-esteem** is associated with low self-confidence, indecision, uncertainty.

**Inadequately high self-esteem** is characteristic of adolescents with ungrounded pretensions and inflated self-conceitedness.

The adolescent's relationship with reality is multidirectional. Adolescents strive to achieve certain results, dream to change and improve in time, strive to meet the expectations of significant others, anticipate and expect certain changes to take place (4). In different situations the adolescent's self-image is presented from a definite, specific angle which allows us to define different types of self-esteem. The following main types of self-appraisal are defined:

- **Real self-esteem**. It is the current state of the qualities possessed. Whether it is adequate or not, it is the basis for behavior and choice of goals, matching them to the opportunities available.
- **Ideal self-esteem**. It reflects the adolescent's views and aspirations for achieving a level of development that meets his ideals and values.
- **Regulatory self-esteem**. It is related to the expectations of others towards the adolescent's behavior and reflects the adolescent's self-appraisal regarding the correspondence between his behavior and social norms and moral rules.
- **Expected self-esteem**. It is formed on the basis of the adolescent's ideas regarding the limits of the possibilities for development of qualities. It takes into account the limiting factors of external environment and adolescent's personality, which prevent the achievement of ideal and regulatory self-regard.
- **Perceived self-esteem**. It reflects the adolescent's subjective notions on how others perceive his/her qualities and on the opinion of the significant others about the adolescent (5).

Self-appraisal may be adequate and inadequate, i.e. it may reflect the adolescent's real abilities correctly or incorrectly (2). Inadequately inflated, as well as inadequately low self-esteem, often lead to conflicting relations with environment and unsuccessful

performance. Carl Rogers (6) is of the opinion that a conflict, including assessment by others and by moral values, may arise in the course of individual development between the adolescent's perceptions of themselves and real experience.

In some cases the conflict may be caused by the discrepancy between the adolescent's self-appraisal and the assessment of the immediate environment; in other cases it is determined by the discrepancy between the adolescent's self-esteem and the ideal qualities he strives to achieve. The author emphasizes that this discrepancy is not always of a pathogenic nature. Analyzing his rich clinical experience he concludes that the conflict outcome largely depends on how self-regard has been formed in the course of the adolescent's individual experience. In such cases some adolescents refuse to recognize their inadequate self-appraisal and misinterpret their real experience. Others are capable of doing so to make sure that their self-esteem corresponds to their real experience. C. Rogers believes that flexibility in appraising one's own self, the ability to correct personal behavior under the influence of experience is a condition for the adolescent's painless adaptation to life conditions (6).

R. Butler (7) considers the personality inadequacy which occurs relatively often in teenagers. Main source of inadequacy is the contradiction between the adolescent's needs and aspirations and the real chances for their satisfaction. She defines its functional role and treats it as a kind of defensive reaction, consisting in the person's neglecting or denying her/his failure and deteriorated interpersonal relationships, thus maintaining a positive attitude towards one's own personality. In this case the inflated self-esteem is achieved through an inadequate attitude to reality, which may lead to the formation of personal traits such as mistrustfulness, suspiciousness, distrust and aggression (7).

The chronic perception of discrepancy between the ideal and real self is associated with frustration, inferiority and depression.

By adhering to these developmental advantages, the aspects of the self-concept are more clearly outlined, differentiated and organized in adolescents than in pre-adolescent children (8). Adolescents begin to see themselves more through the prism of their personal beliefs and standards and less within the framework of social comparisons (9). They

can appraise themselves both globally and with regard to the individual aspects of the self-concept (10).

A major component of the social developmental situation during adolescence is the search for and the process of finding a psychological and social place in society that initiates the processes of self-awareness, self-acceptance and self-appraisal. These processes develop most intensely in this age. Self-awareness is associated with progressive personality differentiation and individualization which are being reflected in the pursuit of autonomy and self-regulation of the personality. Juvenile age is the period in which both the self-concept of the individual, self-appraisal being a part of it, and the various means for its realization are being built (11).

Juvenile age does not contribute much to the clarification of the stable/unstable self-esteem dilemma. Data from the studies conducted in this area do not provide a definite answer.

As the adolescents grow, more existential, subjective and abstract categories appear in the center of their self-descriptions, those being dictated by the adolescent's awareness of self-worth and self-activity (12, 8).

