Coping strategies of depressed and nondepressed adolescents

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COPING STRATEGIES OF
DEPRESSED AND NONDEPRESSED
ADOLESCENTS

A Dissertation
Presented to
The Faculty of the School of Education
The College of William and Mary in Virginia

In Partial Fulfillment
Of the Requirements for the Degree
Doctor of Education

by
Marcia A. Kennedy
December, 1995
COPING STRATEGIES OF DEPRESSED AND NONDEPRESSED ADOLESCENTS

by

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Approved October, 1995 by

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Sandra C. Ward, Ph.D.
To my family,
my husband, George,
and children, Chris and Joe
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COPING STRATEGIES OF DEPRESSED AND NONDEPRESSED ADOLESCENTS

ABSTRACT

The purpose of this study was to determine if there are differences in the regulation of sad affect between depressed and nondepressed adolescents and between younger (12 years to 15 years, 6 months) and older adolescents (15 years, 7 months to 18 years). Using an information processing perspective, this study focused on several steps involved in emotion regulation including the generation, evaluation, and reported use of coping strategies.

Participants included 38 male students, 12 to 18 years of age, attending public middle and high schools in Chesapeake, Virginia. Participants were presented with two scenarios designed to evoke feelings of sadness. They were asked what type of feelings they would have and what coping strategy they would use. After the presentation of each scenario, the participants were given thirty-two strategies to evaluate for effectiveness and to report frequency of use.

The depressed group differed from the nondepressed group in the feelings they expected to have in response to the situations presented, \( p < .02 \). They also differed in the generation \( p < .02 \), evaluation for self and others \( p < .011 \) and \( p < .001 \) and reported use \( p < .002 \) of the strategies. Relative to the nondepressed group, the depressed group generated more passive avoidance strategies, gave higher ratings of effectiveness to less acceptable strategies and reported using maladaptive coping strategies more often.

The younger group differed from the older group in their evaluations of the strategies for self and others \( p < .000 \) and \( p < .007 \). Surprisingly, the older male adolescents provided higher effectiveness ratings for the less acceptable/maladaptive strategies than younger adolescents.

This study also found interaction effects for diagnosis and age in the evaluation \( p < .003 \) and reported use \( p <
.009) of specific affect regulation strategies during adolescence, suggesting emotion regulation processes may not progress in the same sequence for depressed and nondepressed adolescents. This strongly indicates that therapeutic interventions rather than maturation alone are necessary.

Further studies to determine if these results can be replicated, and studies with larger and more diverse populations are needed. Studies designed to explore the processes involved in both the perception of affect and the evaluation of coping strategies are needed to explain the types of results found by this study. If these findings are replicated, professionals who work with clinical populations of adolescents may need to review their intervention programs to determine if they are consistent with the outcomes of studies in this area.

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COPING STRATEGIES OF DEPRESSED AND NONDEPRESSED ADOLESCENTS
CHAPTER I

Introduction

Justification for the Study

Individuals of all ages engage in various strategies to cope with heightened levels of negative emotional arousal. The characteristics and processes involved in modifying or attenuating this arousal are part of a complex system known as emotion regulation. Emotion regulation, to be effective, requires the activation and integration of appropriate responses in three separate domains: cognitive, neurophysiological-biochemical, and behavioral-expressive (Lang, 1968). According to Dodge (1989), responses to any emotional arousal occur simultaneously in each of the three domains and activity in one domain serves to alter activity in the other two.

Focusing on the cognitive and behavioral-expressive domains, Garber, Braafladt, & Zeman (1991) identified six steps, each of which has to be successfully resolved to attain competent emotion regulation. These six steps are:

(1) perception, or the recognition that affect is aroused and needs to be regulated;
(2) interpretation, or the cognitive interpretation of what is causing the emotional arousal and what or who is responsible for altering the negative affect;
(3) goal setting, or the decision as to what, if
anything, needs to be done to alter one's affect; (4) response generation, or the generation of concrete responses to achieve the goal, which can be affected by one's knowledge of appropriate responses and one's ability to access this knowledge; (5) response evaluation, or the evaluation of the responses generated with regard to their expected outcome (i.e., achievement or failure to achieve the desired goal), expected consequences apart from goal attainment (e.g., positive or negative), and one's perceived self-efficacy in producing the response; and (6) enactment, or the actual skill one has to implement the chosen response (pp. 210, 211).

A review of the literature (Brown, Covell, and Abramovitch, 1991; Franko, Powers, Zuroff & Moskowitz, 1985; Garber et al., 1991; Harris, Olthof and Terwogt, 1981; Wertlieb, Weigel & Feldstein, 1987) suggests there is an increasing interest in identifying the developmental changes which occur in emotion regulation and in understanding the differences in children's use of emotion regulating strategies. Few studies, however, have systematically explored emotion regulation by focusing on the six essential steps identified by Garber. In particular, Garber et al.'s (1991) steps of emotion regulation have not been systematically applied to the exploration of differences in the development and use of coping strategies between normal
and clinical populations of adolescents.

There are however, several studies by Garber et al. (1991) which used the six steps to look at similarities and differences in emotion regulation between groups of depressed and nondepressed children. They concluded depressed and nondepressed children generate different types of self regulation strategies, and that the affect modification techniques generated by depressed children are more likely to be maladaptive. They also reported that depressed children, in general, have significantly lower expectations about the ability of coping strategies to alter their negative moods. Since the majority of participants in those studies were in preadolescence, a thorough understanding of differences among normal and depressed adolescents is still incomplete. From these studies, one might assume that similar differences occur between depressed and nondepressed adolescents, however a systematic investigation of this has not yet been conducted and therefore such assumptions would be premature.

Before one can fully appreciate the differences in emotion regulation between clinical and normal populations, it may be helpful to have a thorough understanding of the developmental changes which occur throughout the particular age group of interest. There are studies (Brown, Covell, & Abramovitch, 1991; Franko, Powers, Zuroff & Moskowitz, 1985; Harris, Olthof & Terwogt, 1981; Wertlieb, Weigel & Feldstein, 1987) which have used many of the same steps identified by Garber et al. (1991) to examine
developmental changes in emotion regulation. Brown et al. (1991), Harris et al. (1981), and Wertlieb et al. (1987) reported children of different ages generated different types of strategies for the modification of negative feelings. Harris et al. concluded children understand and generate self control strategies that can be exercised over both the outer expression of emotions and the inner mental components. Each of the researchers found that younger children suggested activity-related strategies designed to change a situation, while older children suggested both activity and emotion management strategies. In these studies, emotion management strategies were defined as those designed to change one's own inner emotional state.

Despite findings of developmental changes in emotion regulation during childhood and preadolescence, few studies have explored the possibility of continuing changes in emotion regulation throughout adolescence. Although adolescents have been included in the studies identifying the normal developmental components (Brown, Covell & Abramovitch, 1991; Franko, Powers, Zuroff, & Moskowitz, 1985; Harris, Olthof & Terwogt, 1981; Wertlieb, Weigel, & Feldstein, 1987), only Harris et al. (1981), included them as a separate age group.

This review of the literature illustrates that two areas of emotion regulation need additional study. The two areas are:

(1) the differences, if any, which occur in affect regulation between normal and depressed adolescents, and
(2) the developmental changes, if any, which occur in affect regulation throughout adolescence.

The application of Garber's six emotion regulation steps to an investigation of these areas could significantly expand the understanding of emotion regulation throughout adolescence and provide a better understanding of the emotion regulation processes in general. Identifying the components of normal emotion regulation and identifying normal developmental differences in the utilization of emotion regulation strategies could result in the development of more effective methods for assisting adolescents to better cope with negative feelings. It could help those working with both normal and clinical populations to teach the coping skills needed to deal effectively with negative feelings throughout the participants lives. Distinguishing the components of ineffective and maladaptive emotion regulation from those of normal emotion regulation could assist in the early identification of adolescents at risk for developing prolonged emotional difficulties. Furthermore, if differences between normal and clinical populations are found at the specific steps identified by Garber et al. (1991), it may be possible to target interventions to remediate specific deficit areas. In general, a better understanding of emotion regulation throughout adolescence could help all who work with adolescents to better assist them in effectively coping with their negative feelings.
Purpose and Research Questions

The purpose of this study was to identify differences in affect regulation between normal and depressed adolescents and to investigate developmental changes in affect regulation during adolescence. The study examined variations in adolescents' use of several steps Garber et al. (1991) identified as necessary for competent emotion regulation. These steps were delineated, using an information-processing theory and by focusing on the cognitive and behavioral-expressive domains of emotional responding. Based on this theoretical framework, the following questions were addressed:

1. Do depressed adolescents differ from nondepressed adolescents in the strategies they generate and report using to alleviate feelings of sadness?

2. Do depressed adolescents differ from nondepressed adolescents in their evaluations of the effectiveness of self-regulating strategies?

3. Do younger adolescents differ from older adolescents in the types of strategies they generate and report using to alleviate feelings of sadness?

4. Do younger and older adolescents differ in their evaluations of the effectiveness of affect regulating strategies?
Definition of Terms

Adolescence, for the purposes of this study, included youth between the ages of 12 and 18 years. Early adolescence included students between the ages of 12 years and 15 years, 6 months and late adolescence included students between the ages of 15 years 7 months and 18 years.

Dysthymia was identified according to The Diagnostic and Statistical Manual of Mental Disorders-III-R (American Psychological Association, 1987) (see Appendix A).

Major Depression was identified according to The Diagnostic and Statistical Manual of Mental Disorders-III-R (American Psychological Association, 1987) (see Appendix A).

Serious Emotional Disturbance was identified according to the 1994 Virginia Department of Education Regulations Governing Special Education Programs for Handicapped Children and Youth in Virginia (see Appendix A).

Regulation of emotion is a term "used to characterize the processes and characteristics involved in coping with heightened levels of positive and negative emotions including joy, pleasure, distress, anger, fear, and other emotions" (Kopp, 1989, p. 343).

Response evaluation involves the evaluation of emotion regulating strategies with regard to their expected outcome (i.e., achievement or failure to achieve the desired goal), expected consequences apart from goal attainment (e.g., positive or negative), and one's perceived self-efficacy in producing the response.
Response generation is the creation or recollection of concrete responses to achieve a goal. It can be affected by one's knowledge of appropriate responses and one's ability to access this knowledge (Garber, 1991).