Gender also affects adolescents' self-esteem. When compared to boys, girls seem particularly vulnerable with regard to the level of their overall self-esteem. Generally, girls have significantly more negative attitudes towards themselves than boys (13). Achieving and maintaining a high and stable self-esteem at that age seems to be a specific challenge for them. It can be speculated that boys accept themselves as more independent and worthy than girls, or that they are more self-confident, thus making it seem that they have fewer problems. This, however, does not mean that boys do not have their feelings, worries or doubts; it is simply indicative of the fact that they cope better in the emotional sphere as compared to girls.

Girls are described as sadder, lonelier and more easily hurt. They are also more sensitive with regard to their inner world than boys (14). Research shows that girls are ashamed of their bodies; they feel ugly and unattractive, while the changes they make in their appearance make them feel even worse (15, 16). As an explanation of the lower self-esteem in teenage girls, researchers assume that boys tend to be more independent of other people's opinion, while girls are more prone to conformism (17). The scientific literature from studies conducted with Bulgarian adolescents is too scarce.

Therefore, the interest in the subject is not exhausted and more studies are yet to be conducted.

The American education system promotes the athletic achievements of pupils at school as being more important than school performance or popularity among other pupils. This leads to the establishing of a relatively independent juvenile society. In contrast, in 1967, Canadian students stated that they prefer academic over sports popularity (17).

Self-assessment is considered to be a key indicator of mental health (18). Researchers find some determinants relevant to self-esteem such as: peer influence (19, 20), family relationships, media influence and depressive symptoms.

### DEPRESSION IN ADOLESCENTS

Until recently studies were concentrated on depressive disorders in adults; only in recent years more attention has been paid to depressive manifestations in children and adolescents.

Depression is characterized by four types of changes – emotional, cognitive, motivational and neuro vegetative. According to ICD-10 there exist three forms of depression – mild, moderate and severe; the adolescents suffers from low mood, inability to experience joy, decrease and drop of energy. Depression is directly related to mood. Normal psychological decrease in mood is referred to as sadness, while the pathological one – as depression (21).

*Depression in childhood* is controversial. There was a theory that children do not suffer from depression. The demonstration of sadness and apathy were not considered to be real symptoms of clinical depression. According to some researchers depression in children is a transient state (22). The same authors claim that children cannot maintain a continuous dysphoric mood and they always find a way to protect themselves from it. Others believe that children have depressive symptoms, which, according to them, can be described as “masked depression” (23). Still others assume that it is possible that child depression is a real phenomenon but it is characterized by specific for children manifestations (24).

In any case, different scientific schools are based on different concepts of depression, expressing a specific opinion about this disorder in adolescents. We can assume that different concepts of mental development explain these differences of opinion when it

comes to depression in children. Thus, in the late 1960-s and early 1970-s the opinion of orthodox psychoanalysts was very popular, according to which childhood depression is unlikely to be observed as the super-ego is not developed yet (25). According to more recent views depression in children is manifested as aggression, anxiety and anger, which replace key symptoms of dysphoric mood, loss of interest, etc. (26).

*Concepts for the absence of depression in children.* The idea that children do not suffer from depressive disorders may be found in the early psychoanalytic thinking. This idea is directly related to the postulate of a strong and punishing superego. The Freudian explanatory model of depression is related to the nature of unsatisfied libidinal impulses. It can be accepted that at a later age, the depressive child’s superego reflects the parental values and ideals with which the child has identified him/her. As a result of the struggle between the depressive child’s superego and self, self-criticism to his/her own personality is born (27).

Thus, according to the psychoanalytic theory, it appears that real depressive symptoms can only occur in individuals who have reached the stage of a developed superego. Since superego develops during the period of late childhood and is unstable for a long time afterwards, the condition observed in children, according to psychoanalysts, cannot be classified as depression. Such a view is also consistent with the idea that depression is associated with the experience of guilt, which is only hypothetical in children. The use of this model for children becomes even more difficult when depression is explained with the presence of low self-esteem, having come as a result of the discrepancy between the ideal and real self.

Modern psychoanalytical views explain childhood depression with the role of parental behavior: disagreement with parents, fixation on the oral phase (related to the mother’s failure to meet the child’s basic needs), loss of self-esteem due to unsatisfied emotional needs by the parents, auto-aggression – result of either psychological or physical abuse by the parents, or the child’s feeling of guilt, suggested again by the parents (28).