Sample Description and Data Gathering

Two groups of male adolescents, matched on several variables, participated in this study. One group (depressed) included students considered to have long standing difficulties with emotion regulation. The other group (nondepressed) included students considered to engage in age appropriate emotion regulation. All participants attended middle schools and high schools within a large public school system serving approximately 33,000 students.

Twenty-five male students were identified as meeting the criteria for inclusion in the depressed group. They had been previously diagnosed with a depressive disorder (dysthymia or major depression) and were attending special education classes for students with serious emotional disturbances. Twenty of these students returned the parent permission forms and agreed to participate in the study. One participant was dropped after identification of a response set invalidated his results. Therefore, nineteen male adolescents participated in the depressed group.

The second group consisted of nondepressed, general education students, and were matched on several variables (ability, age, grade placement, socio-economic status,
family structure and school) to the individuals in the first group. Twenty general education students returned parent permission forms and agreed to participate. One student was dropped from the general education group after determining the need to match only 19 students in the depressed group.

Later, for analytical purposes, the participants were divided according to age rather than diagnosis. Two groups consisting of 19 males in early adolescence (ages 12 years to 15 years, 6 months) and 19 males in late adolescence (age 15 years, 7 months to 18 years) were formed. Age groupings were made by splitting the available population in half.

To assure the safety and ethical treatment of the participants, the proposal for this study was submitted and approved by the Human Subjects Research Committee of the College of William and Mary and the Director of Research, Testing and Student Activities for the Chesapeake Public Schools. Permission to conduct the study within each school was then obtained from each middle and high school principal before identification of potential participants began.

After parent and student permissions were obtained, semi-structured interviews were individually administered. The interview consisted of two scenarios designed to evoke feelings of sadness and was followed by a series of research questions. Following the presentation of each scenario, the students were asked: a) how they would feel in the given situation, b) how intensely they would feel that emotion, and c) what they would do, if anything, to make themselves feel better. The participants were presented with 32
strategies and asked to report how often they actually used each of them. A four point rating scale was used for these responses. The students were also asked to rate the effectiveness of the thirty-two strategies for making both themselves and others their age feel better. A five point rating scale was used for these responses. Presentations of the scenarios were counterbalanced to reduce possible effects of having strategies from the second scenario suggested by the presentation of strategies for the first scenario.

Limitations of the Study

There were several limitations to this study. One limitation was the variability surrounding the diagnosis of depressive disorders. In order to reduce this as much as possible, only those students were included for whom the diagnosis of a depressive disorder was determined in psychiatric evaluations in which the psychiatrists followed the DSM-III-R guidelines.

A second limitation of the study was the use of only male participants. Lewis, Wolman and King (1972) and Franko et al. (1985) reported finding gender differences in self-regulatory strategies for sadness; however, the use of only male participants was necessary due to the relatively limited number of females currently placed in classes for students with serious emotional disturbances and identified with depressive disorders. Results should not be generalized to females.

A third limitation of the study was the use of
participants having more than one identified disability. Some, but not all, depressed participants were also diagnosed with learning disabilities, attention deficit disorders, and conduct disorders. The interaction of these conditions with depression may affect the generation, use, and evaluation of coping strategies differentially. The absolute number of students in each subgroup involving other handicapping conditions was too small to allow for separate analysis.

The use of a semi-structured interview may have been another weakness, since it required self-reported information about behaviors. Reliance on self report, rather than observations of the strategies actually employed by the participants, created concerns since it may not have been reliable and was not necessarily provided when the subject was in an altered mood state. This would be particularly important if the mood state actually interferes with the ability of the subject to utilize strategic knowledge, as is theorized by Bransford (1984) and Garber et al. (1991). For this study, the induction of mood states was not considered to be controllable nor ethical, since alleviating induced negative mood states in certain subjects could not be guaranteed. Furthermore, despite the limitations inherent in the use of semi-structured interviews, the literature has considered it an acceptable means of obtaining information about affect regulation since the type of experiential information needed can be obtained only in this manner (Brown et al., 1991).
Error in the data collected caused by variability in the skill level of interviewers was also considered to be a potential weakness of the use of the semi-structured interview. Training of the interviewers prior to data collection was provided to control for this.

**Ethical Safeguards**

The principles for dealing with human participants in research outlined in the APA document *Ethical Principles of Psychologists* (APA, 1982) were followed in this study. The study was submitted to and approved by the dissertation chairman and committee members, the Human Subjects Research Committee of the College of William and Mary, and the Student Activities Committee of the Chesapeake Public School System.

Informed consent forms (see Appendixes C and D) were obtained from all parents and participants. All assignments of participants to groups and all participant responses were kept confidential and recorded in a manner to assure anonymity. The study results were not and will not be made available to school personnel or others in a format in which any individual's participation in the study, group assignment, or individual responses can be identified. None of the information obtained from the semi-structured interview, nor any record of participation in the study was nor will be included in student, teacher, or school records. Follow-up services were offered for any participants feeling they had been negatively affected by the interview, or
perceiving that they had been negatively affected in any way by participation in the study.
CHAPTER 2

Review of Literature

Theory of The Self-Regulation of Emotion

Emotion and emotional behavior are complex constructs with numerous definitions. They have been described as subjective valence experiences (Block, 1957), an epiphenomena of cognition (Hesse & Ciccetti, 1982), states of physiological arousal (Lang & James, 1992), action tendencies (Izard, 1972; Tomkins, 1962), and discrete expressive behaviors (Plutchik, 1980). Piaget (1952/1981) stated that an emotion may be described as an energy level and therefore all responses may be viewed as emotional. Despite the various definitions, Dodge (1989) stated definitions of emotions generally have in common the concept of "an energized response to a demanding environmental stimulus" (p.339).

Lang (1968) proposed that an organism responds to a demanding stimuli within three component systems or processes: neurophysiological-biochemical, motor-expressive or behavioral-expressive, and subjective-experiential or cognitive. Emotional responding is thought to occur simultaneously within each of these three response systems (Dodge, 1989, p.339). Theories of emotion vary in the emphasis of one system over another, but generally accept that response occurs in all three systems which together constitute emotional responding (Dodge, 1989). Emotion
regulation is the process by which the organism coordinates responses across or between these three response domains. Integration and coordination among the three domains is important to the regulation of emotion, and activation of one response domain serves to alter or modulate activity in the other response domains (Dodge, 1989).

Using information processing theory and focusing on the cognitive domain, Garber et al. (1991) delineated the primary processes needed for competent emotion regulation in this domain. They are:

1. perception, or the recognition that affect is aroused and needs to be regulated;
2. interpretation, or the cognitive interpretation of what is causing the emotional arousal and what or who is responsible for altering the negative affect;
3. goal setting, or the decision as to what, if anything, needs to be done to alter one's affect;
4. response generation, or the generation of concrete responses to achieve the goal, which can be affected by one's knowledge of appropriate responses and one's ability to access this knowledge;
5. response evaluation, or the evaluation of the responses generated with regard to their expected outcome (i.e., achievement or failure to achieve the desired goal), expected consequences apart from goal attainment (e.g., positive or negative), and one's perceived self-efficacy in producing the response; and
6. enactment, or the actual skill one has to implement
the chosen response (pp. 210, 211).

Garber (1991) pointed out that although information-processing models sometimes make it appear as though the processing at each step is slow and deliberate, it typically occurs rapidly and without awareness. In a research study, the act of inquiring about individuals' thinking forces the processes into awareness, but we cannot assume that subjects are necessarily cognizant of these processes as they are occurring (p. 217).

Although the current study focused primarily on the response generation and response evaluation steps, a brief explanation of possible deficits at each step of emotion regulation and the research currently available concerning their effect on the over-all regulation of emotion for normal and depressed populations is necessary. This model of emotion regulation is interactive and therefore requires an understanding of influencing factors from every step.

Dysregulation of emotions can result from deficits at one or several of the information-processing steps. A deficit at the first step is a perceptual deficit and involves failure to encode the negative emotion or distress. This is considered a deficit in the self-regulation of emotion since, generally, it is necessary to recognize one is experiencing negative feelings in order to begin a process of regulating them. Somatic complaints may be the result of difficulty at this step (Apley, 1975; Shapiro &
Rosenfeld, 1987) and in adolescence an inability to identify personal feelings may indicate difficulty with the encoding of emotions, although other explanations are also possible. Reichenbach and Masters (1983) and McCoy and Masters (1985) have reported on children's ability to decode the affect of others; however, studies addressing the accuracy with which individuals identify their own affect have not been conducted.

A deficit at the second identified step in emotion regulation is an interpretation deficit which results from misdiagnosing the cause of emotional distress or misinterpreting who is responsible for altering the emotional distress (Brickman et al., 1982).

Failure to choose an appropriate goal is considered to be a goal setting deficit (Step 3). In the case of the self-regulation of negative affect, this may involve choosing goals that prolong one's own experience of distress or involve the failure to choose the modification of negative affect as a goal.

Goal setting deficits and interpretation deficits in depressed populations are thought to occur either because of the depressed individual's low energy level and subsequent failure to initiate behavior or because goals are chosen that interfere with the alleviation of negative feelings. In the latter case, the depressed individual may choose to continue being depressed in order to maintain secondary gains. Obtaining increased attention, expressing anger, or using one's depression to reduce aggressive behavior in
other family members (Hops, Biglan, Sherman, Arthur, Friedman, & Osteen, 1987) are examples of conflicting goals which may interfere or prolong the decision to modify one's own depressive mood. Studies indicate depressed adolescents attribute negative events to internal, stable and global causes (Peterson & Seligman, 1984; Sweeney, Anderson, & Bailey, 1986), thus suggesting depressed adolescents would be vulnerable to deficits at the interpretation and goal setting steps since believing their negative moods cannot be modified, they fail to assume responsibility for altering them.

Failure at the fourth step results in a response generation deficit. This is defined as a difficulty or failure to generate appropriate emotion regulating strategies. Response generation deficits are considered to result from either a knowledge or an accessing deficit. A knowledge deficit occurs if the individual has failed to learn effective strategies or if the individual has learned maladaptive strategies. An accessing deficit occurs if despite an adequate strategic knowledge repertoire, the individual is unable to access it at appropriate times or while in a certain mood state (Bransford, 1984; Garber et al., 1991).

Response generation deficits affecting interpersonal problem-solving (Akhtar & Bradley, 1991) and the self-regulation of affect (Garber et al., 1991) have been identified in aggressive and depressed children, however, it is not known if they occur because of a lack of strategic
knowledge or because of difficulty accessing appropriate strategies while experiencing intense emotions. Garber et al. reported that in their studies, a knowledge accessing deficit did not account for the differences obtained when interviewing depressed and nondepressed subjects concerning emotion regulation.

Failure at the fifth step results in a response evaluation deficit. At this step, individuals evaluate their previously generated strategies. Inaccurate evaluations of available strategies can result in the use of less effective strategies. Garber et al. (1991) hypothesized that depressed individuals do not engage in effective affect regulation because they do not expect that the strategies will help modify their negative affect (outcome expectancy); they expect that engaging in the strategies will produce additional undesirable effects (consequence expectancy); and/or they believe that they lack the skill to implement the affect regulation strategies effectively (self-efficacy) (p.215).

A deficit in enactment, the fifth step, results from a lack of necessary skills to initiate the strategy or strategies selected. This step has received very little attention in the literature. As Taylor and Harris (1984) suggested, "It is tempting to conclude that maladjusted boys lack knowledge of control strategies. However, it could also be argued that while they know of such strategies, they find them difficult to apply in practice" (p.144). It is
possible depression interferes with one's ability to "apply strategies in practice" (Taylor & Harris, 1984); however, it must first be determined if depressed individuals can generate, access, and evaluate strategies before assuming difficulties are solely the result of failure to effectively implement appropriately chosen strategies.

**Literature Review of the Self-Regulation of Emotion in Children**

Before differences in the use of coping strategies between normal and clinical populations can be fully understood, it is necessary to review what is currently known about the normal development of emotion regulation. Several studies have focused on the self-regulation of affect in youth (Brown, Covell & Abramovitch, 1991; Franko, Powers, Zuroff, & Moskowitz, 1985; Garber, Braafladt & Zeman, 1991; Harris, Olthof & Terwogt, 1981; Wertlieb, Weigel, & Feldstein, 1987). With the exception of Garber et al. (1991), these studies have focused on the self-regulation of affect among normal populations of preadolescent children. Overall, the researchers reported the existence of age changes in children's conceptualization and understanding of emotion and in their use of self-regulatory strategies to manage their own feelings of distress.

**Studies of Age Differences**

Studies indicate with maturation, sophisticated regulatory behaviors develop, including response inhibition, delay of gratification, language, and defensive attributions
(Dodge, Pettit, McClaskey & Brown, 1987; Kopp, 1989). With increases in the repertoire of emotion regulating strategies come improvements in the child's understanding of when to deploy specific regulatory behaviors. The child develops the concept of intentionality and learns to anticipate the outcome of his or her behaviors (Campos & Sternberg, 1981). By preadolescence, individuals generate numerous types of strategies and display diverse responses in the regulation of emotions (Wertlieb et al., 1987).

Harris et al. (1981) and Brown et al. (1991) looked specifically at age changes in the generation of strategies for the modification of negative feelings. Harris et al. (1981) interviewed 72 Dutch children to find among other things, if the expression of emotion or its duration could be controlled by strategic intervention on the part of the subjects. The children were divided into three age groups, with the youngest group having a mean age of 6 years, 6 months, the intermediate group a mean age of 11 years, 0 months, and the oldest group having a mean age of 15 years, 7 months. An interview format was used. Responses to questions such as "Could you do anything to make sure that you were really not angry?" or "Could you do anything to make sure that you were not really afraid?" (p.253) were placed into one of seven categories. These categories were defined as follows:

1. Crying: responses such as "you feel better if you stop crying"

2. Situation change: responses indicating the
situation must be changed

3. Autonomous: responses indicating the emotion is autonomous and unalterable

4. Display: positive answers involving the display of a substitute emotion by verbal, behavioral or facial reactions

5. Inner redirection: positive answers stressing control via the re-direction of mental processes

6. Residual: positive or negative replies with no justification offered (Harris et al., 1981)

Harris et al. concluded children generate self control strategies that can be exercised over both outer expression of emotions and inner mental components. They stated, "While all three age groups frequently propose changing the situation, only the two older groups propose cognitive strategies such as re-directing one's thoughts, particularly as a means of alleviating sadness, rather than fear and anger" (p. 255).

Brown et al. (1991) interviewed 92 children to determine if there were age differences in the use of situational and cognitive strategies and to assess differences in judgement about the efficacy of various situational and cognitive emotion control strategies. Three groups consisting of children ages 4 to 6, 7 to 9, and 10 to 15 were used. The rationale for choosing these particular age groupings was not given. Brief stories were read and after each story the children were asked to generate strategies to control the emotion they would expect to feel
if involved in that situation. Brown et al. (1991) categorized their responses as either situational or cognitive. Situational strategies were defined as those describing overt behavior designed to change the situation. Cognitive control strategies were defined as those describing covert mental activity designed to change one's inner state. An example of a situational modification strategy was "Go do something else" while an example of a cognitive strategy was "Try to think about something nice that happened to you" (p. 277). Brown et al. (1991) reported findings similar to Harris et al. (1981) where across ages, children were more likely to suggest situational rather than cognitive strategies and older children are more likely than younger children to generate cognitive strategies. Brown et al. (1991) also reported finding age differences in children's ability to judge the effectiveness of situational and cognitive strategies with the oldest age group most accurate in rating the expected effectiveness of cognitive strategies.

In a study by Wertlieb et al. (1987), coping strategies among 7 to 11 year old children were elicited through the use of semi-structured interviews. Wertlieb et al. reported a wide range of strategies were generated by the 176 children in the sample. The strategies were coded into the three general terms of focus, function, and mode. These three terms were further subdivided as follows:

1. Focus was coded as Self when the child's coping behavior was directed at his or her own action or subjective
distress. It was coded as Environment when the behavior was directed toward things or persons other than self and was coded as Other when the child did not do anything to cope but was instead "rescued" by someone in the environment.

2. Function was coded as Problem-solving if the behavior was problem-focused and instrumental. It was coded as Emotion-Management if the coping was to manage somatic, subjective, and affective components of stress-related experience.

3. Mode was coded as Information-Seeking if it referred to any behaviors to gain more information about the problem situation. It was coded as Support-Seeking if the behaviors elicited assistance of another person. It was coded as Direct Action if something was done by the child to handle the stressful situation (not including cognitive). It was coded as Inhibition of Action if limiting action or behavior and as Intrapsychic if it involved cognitive processes designed to regulate emotion.

According to Wertlieb et al. (1987), "Among the most prevalent and perhaps normative strategies were those with a focus on the self, those oriented toward problem-solving rather than emotion-management, and those involving overt and direct action modes" (p.557). Among older groups reports of emotion-management were more prevalent. Wertlieb et al. (1987) interpreted these age differences "as manifestations of developmental processes that provide older children with increasing capacities for cognitive mediational control" (p.558).
Franko, Powers, Zuroff and Moskowitz (1985) studied children's means of coping. They interviewed children 6 to 11 years old and asked them "Could you describe for me some times when you felt bad about something? How did that make you feel? What could a boy (girl) do to feel better if that happened?" (p.213). To the 232 episodes elicited by the children,

Regardless of age or sex, in an overwhelming proportion of situations (92%), the children's responses were rated as active rather than passive, i.e., as direct attempts at self-regulation. Their responses were also predominantly behavioral rather than cognitive (73%), nonverbalized rather than verbalized (76%), and self-oriented (62%) rather than other-oriented (p.214).

According to their study, the most common response of normal children was to distract one's own attention by doing something else, which "exemplifies the grade school child's use of active behavioral strategies that neither involve the expression of negative feelings nor require interaction with another person" (p. 214).

Taylor and Harris (1984) conducted a study "to compare normal and emotionally disturbed children in their knowledge about strategies for the display of emotion" (p. 141). Thirty-six boys (7 to 11 years old) attending normal schools and 36 boys (7 to 11 years old) attending schools for the maladjusted were asked to imagine themselves as the central
character in several short stories. Subjects were then asked how they would feel, and what they would do. Results indicated the groups differed in the strategies they proposed, but not in the emotion they expected to feel.

**Studies of Diagnostic Differences**

Garber et al. (1991) explored differences in the self-regulation of affect between depressed and nondepressed children using an information processing theory and the six steps of competent emotion regulation. Their first study focused on the response generation step of emotion regulation. This study was designed to determine if depressed and nondepressed children generated different strategies for modifying their own negative affect. They recruited 14 children having DSM-III-R diagnoses of depressive disorders from a psychiatric clinic, and 16 children who were not diagnosed as depressed from a medical clinic. The 30 children were between the ages of 8 and 17. The subjects were asked a series of questions about their emotions, including "What makes you feel X?" What does it feel like?", and "What do you do about it?" (p. 219). The children's responses to the question "What do you do about it?" were coded into one of the following eight categories: active avoidance, passive avoidance, negative behaviors, problem-focused, engaging in pleasant activities, seeking social contact, cognitive strategies, and expression of affect. Garber et al. (1991) reported "that in response to negative affect, nondepressed children were more likely to nominate problem-focused and active distraction strategies,
whereas depressed children were more likely to choose active avoidance or negative behaviors (e.g., aggression)" (p.219). From this study, Garber et al. (1991) concluded depressed children generate different regulation strategies than do nondepressed children and the affect modification techniques generated by depressed children may act to exacerbate their distress by isolating them further or antagonizing sources of assistance.

In a second study by Garber et al. (1991), 275 children in kindergarten through eighth grade were presented with one of two scenarios and then asked to rate the effectiveness of each of 100 strategies provided to them. The purpose of this study was to

address the response evaluation step of the information-processing framework and to compare depressed and nondepressed children's expectations about the efficacy of different emotion regulation strategies....In addition, the strategies were divided into self-generated and other generated in order to examine specific outcome versus self-efficacy expectancies (p.221).