*Concepts for the presence of transient depressive states in children.* The idea that children experience transient depressive conditions is related to the opinion that children’s affects are short-lived as they cannot resist these painful feelings for a longer period

of time. In such cases the child's protective reaction is to focus their attention on some enjoyable experience. On the other hand, manifestations of aggression and hyperactivity are treated as masked depression and an attempt to cope with trauma (23).

People suffer from depression from an early age and in children it can be diagnosed through verbalization, communication, games and external mood. Views on depression in children fall into two categories: children suffer from *disguised depression* or they *have depression states similar to those in adults*.

Representatives of the first group insist that children suffer from depressive equivalents or masked depression (23). Besides the depressive symptoms, related to emotional manifestations such as feelings of helplessness and inadequacy, behavioral problems are added – aggression, hyperactivity, outbursts of anger, demonstrative behavior, opposition to authority, etc. The main question in such cases is whether masked depression is the most common way to define childhood depression and why sometimes masked depressions are being successfully treated with antidepressants. Psychologists, supporting the second view, claim that children experience depression similar to that in adults. J. Asarnow (29) points out that, when assessing children, a distinction must be made between normal low mood and depression. He emphasizes the fact that feelings such as guilt and self-condemnation are part of the depression diagnosis in children. J. Anderson (30) also makes a difference between children with depressed affect, accompanying other psychopathological conditions and those with depressive syndrome, meeting the criterion of depressive disorders in adults.

Comparative research shows that depressed children have difficulties in social interaction and possess fewer social skills as compared to non-depressive children (26). Another finding from a social study conducted is that social isolation is a stronger indicator of depression during latency in girls than in boys (31).

Difficulties arise in attempting to assess the level of self-appraisal in younger children as the concept of self develops between the age of 6 and 9. The depressed child most often denies to have been hurt. Similarly, there are ambiguities in registering the feeling of guilt in children.

A. Kazdin (32) summarizes data, demonstrating similarity in depressive signs in adults and children. Somatic symptoms are

most common in younger children due to their inability to express low mood and dysphonic (angry) mood. In older children there is a cognitive aspect as well – low self-esteem and negative views about one's own self and the surrounding world. Learned helplessness, related to a certain attributive style, external locus of control and problem-solving deficit are often observed in children (33).

Similar conclusions can be drawn from the results of the model of social skills deficit – depressed children more rarely enter social relationships and have low level of expression (26).

The “normative” side of depression in adolescents is related to the activation of instincts and urges and the struggle with them. The inability to overcome this conflict leads to low self-esteem, guilt and depressive experiences.

Theoretical views and empirical studies make it possible to assume that there is a connection between juvenile depression and the process of achieving autonomy from parents in that period. The main problem of adolescents is the conflict between the desire to stay connected with their parents and the need to achieve autonomy from their families and deepen their relationships with peers. Autonomy does not develop in isolation but in the context of a close relationship with parents. Adolescents from families in which autonomy is hard to achieve experience severe stress (34). The *affection* existing between family members is important. More organized, flexible and united families are characterized by unquestionable affection, while distant and conflicting families tend to develop insecure, avoiding affection (35). In adolescence unquestionable attachment is characterized by warm relationships with parents. Adolescents, experiencing insecure affection are ambivalent and distant from their parents.

H. Kohut (36) thinks that adolescent affection is different from that in childhood. According to this author, *the withdrawal of parental attention during this period is an adequate reaction*. Parents who change their style of upbringing in keeping with the adolescents' needs are more effective than those who are trying to control the child's life outside the family. Adequate parental behavior involves giving more autonomy, inviting the child to participate in the decision-making process in the family and discussing parental supervision in a democratic way. While in childhood the parent is a source of support, relationships

between parents and adolescents become reciprocal. We may assume that adolescents' self-esteem, which is directly related to depression, is related to the child's affection to their parents. Uncertain affection can lead to a serious crisis in the adolescent period. If the adolescent's strive to autonomy is not balanced with affection within the family, emotional disorders, such as depression, may occur. Experiencing tension, anger, sadness and anxiety towards their parents and being uncertain in their parents' love, adolescents are not able to explore the world with calm and balance.