The students were identified as depressed or nondepressed from scores on the Children's Depression Inventory (CDI; Kovacs, 1980/1981; Kovacs & Beck, 1977) a self-report measure of depression in children. Garber et al. (1991) stated that the results indicated "Depressed children had significantly lower expectations about the efficacy of strategies for altering negative mood than did
nondepressed children ... and that depressed children expect that neither self nor other-generated emotion regulation strategies will be effective" (p.223).

According to Garber et al. (1991), another goal of this study was to compare the emotion regulation strategies reported by depressed and nondepressed children using a methodology that required recognizing rather than accessing knowledge (p.225). Under these conditions and for interpersonal situations depressed children reported using negative behaviors (e.g., yelling at someone, fighting back by hitting or kicking, trying to get back at your friend by doing something mean to him or her) and 'catastrophizing' (e.g., 'You think that your friend will hate you and you'll never see that friend again'; 'You think the friend will tell your other friends not to play with you, so you'll have no friends left') significantly more often than did the nondepressed children (p.225). Garber et al. stated that a knowledge accessing deficit did not account for the differences obtained. Rather, depressed children appear to have a specific outcome expectancy that their own affect is difficult to alter. Since depressed subjects rated some of the more effective strategies to be more effective than the maladaptive strategies but still reported using the maladaptive strategies more often, Garber et al. proposed depressed
subjects fail to consider or care about the consequences of using maladaptive strategies. According to Garber et al. (1991), the differences in the reported use of effective strategies "may be the result of a developmental lag in depressed children's cognitive development or a temporary cognitive, perceptual, or motivational deficit that results from being depressed" (p.234).

**Limitations of Studies in the Literature**

A review of the literature indicated limited information is available concerning differences in the use of affect regulating strategies among depressed and nondepressed adolescents. There was also limited information concerning the developmental changes which occur in affect regulation throughout adolescence. This is surprising since differences in cognitive development and experience suggest individuals from younger or older developmental groups cannot automatically be assumed to respond in the same manner as adolescents. The literature identified developmental changes in school aged children's abilities to conceptualize about emotions (Franko et al., 1985; Kovacs, 1986; Wertlieb et al., 1987) and generate strategies (Harris et al., 1981; Brown et al., 1991; Wertlieb, et al., 1987), however, the age groupings studied were not extensive nor systematically chosen. The study by Harris et al. (1981) was the single exception since a separate group of adolescents was included. Since the adolescent sample apparently only contained 24 subjects the results cannot be considered definitive. Another study, by
Brown et al. (1991), included adolescent subjects but without explanation they were grouped in a 10 to 15 year age sample set. This was a questionable age grouping for this subject and does not provide specific information to those interested in the study of affect regulation throughout adolescence.

Difficulty comparing results due to extreme variations in the coding systems used to categorize the strategies is another area of concern created from the previous studies. Brown et al. (1991) used only two categories to evaluate the strategies generated. This is too global to yield information for the understanding of the diverse types of emotion regulating strategies suggested by youth. Further, it is too global to assist in the development of prevention or treatment interventions. The coding systems used by Franko et al. (1985), Garber et al. (1991), and Wertlieb et al. (1987) were more informative but not necessarily comparable.

Another limitation apparent in the literature was the limited number of studies addressing differences in the self-regulation of emotion between contrasting populations: those who effectively regulate their emotions and those who do not. Although Garber et al. (1991) addressed differences in emotion regulation between depressed and nondepressed populations, there were several limitations to their studies. In their first study, only 14 of 30 children were diagnosed with a depressive disorder suggesting that reported differences between depressed and nondepressed
children in the generation of strategies for the self-regulation of negative emotions may have lacked statistical validity and been overly generalized. Also, the age grouping (8 to 17 years) was unusual and the specific number of adolescents included was not reported. This does not allow for confidence in attribution of the results to adolescence.

In the second of their studies, a larger sample was obtained; however, a psychiatric diagnosis was not used to identify the children as depressed. A self-report scale, Children's Depression Inventory (Kovacs, 1980/1981), was completed by the children to identify the depressed group. One cannot assume it is representative of a clinically depressed population since the correlation coefficient of the Children's Depression Inventory and psychiatric diagnoses is moderate (r=.54, Kazdin, 1981). Furthermore, the population was predominately middle class, Caucasian and from midwestern metropolitan areas. This limits extrapolation of the results to other socio-economic, ethnic, and geographically located groups. Perhaps a profound limitation of their study was the type of school attended by all the subjects. They attended private schools which may make the sample population different from the general population of depressed children. Private schools may be less likely to include students whose depressive symptoms are severe enough to result in the need for special education services as is common in public schools.

The Taylor and Harris (1984) study was limited for the
purposes of this study, since it did not define the goal of the strategies as the reduction of distress; it did not access strategy generation in adolescent populations; and it did not adequately define the "maladjusted" population.

Limitations were also created by the methodologies used. The studies used self-report, semi-structured interviews and/or the presentation of scenarios followed by semi-structured interviews. Limitations of the self-report method include concerns that children use different coping skills than those reported because they are either not aware of or not able to verbalize them. Self-report and semi-structured interviews are limited sources of information since the reliability and validity of these procedures has not been established for their use in assessing differences in the regulation of affect. It must be said, however, that despite these limitations, self-report and the use of semi-structured interviews have been accepted as the method of choice for examining youth's understanding of emotions and their generation of strategies for the self-regulation of affect, since the information to be gathered includes mental activity.

In summary, a review of the literature indicated the need for further research concerning differences in affect regulation between normal and clinical populations and throughout the adolescent age span.
CHAPTER 3

Methodology

Purpose

The primary objective of this study was to determine if adolescents diagnosed with depressive disorders differ from adolescents that are not depressed in the generation, evaluation, and reported use of strategies for modifying their feelings of sadness. The secondary objective of this study was to determine if there are differences between early adolescence and late adolescence in the generation, evaluation, and reported use of strategies for modifying feelings of sadness. Information of this type can broaden the understanding of emotion regulation and can lead to the development of better prevention and intervention techniques in this area.

Sample

Thirty-eight male students attending middle schools and high schools in the Chesapeake School System participated in this study. The Chesapeake School System serves a large southeastern city (population of approximately 180,000) in Virginia. The city is comprised of families ranging broadly in socioeconomic, educational, and vocational status. The area is predominantly rural-suburban with light and medium industry. The Chesapeake Public Schools have a pupil enrollment of approximately 34,000 students (Chesapeake Public Schools, December, 1994). Minority students make up 8% of the total school population.
Initially, two groups of adolescents (ages 12-18 years) were identified and interviewed. A depressed group was identified and compared to a control group or nondepressed group. The depressed group was chosen from students currently attending special education classes for students with serious emotional disturbances. Students in these classes had been found eligible following the placement criteria found in the Virginia Department of Education Regulations Governing Special Education Programs for Handicapped Children and Youth in Virginia (see Appendix A). Those chosen for this study had also received a clinical diagnosis of dysthymia or major depression from a psychiatrist. These diagnoses were made using the Diagnostic and Statistical Manual of Mental Disorders-III-R (American Psychological Association, 1987) (see Appendix A).

At the time of this study, special education services were being provided to twelve percent of the Chesapeake students. Less than 1% (0.93%) of the total student population was being served in classes for students with serious emotional disturbances (Chesapeake Public Schools, Dec, 1994). This was consistent with the rate of identification at state (1%) (Virginia Department of Education, 1994) and national levels (0.7%) (Special Education Report, 1995).

The nondepressed group consisted of students meeting the age and grade criteria and attending general education classes. A similarly sized sample (19) of male students was matched to the students in the group with depressive
disorders on the following characteristics: ability, age, grade placement, socio-economic status, family structure, race, and the school they were attending. Matching on these characteristics was attempted to reduce the variables other than the diagnosis of depression that may affect the self-regulation of affect among adolescent males. Exact matching of special education and general education participants could not be accomplished and minor differences between the groups occurred (see Appendix B). These differences were not considered to be great enough to have any significant effect on the study results. The nondepressed group was considered representative of male adolescents with "normal" affect regulation skills.

For analytical purposes, the adolescents were also divided according to age rather than diagnosis. These groups consisted of 19 males in early adolescence (ages 12 years to 15 years, 6 months) with a group mean age of 13 years, 3 months and 19 males in late adolescence (ages 15 years, 7 months to 18 years) with a group mean age of 16 years, 8 months. Age groups were made by splitting the available population in half. This division was considered acceptable, since it allowed for exploration of younger and older adolescence and was generally consistent with chronological placement in grades six through mid-ninth grade and mid-ninth grade through twelfth grade.

Since the participants were originally matched on several variables according to diagnostic criteria, minor differences occurred when the groups were defined by age
criteria (See Appendix B). The significance of these differences is not known, but is considered negligible.

Once the students were identified for possible inclusion in the study, parental and student consent to participate forms were distributed (see Appendixes C and D).

Assessment Procedures and Instrumentation

A semi-structured interview, developed specifically for this study, was individually administered to each participant. A semi-structured interview format was chosen for this study because it had the advantage of being reasonably objective while still permitting a thorough understanding of the respondents' opinions and the reasons behind them (Borg & Gall, 1989). Previously conducted studies in emotion regulation (Brown et al., 1991; Franko et al., 1985; Garber et al., 1991; Harris et al., 1981; Wertlieb, Weigel, & Feldstein, 1987) have used semi-structured interviews. It has also been used to assess adolescents in other areas of study requiring self report including bereavement following the death of a parent (Harris, 1991), perceived benefits from social relationships with handicapped peers (Peck, Donaldson, & Pezzoli, 1990), friendship difficulties and life events in depressed school age children (Goodyer, Wright & Altham, 1990), and moral reasoning in the context of personal relationships (Skrimshire, 1987). These cited studies suggest semi-structured interviews are accepted as appropriate for the particular group of interest and can be effectively used with depressed adolescents. Despite their widespread use,
specific information concerning the reliability of responses from adolescents using this format was unavailable.

The semi-structured interview used in this study consisted of two scenarios, a list of 32 coping strategies, and a series of research questions. The scenarios described two situations, one involving long-term separation from a friend and the other involving separation from one's family. The adolescents were told to imagine themselves in the situations and asked the following questions: "What would you feel?", "How would you feel?", and "Would you do anything to make yourself feel better and if so what would you do?"