There exist several factors in *parenting style* that could lead to depression. First of all this is *emotional abuse*, that is expressed in the predominance of destructive parental emotions, which are imperative in the relationship with the child, thus neglecting the child's personality.

Secondly, this is the problem of setting *boundaries of relationships* in a family with a depressed adolescent (37). The boundaries between individuals can be rigid (characterized with distancing, coldness and lack of emotional sharing), or unclear (characterized with emotional fusion, lack of personal space and autonomy). We can assume that fusion, or *emotional differentiation* in the family is the leading cause of depression in adolescents. Individuals with low emotional differentiation are dependent on the emotional response of others, and feel strong anxiety when it comes to communication and intimacy. Such dysfunctional relationship between the adolescent and the parent leads to the adolescent's losing their own self. The adolescent turns out to be dependent and dominated although the parent has the same reactivity and sensitivity as the child. Tension, insecurity, anger and low mood are experiences that are typical of an adolescent raised in such a family. Not only breaking the boundaries, but coldness in relationships as well, can be considered a predictor of depression in adolescents.

We can summarize the above opinions with S. Minuchin's theory that both rigid and unclear boundaries are inadequate. Too rigid boundaries create constant tension between people with their desire for constant control and avoidance the "weakness" of love. Too unclear boundaries suppress the adolescents, make them uncertain and angry. In this sense, adolescents' emotional problems may be related to the quality of family boundaries, as teenage crises, including depression, cannot be

overcome adaptively without the existence of flexible boundaries among generations (38). This means the presence of a balance between *support and control by the parents during this period*.

In adolescents depression incidence increases many times and reaches 14% among the 14-18 year olds as compared to the 3% incidence in childhood. Between 3 and 8% of the adolescents are diagnosed with depression, making it one of the most common chronic diseases, its incidence being bigger than that of bronchial asthma.

Depression, in turn, is conducive to concomitant pathologies such as alcohol abuse, drug addiction, obesity, behavioural abnormalities, interpersonal conflicts, school problems.

Depression incidence (major depressive episode) varies from 0.4-2.5% in children to 0.4-8.3 % in adolescents and increases to 17-20% in adults over the age of 18.

More than 90% of the patients with major depressive episodes reach full remission within 1.5 - 2 years, the remission lasting seven-nine months on the average. Recurrences within five years are observed in over 70% of the cases.

Genetic factors: Data from epidemiologic studies reveal family history in 23-58% of the cases. Up to 50% of adolescents with depression have a family history of mental illnesses (most often bipolar disorder).

Environmental factors: in these cases life events and environmental factors (chronic stress) may trigger a mental disorder. On the other hand, a healthy family environment, positive school environment and good relationships with classmates may play a protective role (39). Depression in parents influences the risk not only because of the family history, but also through hostile or passive parental attitude towards the child and lack of parental care (40).

Among the risk factors for adolescent depression is the unstable family environment, low social status, death of a parent, sexual and physical abuse, divorce. These factors can also act as modulators in cases with diagnosed depression.

Risk factors for depression include increased level of anxiety, low self-esteem, high self-criticism, poor performance at school, lack of social skills. Depressive adolescents feel guilty of any negative event and loss in their life.

Minor depressive episodes are characterized with the presence of at least two of the main criteria, with the average adolescent's activities being difficult but not disturbed.

All main criteria and most of the additional ones are present in a case of major depressive episode, the adolescent being unable to perform his/her everyday activities. Atypical manifestations include lethargy, increased appetite, hypersomnia.

Adolescent depression is characterized with sleep and appetite abnormalities, suicidal attempts and behavioural disorders, the neuro-vegetative symptoms being rarer as compared to adults with depression.

In terms of gender differentiation of child depression literature has been scarce and ambiguous. The results show that up to the age of 12 boys have higher levels of depressive symptoms than girls. In adolescence, however, depressive symptoms occur twice as often in girls. They more often experience major depressive episodes and have low self-esteem and anhedonia, while boys generally have problems with interpersonal relationships. Girls tend to direct their experiences to themselves and get depressed, while boys, when having a problem, become antisocial and dependent in their behavior.

Every adolescent with suspicion of depression has to undergo an assessment of mental status, including: appearance (personal hygiene, facial expression), orientation, intellect, emotions, psychomotor skills, speech, memory, neuropsychological development, manifestation of psychotic symptoms, level of self-esteem, understanding of the problem.