Thirty-two strategies were then presented for the participants to evaluate. Each strategy was read and the students were asked, "How would your expect this to make you feel?" and "How do you think this would make others your age feel?" Response choices were "much worse, a little worse, the same, a little better, or a lot better" and recorded on a five point Likert-type scale.

A rating for the frequency of use for each of the strategies was also requested. For each of the 32 strategies they were asked "How often have you actually used this to make yourself feel better?" Response choices were "never or none of the time, not very often, some of the time, or a lot of the time" and recorded on a four point Likert-type scale.

The entire procedure was conducted using one of the scenarios, then repeated using the other scenario. At the
end of the interview, students were asked how they felt and asked to tell about something in the past that has made them happy. The semi-structured interview is available in the Appendixes (see Appendix E).

The scenarios were counterbalanced in presentation to reduce possible effects from bias in strategy generation introduced by the presentation of strategies for evaluation in the second step of the assessment. Fifty percent of each sample group were presented with Scenario 1 first and fifty percent of each sample group were presented with Scenario 2 first.

The first strategy generated for each scenario was used for analysis. This was considered acceptable, since Spivack and Shure (1974) reported the first strategy nominated is likely to be the most salient and subsequently the first tried in actual social situations. Evaluating the first strategy generated was also consistent with the method of response analysis used in previous studies.

Students were presented with 32 strategies to evaluate rather than evaluating self-generated strategies since this procedure eliminated "the knowledge-accessing problem that affects reporting about strategy utilization,... " (Garber et al., 1991, p.222). Furthermore, it is believed the use of generated strategies in previous studies has "underestimated children's understanding of control strategies" (Brown et. al., 1991). It also had the additional benefit of providing a common data base to compare.
Garber et al. (1991) proposed effective strategy evaluation involves accurate outcome, consequence, and self-efficacy expectations. They stated depressed children have a specific outcome expectancy that their own affect is difficult to alter, fail to consider or care about the consequences of using maladaptive strategies, and may have lower self-efficacy expectations. This study compared the ratings of nondepressed and depressed adolescents when the strategies were evaluated for one's own use to determine if the results would be consistent with outcome and consequence expectancies reported by Garber et al. (1991). Comparison of the ratings by nondepressed and depressed adolescents when the strategies were to be used by others was conducted to determine if the results would be consistent with previously reported differences in self-efficacy expectations.

In developing the semi-structured interview, four school psychologists independently categorized strategies developed from information reported in the literature. To determine the types, coding systems from previous research were reviewed, including those developed by McCoy and Masters (1985), Franko et al., (1985), and Wertlieb, et al., (1987). Using these systems, Garber et al. (1991) developed eight categories of children's strategic responses. They were: active avoidance, passive avoidance, negative behaviors, problem-focused behavior, engaging in pleasant activities, seeking social contact, cognitive strategies, and expression of affect. These eight
types of strategies were adopted for this research. The strategies developed from the literature were selected for inclusion only where there was 100% agreement among the school psychologists as to the type. A card sorting technique was used and four strategies were chosen for each of the eight types (see Appendix F).

For interpretive purposes the strategies were also independently identified as either socially acceptable/adaptive or socially unacceptable/maladaptive. Twenty one strategies were considered socially acceptable and eleven were considered socially unacceptable. The eleven unacceptable strategies included all of the negative behaviors and passive avoidance strategies and three strategies from the active avoidance category (See Appendix F).

The 32 strategies were placed on the profile in random order. After the interviews were completed, the same school psychologists categorized the student generated strategies into the eight original types.

Five Chesapeake school psychologists were trained to administer the semi-structured interview. They were instructed to probe for further information concerning the students' thinking and valuative processes on responses that were unexpected or unusual. The categories, special education/general education, of the participants were not provided to the interviewers. The interviews were conducted between October, 1994 and March, 1995.
Specific Null Hypotheses

The research hypotheses for this study are the following:

(1) There are no significant differences between groups of depressed and nondepressed male adolescents in the types of feelings they report in response to scenarios designed to evoke feelings of sadness.

(2) There are no significant differences between groups of depressed and nondepressed male adolescents in the types of strategies they generate to modify their own negative feelings.

(3) There are no significant differences between groups of depressed and nondepressed male adolescents in evaluations of the effectiveness of strategies to modify their own negative feelings.

(4) There are no significant differences between groups of depressed and nondepressed adolescents in the evaluations of the effectiveness of strategies to modify other adolescents' negative feelings.

(5) There are no significant differences between groups of depressed and nondepressed male adolescents in the types of strategies they report using to modify their own negative feelings.

Due to the wide age span identified, another set of hypotheses was generated to determine if age differences within adolescence (early adolescence vs. late adolescence) effect the generation, evaluation, and reported use of self-regulating strategies. These hypotheses are the following:
(6) There are no significant differences between groups of male students in early adolescence and late adolescence in the types of feelings reported in response to the scenarios designed to evoke sadness.

(7) There are no significant differences between groups of male students in early and late adolescence in the types of strategies they generate to modify their own negative feelings.

(8) There are no significant differences between groups of male students in early and late adolescence in the evaluations of the effectiveness of strategies to modify their own negative feelings.

(9) There are no significant differences between groups of male students in early and late adolescence in the evaluations of the effectiveness of strategies to modify other adolescents' negative feelings.

(10) There are no significant differences between groups of male students in early and late adolescence in the types of strategies they report using to modify their own negative feelings.

**Research Design and Data Analysis Techniques**

A comparative study was used to determine if adolescents diagnosed with depressive disorders differ from nondepressed adolescents in the generation, evaluation, and reported use of strategies for modifying feelings of sadness. A comparative study was also used to identify age differences between younger adolescents and older adolescents in the generation, evaluation, and reported use
of strategies for modifying feelings of sadness.

Two groups of adolescents (ages 12-18 years) were identified and interviewed. A depressed group was compared to a control group or nondepressed group. The participants were matched on ability, age, grade placement, socio-economic status, family structure, race, and the school they were attending.

For analytical purposes, the participants were divided into age groups. Responses from a group of younger students (the early adolescence group) were compared to responses from a group of older students (the late adolescence group). The early adolescence group consisted of 19 male participants, ages 12 years to 15 years, 6 months with a mean age of 13 years, 3 months. The late adolescence group consisted of 19 participants, ages 15 years, 7 months to 18 years with a mean age of 16 years, 8 months. These groups were formed by rank ordering the 38 participants by age and dividing the total group in half.

A semi-structured interview, consisting of the presentation of two situations followed by a series of questions, was administered to each participant. Responses to the question, "How would this make you feel"?" were classified into seven categories (see Appendix G) and responses to the question, "Would you do anything to make yourself feel better and if so what would you do?" were sorted into the eight strategic types (see Appendix F). Chi-square analysis was applied to determine if significant differences were present between the diagnostic groups and
the age groups. Responses to thirty-two strategies, presented for the participants to evaluate and rate for frequency of use, were coded on a Likert-type scale. Multivariate tests of significance to reveal interaction effects (order by age by diagnosis and age by diagnosis) were applied. Multivariate analysis was also conducted with the diagnostic and age categories as independent variables and the groups means from responses to the valuative and reported use questions for each of the eight strategic types (see Appendix F) as dependent variables.

The results of the statistical analysis were used to accept or reject the ten proposed hypotheses. A .05 level of significance was used to determine acceptance or rejection of each hypothesis. The data was analyzed using the computer program SPSS.
Analysis of Results

Summary

The primary objective of this study was to determine if adolescents diagnosed with depressive disorders differ from nondepressed adolescents in the generation, evaluation, and reported use of strategies for modifying their feelings of sadness. The secondary objective of this study was to determine if differences exist between early adolescence and late adolescence in the generation, evaluation, and reported use of strategies for modifying feelings of sadness.

Garber et al.'s (1991) identified steps for competent emotion regulation were used as the theoretical basis for the study. Ten hypotheses were separately considered in the analysis of the results. Chi-square tests were used for analysis of categorical information and multiple analysis of variance tests were used for the analysis of interval variables. Three factor multivariate tests of significance (order by age by diagnosis) were applied and indicated no significant effects from the order of presentation. A question concerning the intensity of feelings the participants expected to experience was asked. No significant differences were found for this factor for age or diagnostic groupings. A .05 level of significance was used to determine acceptance or rejection of each hypothesis. The statistical analysis was conducted using the SPSS computer program.
Hypotheses and Findings for Diagnostic Groups

Hypothesis One

There are no significant differences between groups of depressed and nondepressed male adolescents in the types of feelings they report in response to scenarios designed to evoke feelings of sadness.

A chi-square analysis indicated significant differences were present for the types of feelings nondepressed and depressed groups reported in response to the scenarios, $\chi^2 (6, N = 76) = 14.9, p < .02$, (see Appendix I, Figure 1). The depressed group was significantly less likely to report negative feelings in response to the scenarios. The null hypothesis was rejected.

Hypothesis Two

There are no significant differences between groups of depressed and nondepressed male adolescents in the types of strategies they generate to modify their own negative feelings.

A chi-square analysis indicated significant differences were present for the types of strategies generated by nondepressed and depressed groups $\chi^2 (6, N = 76) = 14.68, p < .02$, (see Appendix I, Figure 2). The depressed group generated significantly more maladaptive strategies than the nondepressed group. The null hypothesis was rejected.

Hypothesis Three

There are no significant differences between groups of depressed and nondepressed male adolescents in evaluations of the effectiveness of strategies to modify their own
negative feelings.

Two factor multivariate tests of significance (age by diagnosis) revealed interaction effects were present on the effectiveness ratings for self, $F(8) = 3.39$, $p < .003$. Age by diagnosis interactions were found for the cognitive and pleasant activity strategic types (see Appendix H, Table 1 and Appendix I, Figures 3 & 4).

Further multivariate tests of significance revealed main effects for diagnosis, $F(8) = 2.78$, $p < .011$. These main effects were found for the active avoidance, negative behaviors, problem-focused, social contact, and expressing emotions strategic types (see Appendix H, Table 2). The null hypothesis was rejected.