Depression assessment scales include a variety of questions that the adolescents have to answer. Based on responses, adolescents who are at risk of a mental disorder are identified and the severity of depressive symptoms is determined.

The Pediatric Symptom Checklist scale consists of 35 questions, including different spheres such as: school performance, emotional sphere, psychosomatic complaints. Possible answers are: never, sometimes, often, receiving 0, 1 and 3 points respectively. A sum > 28 points indicates a mental disorder.

The Guidelines for Adolescent Preventive Service questionnaire can also prove a mental disorder, without identifying the nosological unit. The purpose of using these questionnaires is to find out whether the adolescent suffers

from a mental disorder and refer him to a psychiatrist for further tests and therapy.

The Home, Education, Activities, Drugs, Sexuality, and Suicide / Depression (HEADSS) scale can be used by general practitioners in an outpatient setting and it can identify adolescent depression and suicide risk. Depressed adolescents have an increased risk of developing bipolar affective disorder, which requires screening for emotional abnormalities whenever depression is detected. It is necessary to actively seek symptoms of mania and hypomania.

Affective disorder may be severe and may require hospitalization. In some cases, additional drug therapy may be required which may be administered together with the Selective serotonin uptake inhibitors (SSRIs). The Parent Young Mania Rating Scale and the Parent General Behavior Inventory Scale are appropriate scales for assessing bipolar affective disorders.

Research on adolescents with depression: Information about past diseases, peculiarities of the family environment, psychological features, neuropsychological development, medication therapy, behavioural disorders and suicide risk is collected (41).

The general condition assessment must exclude any organic causes for depression – infections, neurological diseases, endocrinopathies. Hypothyroidism, for example, may cause asthenodynamia, changes in sleep and appetite. Chronic diseases can also have symptoms similar to those of depression. Alcohol also has a depressive effect and 50% of the suicides of depressive adolescents are under the influence of alcohol.

If the adolescent has suicidal thoughts and displays marked hostility (aggression, opposition and anger), the clinician has to find out whether the adolescent has a plan for deliberate self-harm or suicide – manner, time, place, means. Adolescents with a well-thought out (ready) action plan are at the highest risk of implementing that plan and must be urgently examined by a psychiatrist.

The two main risk factors for suicidal behavior are any previous suicide attempts and a mental disorder, mainly depression. Previous attempts to commit suicide are the most important predictor of a further attempt.

About 80% of the adolescents having attempted to commit suicide and over 90% of those who have succeeded have a history of

mental disorder. The most common disorders include depression, alcohol and drug addiction, anxiety disorders.

Suicide risk assessment includes a review of family history, previous suicide attempts, mental disorders, negative life events, stress, family violence, physical and sexual abuse, interpersonal conflicts, separation from a loved one, and suicide of a close friend.

Adolescents suffering from depression often have psychosomatic complaints such as headache or abdominal pains. In most cases, having conducted lots of laboratory tests without finding any pathological abnormalities, the doctors classify the symptoms as being part of the depressive episode clinical signs.

Between 40 and 90% of the adolescents with depression suffer from concomitant mental disorders such as anxiety disorders, low self-esteem, drug addiction, attention deficit hyperactivity, dysthymia, eating disorders.

## CONCLUSION

This theoretical analysis shows that work with adolescents increases the challenges for clinical psychologists as it requires a broader view that goes beyond knowing the symptoms. According to recent psychological research, in recent years, both in Bulgaria and other countries, the depressive symptoms at the end of the adolescent period are widespread. In this age depressive disorders increase two to three times. This gives us reason to study the dynamics, associated with self-esteem and depressive symptoms in high school pupils.

Scientific literature has established the relationship between self-esteem and depressive symptoms. This relationship is important for health care. A more extensive research of that relationship will be conducive for providing more efficient health care for adolescents with depressive symptoms.

The factors for the incidence of depression in adolescents are not well specified in scientific literature, which is why researchers focus their interest on their study. We believe that their identification will enhance the understanding of illness behavior, will promote the interaction with adolescents and improve the individual approaches to their treatment.

Knowledge of these factors in practical work may be conducive for the development of psychological interventions aimed at changing the non-adaptive models for coping with

diseases, health policy programs and last, but not least, health promotion programs.

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