**Hypothesis Four**

There are no significant differences between groups of depressed and nondepressed adolescents in the evaluations of the effectiveness of strategies to modify other adolescents' negative feelings.

Multivariate tests of significance revealed main effects were present for diagnosis on the ratings of effectiveness for other, $F(8) = 4.03$, $p < .001$. Main effects were found for the negative behaviors, cognitive strategies, engaging in pleasant activities, problem-focused, seeking social contact, and expressing emotions strategic types (see Appendix H, Table 3). The null hypothesis was rejected.

**Hypothesis Five**

There are no significant differences between groups of
depressed and nondepressed male adolescents in the types of strategies they report using to modify their own negative feelings.

Two factor multivariate tests of significance (age by diagnosis) revealed interaction effects for the reported use of strategies, $F(8) = 2.84, p < .009$. Age by diagnosis interaction effects were found for the cognitive strategies, pleasant activities, and social contact strategic types (see Appendix H, Table 4 and Appendix I, Figures 5, 6, & 7). Multivariate tests of significance also revealed main effects for diagnosis, $F(8) = 3.59, p < .002$. Main effects were found for the negative behaviors and problem-focused strategic types (see Appendix H, Table 5). The null hypothesis was rejected.

Summary of Diagnostic Differences

The statistical analysis revealed significant differences between the groups of depressed and nondepressed adolescents at the perception of affect, response generation, and strategy evaluation steps of emotion regulation. Significant differences between the nondepressed and depressed groups in the reported use of strategic types was also found. Therefore, each of the five null hypotheses was rejected.

Hypotheses and Findings for Age Groups

Hypothesis Six

There are no significant differences between groups of male students in early adolescence and late adolescence in the types of feelings reported in response to the scenarios
designed to evoke sadness.

Results of a chi-square analysis revealed no significant differences were present between the early and late adolescence groups in the types of feelings they reported (see Appendix I, Figure 8). The null hypothesis was accepted.

**Hypothesis Seven**

There are no significant differences between groups of male students in early and late adolescence in the types of strategies they **generate** to modify their own negative feelings.

Results of a chi-square analysis revealed no significant differences in the types of strategies generated by the early and late adolescence groups, $\chi^2(6, N = 76) = 5.4, p < .49$. The null hypothesis was accepted.

**Hypothesis Eight**

There are no significant differences between groups of male students in early and late adolescence in **evaluations** of the effectiveness of strategies to modify their own negative feelings.

Two factor multivariate tests of significance (age by diagnosis) revealed interaction effects for the effectiveness ratings for self, $F(8) = 3.9, p < .003$. The age by diagnosis interaction was found for the cognitive and pleasant activities strategic types (see Appendix H, Table 1 and Appendix I, Figures 3 & 4).

Multivariate tests of significance revealed main effects for age, $F(8) = 4.35, p < .000$. Main effects were
found for the active avoidance, passive avoidance, and negative behaviors strategic types (see Appendix H, Table 6). The late adolescent group rated these strategic types as more effective than the early adolescent group. The null hypothesis was rejected.

Hypothesis Nine

There are no significant differences between groups of male students in early and late adolescence in the evaluations of the effectiveness of strategies to modify other adolescents' negative feelings.

Multivariate tests of significance revealed main effects for age, $F(8) = 2.96, p < .007$. Main effects were found for the active avoidance and passive avoidance strategic types (see Appendix H, Table 7). The late adolescent group rated these strategic types as more effective than the early adolescent group. The null hypothesis was rejected.

Hypothesis Ten

There are no significant differences between groups of male students in early and late adolescence in the types of strategies they report using to modify their own negative feelings.

Two factor, multivariate tests of significance (age by diagnosis) revealed interaction effects for the reported use of strategies, $F(8) = 2.84, p < .009$. Age by diagnosis interaction effects were found for the cognitive strategies, pleasant activities, and social contact strategic types (see Appendix H, Table 4 and Appendix I, Figures 5, 6, & 7). The
null hypothesis was rejected.

Summary of Age Differences

The statistical analysis revealed significant differences between the groups of younger and older adolescents at the strategy evaluation step of emotion regulation. Significant differences were also found in the reported use of coping strategies. No significant differences were found at the perception of affect and response generation steps of emotion regulation. Three of the five null hypotheses were rejected.
CHAPTER 5

Summary, Conclusions, and Recommendations

Individuals use various regulation strategies to cope with heightened levels of negative emotional arousal. This study, using the identified steps of competent emotion regulation (Garber et al., 1991), investigated differences between depressed and nondepressed adolescents in the generation, evaluation, and reported use of strategies for modifying feelings of sadness. The study also examined differences in these areas between groups of younger and older adolescents.

Two groups of male adolescents, matched on several variables (ability, age, grade placement, socio-economic status, family structure, and school) participated in the study. One group (depressed) included 19 students attending classes for students with serious emotional disturbances. These students had been previously diagnosed with a depressive disorder and were considered to have long standing difficulties with emotion regulation. The second group (nondepressed) consisted of general education students and were considered to have normal emotion regulation skills.

For analytical purposes the participants were also divided into age rather than diagnostic groups. This created an early adolescence group with a mean age of 13
years, 3 months ranging in age from 12 years, 0 months to 15 years, 6 months. A late adolescence group was formed with a mean age of 16 years, 8 months ranging from 15 years, 6 months to 18 years, 0 months.

Semi-structured interviews were individually administered to each participant. Two situations designed to elicit feelings of sadness were presented. Presentations of the situations were counterbalanced with fifty percent of each group receiving Situation A then Situation B and 50% receiving Situation B then Situation A. This was done to reduce possible effects from bias in the second set of questions from the presentation of strategies for the first situation. A three factorial analysis of multivariance examining the order of presentation, age, and diagnosis determined the order of presentation did not significantly effect the responses. Order of presentation was therefore not considered to be a factor for any of the results or interpretations.

After the presentation of each situation, the students were asked to generate a single strategy for modifying their own feelings and then presented with 32 strategies to rate for effectiveness when used by themselves and by others. The participants were also asked to report how frequently they actually used each of the 32 emotion regulation strategies. The group responses were compared using chi-square and multivariate analysis.
Results and Conclusions
for Diagnostic Differences

Perception of Affect

According to Garber et al. (1991), the first step of competent emotion regulation involves the perception or recognition that affect is aroused and needs to be regulated. The question "How would this make you feel?" was included in this study to determine if there were initial differences between the groups in their interpretations of the situations. The feelings reported ranged from non-specific negative feelings to positive feelings. These responses were classified into seven categories (see Appendix G). Significant differences were present between the nondepressed and depressed groups. The majority of nondepressed participants (76%) reported expecting to feel "sad" or "unhappy" and all but 3% expected to experience some type of negative feeling. Less than half the depressed group (42.1%) reported expecting to feel "sad" or "unhappy" and 21% reported expecting to feel "alright" or some positive emotion in response to the imagined loss (see Appendix I, Figure 1).

These empirically determined differences in the recognition or perception of affect are expected to translate into likewise measurable variations in affect regulation. Since 21% of the depressed group failed to identify the situation as one requiring the modification of affect and only 42% identified their emotional response as sadness, this group would be expected to be significantly
less likely to engage in "self-soothing" regulatory strategies.

Reasons for variations in the perception of affect are unclear due to limited knowledge about adolescents' abilities to accurately identify their own negative affect. It is possible depressed adolescents simply fail to recognize or acknowledge their own negative feelings. It is also possible the events presented were not salient for the depressed group and they had difficulty imagining themselves in the given situations.

Despite differences in the recognition of the feelings, significant differences were not found for the reported intensity of feelings. Although Garber et al. (1991) obtained similar results in their studies, the reasons for this are also unclear.

**Strategy Generation**

One of the goals of this study was to determine if differences existed between the depressed and nondepressed groups in the generation of strategies for alleviating sadness. According to Garber et al. (1991), strategy generation is the point at which the individual generates concrete responses designed to achieve a given goal. In this case, the goal of "making oneself feel better" was provided in the wording of the question, "Would you do anything to make yourself feel better and if so what would you do?"

The strategies generated by the participants were sorted into eight strategic types (see Appendix F).
Participant responses were recorded in only seven of the eight types. Neither group generated any negative behavioral strategies and the nondepressed group did not generate any cognitive strategies. In previous studies (Garber et al., 1991), negative behaviors have not been found to be significant in the modification of sadness, although they have been for anger. The finding that negative behaviors were not generated is therefore not surprising and is supportive of Garber et al.'s (1991) work.

Cognitive strategies have been generated by older nondepressed adolescents in response to negative affect in several previous studies (Brown et al., 1991; Garber et al., 1991; Harris et al., 1981; Wertlieb et al., 1987). In contrast to those studies, neither of these groups generated a significant number of cognitive strategies (2.6%). It is possible previous studies did not address sad affect, per se, but rather addressed negative affect in general.

Significant differences were found between the depressed and nondepressed groups in the types of strategies generated. The depressed group generated more passive avoidance and activity-focused approaches, while the nondepressed group generated more social contact approaches. Thirty-four per cent (34%) of the strategies generated by the depressed group fell within the passive avoidance category and approximately twenty-four percent (23.7%) fell within the pleasant activities category. Almost forty-five percent (44.7%) of the strategies generated by the nondepressed adolescents fell within the seeking social
contact category (see Appendix I, Figure 2).

In this study, the depressed participants' elevated use of passive avoidance was due to a large number of responses stating they would do "nothing" to make themselves feel better. Since in later questioning, the depressed group did not actually report using passive avoidance strategies more often than the nondepressed group, nor did they rate them as more effective, the disproportionate use of "nothing" as a generated strategy could be an artifact of the interview situation. It is possible the depressed students had a harder time imagining the situations and required more stimuli than provided to get involved.

Doing "nothing" could also be a result of the depressed group's previous failure to interpret the situations as causing negative emotion and thereby requiring emotion regulation. Doing "nothing", however, is consistent with the observed passivity of many depressed students and may actually be an accurate reflection of their first response to unpleasant events. Depression typically involves low energy and a deficit in initiating behaviors. Depressed adolescents may choose to do "nothing" because of this lack of energy. It is also possible depressed adolescents, by attributing negative events to internal, stable and global causes (Peterson & Seligman, 1984; Sweeney, Anderson, and Bailey, 1986), simply fail to seek a solution to their negative feelings, believing they are unalterable.

**Strategy Evaluation**

Another goal of this study was to determine if
depressed and nondepressed adolescents differed in evaluations of the effectiveness of coping strategies. According to Garber et al. (1991), appropriate evaluations of available strategies are necessary for competent emotion regulation. Strategy evaluation is considered to be influenced by outcome, consequence, and self-efficacy expectations. Variations in evaluations may be due to differential use of these factors.

Significant differences were found between the nondepressed and depressed adolescents in their ratings of the effectiveness of coping strategies. When rating the effectiveness of the strategies for modifying their own feelings, the nondepressed group rated the problem-focused, seeking social contact, and expressing emotion categories significantly higher than the depressed group (see Appendix H, Table 2). The depressed group rated the maladaptive strategies, active avoidance and negative behaviors significantly higher than the nondepressed group. The statistical analysis conducted only reveals that there were differences between the two groups and definitive conclusions concerning beliefs about the relative effectiveness of strategic types within groups cannot not be drawn from this information. Preliminary indications, however, from rank ordering the means obtained for effectiveness ratings suggest that both the depressed and nondepressed groups view the maladaptive strategic types as the least effective of the types presented (see Appendix H, Tables 8, & 9).
Multivariate analysis indicated an interaction effect (age by diagnosis) for two of the strategic types—cognitive strategies and engaging in pleasant activities. Among the nondepressed, the older adolescents rated cognitive strategies and engaging in pleasant activities as more effective than the younger adolescents. This was supportive of the results from a study by Brown et al. (1991) where increased valuative skills accompanied increased age for normal youth. In this study, the opposite is apparently indicated for the clinical group since, among the depressed, the older adolescents rated cognitive strategies and engaging in pleasant activities as less effective than the younger adolescents (see Appendix I, Figures 3 & 4).

The reasons older, depressed adolescents had lower expectations than the younger depressed adolescents is not clear; nor was it expected from a review of previous research. It is possible depressed adolescents find their mood disorders do not respond to the use of cognitive nor pleasant activities and therefore, after trying them, rate them as less effective as they get older. It is also possible older depressed adolescents, having a longer history of depressive symptomatology, are less effective at evaluating self-regulatory behaviors.

To further explore differences in evaluations of coping strategies, the participants were asked to rate the effectiveness of the self-regulatory strategies if used by others. This should have eliminate the proposed negative effects of self-efficacy deficits in the depressed group
(Garber et al., 1991). Again, the nondepressed group gave significantly higher ratings than the depressed group to five of the strategic types—cognitive, pleasant activities, problem-focused, social contact, and expressing emotions. These were the five socially acceptable/adaptive strategic types. The depressed group gave a significantly higher rating than the nondepressed group to the negative behavior category. This does not mean the depressed group viewed the negative behavior category as more effective than other categories. Preliminary indications suggest they did not (see Appendix H, Table 9). Instead, it seems to indicate that the depressed group viewed it as more effective than the nondepressed group.

The specific reasons for the differences found in the evaluations of the strategic types is not clear. The depressed group appeared to have a general outcome expectancy that negative affect is difficult to alter through the use of either adaptive or maladaptive strategies. It is possible differences in the evaluations of the effectiveness of the strategic types were due to deficits in depressed adolescent's cognitive, perceptual, or motivational development which interfered with the depressed groups' use of complex valuative processes. It is also possible other factors account for the differences in their evaluations. For instance, the depressed group could actually experience the acceptable strategies as less effective than the nondepressed because of the social environments in which they live. Social reinforcers and
effective emotion regulation through acceptable means may not be readily available to them due to increased depressive symptomatology in other family members.

**Reported Use of Strategies**

A comparison of the types of strategies reportedly used by the diagnostic groups was conducted. Significant differences were found between the depressed and nondepressed groups.

Significant interaction effects were found (age by diagnosis) for the cognitive, pleasant activities, and seeking social contact strategies. For the nondepressed, the older group reported using the cognitive strategies, engaging in pleasant activities and seeking social contact more often than the younger group. For the depressed, the older adolescents reported using the cognitive strategies, engaging in pleasant activities, and seeking social contact less often than the younger group (see Appendix I, Figures 5, 6, & 7).

Significant main effects were also found in the reported use of two strategic types. The nondepressed group reported using problem-focused behaviors significantly more often than the depressed group. This is consistent with preliminary indications that the nondepressed group viewed the problem-focused strategies as the most effective of the strategic types presented (see Appendix H, Tables 8 & 9). The depressed group reported using negative behaviors significantly more often than the nondepressed group. These findings are consistent with Garber et al.'s (1991)
study where depressed children reported using negative behaviors significantly more often than nondepressed children. These findings do not mean that all strategic choices of depressed adolescents fell into this category, since they clearly did not. However, it appears that as depressed adolescents get older, they may be at risk of decreasing their use of certain socially acceptable strategies.

Conclusions from Diagnostic Differences

This study indicated there are significant differences between nondepressed and depressed adolescents in the self-regulation of affect. These differences were noted at the perception of affect, generation, and strategy evaluation steps. Significant differences were also found in the reported use of emotion management strategies. At every step of emotion management explored, the depressed group responded in ways which may act to further exacerbate their problems and alienate them from sources of assistance.

At the perception and response generation steps, the depressed were less likely to identify their feelings as sadness or distress and more likely to report they would do "nothing" when some type of active regulation of emotion would be expected. At the response evaluation step, an interaction effect between age and diagnosis indicated depressed adolescents, as they get older, may decrease their ratings of certain strategies considered effective by nondepressed peers. These effective strategies are actually the ones nondepressed adolescents are increasingly
identifying as effective as they grow older. In general, the depressed group generally had significantly lower expectations than the nondepressed for the socially acceptable strategies and higher expectations than the nondepressed group for the less acceptable strategies. Although this study did not directly explore differences in the criteria used to evaluate emotion regulation strategies, the results were consistent with the theory that depressed adolescents are more likely to evaluate strategy effectiveness based on the ability of the strategy to provide immediate relief. Further, they probably fail to consider or, at the very least, minimize considerations of future negative consequences. Self-efficacy considerations did not appear to be a significant factor.

Differences between the depressed and nondepressed groups in their reported use of the strategies were generally consistent with their differences in the evaluations of the strategies. The depressed group was more likely to report using negative behaviors than the nondepressed group. Additionally, the nondepressed group, at least as they got older, were more likely to report using socially acceptable strategies. Again, interaction effects for age and diagnosis were found indicating depressed adolescents may be at risk of decreasing their use of socially acceptable strategies as they get older.

These findings are generally consistent with previous studies in this area (Garber et al., 1991); however, direct comparison cannot be made since previous studies looked at
negative affect in general, included female participants, and did not focus on affect regulation in adolescence.

This type of study needs to be repeated with larger and more diverse samples. Additional studies designed to explore reasons for the differences found in the perception, generation, and evaluation processes are also needed, as well as studies designed to explore the steps of emotion regulation using adolescents directly involved in emotion-rousing situations. Research of this type is needed to improve the understanding of how deficits in emotion regulation occur and how to direct intervention efforts. This study indicates efforts at identifying adaptive strategies that depressed adolescents find effective needs to continue.

Results and Conclusions for Age Differences

Previous studies (Harris et al., 1981; Brown et al., 1991; Wertlieb et al., 1987) reported age differences between pre-adolescents and adolescents in the type of coping strategies used for the management of distress. They found, across ages, children were more likely to suggest situational strategies rather than cognitive strategies and older children were more likely than younger children to generate cognitive strategies.

In this study, the responses of the participants were compared to determine if similar patterns would be found within the adolescent group. The same analytic procedures were used with the age analysis as had been used for the
diagnostic analysis. Significant interaction effects between the age and diagnostic groups and main effects for age were found. The order of the presentation of the scenarios was determined not to have a significant effect on the test results.

**Perception of Affect**

A chi-square analysis of responses to the question, "What would you feel?" was conducted to determine if there were main effects for age in the perception of affect. No significant differences for age were found. The majority of participants in the younger group (68.4%) and the older group (50.0%) reported expecting to feel sad or unhappy.

As in Garber et al.'s (1991) previous study, significant differences between the age groups were not present for the intensity of the feelings reported.

**Strategy Generation**

One goal of this study was to determine if younger adolescents differed from older adolescents in the types of strategies they generated to alleviate feelings of sadness. No significant differences were present between the younger and older adolescents in the types of strategies generated. Increases in the generation of cognitive strategies reported in previous studies (Brown et al., 1991; Harris et al., 1981; Wertlieb et al., 1987) were not found in this study.

**Strategy Evaluation**

Another goal of this study was to determine if younger and older adolescents differed in their ratings of the effectiveness of strategies for modifying their own
experiences of sadness. Previous studies (Brown et al., 1981) reported increased ratings for cognitive strategies with increased age. In this study, multivariate tests of significance indicated increased ratings for cognitive and pleasant activities strategies among nondepressed older adolescents, but not for depressed adolescents. Interaction effects, (age by diagnosis) were found for cognitive strategies and pleasant activities. In the nondepressed group, the older adolescents rated cognitive strategies and pleasant activities as more effective than the younger adolescents. This was expected and is consistent with previous research findings (Brown et al., 1981). In the depressed group, the older adolescents rated the cognitive strategies and pleasant activities as less effective than the younger adolescents (see Figure 3). As stated before, the reasons for this finding are not clear. It is possible depressed adolescents find their mood disorders do not respond to cognitive strategies or engaging in pleasant activities, and therefore find these types of strategies less effective as they get older. Perhaps older adolescents simply have less effective valuative skills from having been depressed for longer periods of time.

Significant age differences in the evaluations of other strategic types were also found. Older adolescents gave significantly higher ratings to active avoidance, passive avoidance, and negative behaviors. These were the less acceptable/adaptive emotion regulation strategies presented. It is possible previous studies reporting improved valuative
skills among older children (Brown et al., 1981) did not include a wide enough range of maladaptive strategies for evaluation. Examples of maladaptive strategies from Brown et al.'s study included "Just wait 'til something happens that lets you stop feeling sad", Tell yourself that was a bad thing to happen to you." and "Just sit and be sad" (p.278). While strategies similar to these were included in this study, failure to include strategies such as sleeping, cussing, walking away, yelling, and drinking may have limited adolescents' opportunity to provide valuative responses to the full range of strategies utilized by this age group. It is also possible younger adolescents do not have the same "freedom" to walk away, avoid, drink, swear or yell that older adolescents have, thus making such strategies less available (self-efficacy) and therefore less effective for younger students.

The relative ratings of the effectiveness of the self-regulation strategies when used by others were generally consistent with the ratings of effectiveness of strategies for oneself. Older adolescents gave higher ratings to active and passive avoidance strategies when used by others than younger adolescents did. They did not, however, rate negative behaviors as more effective when used by others.

Reported Use of Strategies

A comparison of the types of strategies reportedly used by the age groups revealed that interaction effects between age and diagnosis were present for three of the strategic types: cognitive strategies, pleasant activities, and
seeking social contact. For the nondepressed, the older group reported using the cognitive strategies, pleasant activities, and seeking social contact more often than the younger group. This is consistent with previous research findings (Brown et al., 1991; Garber et al., 1991; Wertlieb et al., 1987). For the depressed, the older adolescents reported using the cognitive strategies, pleasant activities, and seeking social contact less often than the younger adolescents (see Appendix I, Figures 5, 6, & 7). The depressed group also reported using negative behaviors more often than the nondepressed group indicating older depressed adolescents relative to nondepressed adolescents may decrease their use of appropriate strategies and increase their use of inappropriate strategies with age. Significant differences between younger and older adolescents in the reported use of other strategic types were not present.

Conclusions from Age Differences

This study found significant differences between younger and older adolescents at several of the steps involved in emotion regulation. The early and late adolescence groups displayed significant differences in their evaluations and reported use of coping strategies. Significant differences were not found at the perception of affect and strategy generation steps.

In this study, significant differences between younger and older adolescents in their ratings of the less socially acceptable strategies (active avoidance, passive avoidance,
and negative behaviors) were found. Surprisingly, the older adolescents rated these strategies as more effective than the younger adolescents. The groups did not differ, however, in their reported use of these strategies.

Interaction effects between age and diagnosis for strategy evaluation and reported use suggested that specific developmental changes in emotion regulation may be altered by the condition of depression. This indicates emotion management among clinical populations may not proceed in the same sequence as with normal populations, suggesting that maturation alone may not be sufficient. Rather, interventions targeted toward specific deficits and emphasizing effective strategies may be necessary.

Further research is needed to determine if these findings can be replicated and to explore the reasons for the interaction effects and increases in ratings for maladaptive strategies by older adolescents. Studies with larger and more diverse samples are needed. Further information about developmental differences in emotion regulation could be helpful in providing prevention and therapeutic interventions.

Recommendations and Implications for Professionals

If these results are replicated in future studies, professionals who work with normal and clinical populations of adolescents may want to be more aware of the developmental changes which occur in emotion regulation and of the possibility of interaction effects between age and differing diagnostic categories. Professionals who work
with depressed populations also may want to review their techniques and procedures to see if their interventions directly address the areas identified as problematic in the research. For instance, depressed adolescents report using maladaptive strategies at an increased rate, despite appearing to give higher effectiveness ratings to other adaptive strategies. Therefore, with depressed adolescents, it may be important to focus directly on the connection between the use of maladaptive strategies and their negative personal consequences.

The results of this study also imply that practitioners may want to engage in a comprehensive assessment and verbal processing of an individual's emotion regulating processes, including how the individual interprets a given situation, how they evaluate their options, and why they choose to engage in any particular strategies. It is probable that the operation of making explicit to the individual the steps involved in the appropriate self-regulation of emotion and the varied effectiveness of different types of strategic choices will need to be repeated numerous times and with varied situations in order for the depressed adolescent to adequately learn and internalize this complex skill.

It is also possible, since nondepressed adolescents generated and reported as effective adaptive strategies involving skills that depressed adolescents frequently do not display, including complex social and problem-solving skills, assisting depressed students to develop prerequisite skills in these areas may also improve their emotional self-
regulatory skills.

As stated previously, this type of study needs to be repeated and further research is needed that focuses on the reasons for the differences found in the perception, generation, and evaluation processes of emotion regulation.
Appendix A

CLINICAL/EDUCATIONAL DEFINITIONS

Dysthymia

A. Depressed mood (or can be irritable mood in children and adolescents) for most of the day, more days than not, as indicated either by subjective account or observation by others, for at least two years (one year for children and adolescents)

B. Presence, while depressed, of at least two of the following:
   (1) poor appetite or overeating
   (2) insomnia or hypersomnia
   (3) low energy or fatigue
   (4) low self-esteem
   (5) poor concentration or difficulty making decisions
   (6) feelings of hopelessness

C. During a two year period (one-year for children and adolescents) of the disturbance, never without symptoms in A for more than two months at a time.

D. No evidence of an unequivocal Major Depressive Episode during the first two years (one year for children and adolescents) of the disturbance.

E. Has never has a Manic Episode or an unequivocal Hypomanic Episode

F. Not superimposed on a chronic psychotic disorder, such as Schizophrenia or Delusional Disorder.

G. It cannot be established that an organic factor
initiated and maintained the disturbance, e.g., prolonged administration of an antihypertensive medication (American Psychiatric Association, 1987, p. 232).

**Major Depression**

A. At least five of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is (1) depressed mood, or (2) loss of interest or pleasure. (Do not include symptoms that are clearly due to a physical condition, mood-incongruent delusions or hallucinations, incoherence, or marked loosening of associations.)

(1) depressed mood (or can be irritable mood in children and adolescents) most of the day, nearly every day, as indicated either by subjective account or observation by others

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day, (as indicated either by subjective account or observation by others of apathy most of the time)

(3) significant weight loss or weight gain when not dieting (e.g. more than 5% of body weight a month), or decrease in appetite
nearly every day (in children, consider failure to make expected weight gains)
(4) insomnia or hypersomnia nearly every day
(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
(6) fatigue or loss of energy nearly every day
(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
(9) recurrent thought of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. (1) It cannot be established that an organic factor initiated and maintained the disturbance
(2) The disturbance is not a normal reaction to the death of a loved one

C. At no time during the disturbance have there been delusions or hallucinations for as long as two weeks in the absence of prominent mood symptoms
(i.e. before the mood symptoms developed or after they were remitted.)


**Serious Emotional Disturbance**

1. The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance:
   a. An inability to learn, which can not be explained by intellectual, sensory or health factors
   b. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers
   c. Inappropriate types of behavior or feelings under normal circumstances
   d. A general pervasive mood of unhappiness or depression
   e. A tendency to develop physical symptoms or fears associated with personal or school problems.

2. The term includes children who are schizophrenic. The term does not include
children who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed (Virginia Department of Education, 1994, p. 9).
### APPENDIX B

#### PARTICIPANT CHARACTERISTICS

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Appendix C

Student:_______________  School:_________  Birthdate:________

PARENT PERMISSION FORM

Dear _________________

I am conducting a study titled "The Regulation of Sad Affect During Adolescence" to find out what kinds of coping strategies adolescents think are helpful for dealing with sadness. Students have been randomly selected from several Chesapeake schools to participate in the study. I would like your permission for _____________________ to be part of the study.

His participation would involve a 30 minute interview in which he would be asked about the kinds of coping strategies he thinks are helpful for changing negative feelings. He would be asked to name things that might make him feel better, as well as, rate the effectiveness of strategies other adolescents have suggested. This interview would take place during the school day.

Each participant's responses will be kept confidential and not reported to anyone else or reported directly in the study results. Rather, participant responses will be grouped together and only the group data will be used for analysis and discussion or be available for others to see.

The study is expected to yield information that can be used to develop more effective and appropriate ways for adolescents to deal with emotional stressors. The information obtained will only be used for this purpose.

The study is being conducted by Marcia Kennedy, School Psychologist with the Chesapeake Public Schools, 2107 East Liberty Street, Chesapeake, VA 23324, 4947600, under the supervision of Dr. Roger Ries, Professor, School of Education, College of William and Mary, Williamsburg, VA 23145, 221-2345.

Participation in this study is strictly voluntary. Each individual has the right to decline to participate or withdraw at any time without penalty.

If you agree for your son to participate, his teacher will request his cooperation and obtain his agreement to participate. If you have any questions about the proposed study or if you wish to know the results at the conclusion of the study, Marcia Kennedy may be contacted at 494-7600.
Informed and Voluntary Consent to Participate

I have been fully informed of the study and understand the information described above concerning confidentiality and voluntary participation. I agree that if ____________________________ wishes, he may participate in the study.

YES

Parent's signature ____________________________ Date ___________

NO

Parent's signature ____________________________ Date ___________
STUDENT CONSENT TO PARTICIPATE

Marcia Kennedy is conducting a study titled "The Regulation of Sad Affect During Adolescence" to find out what kinds of coping strategies adolescents think are helpful for changing negative feelings. Students will be interviewed and asked what they do to deal with certain kinds of feelings. The study is expected to yield information that can be used to help other adolescents deal with emotional stress. She would like you to participate in the study. You will just be asked to answer questions. It will take about 30 minutes and be conducted during the school day.

Your specific responses to this study will be kept confidential. A code will be used to identify you with your answers and only Mrs. Kennedy will have access to the code. The different responses to questions will be grouped together and only this group data will be used for analysis and discussion. This will prevent your responses from being identified in the reporting of the study results. The information obtained will only be used for the purposes specified in this study.

Your participation in this study is strictly voluntary. You have the right to decline to participate or withdraw at any time without penalty.

Informed and Voluntary Consent to Participate

I have been fully informed of the study and understand the information described above concerning confidentiality and voluntary participation.

I agree to participate in the study. _____________________

Student's signature

I do not agree to participate in the study. _____________________

Student's signature
APPENDIX E

INTERVIEW-- COPING STRATEGIES

Student's Name ____________________________ Date ____________

Interviewer's Name ____________________________

I am collecting information about how students cope with stress and what things they do to change unpleasant feelings. I will present you with two situations and I want you to imagine how you would feel and what you would do. I am going to read a list of things other kids have said they would do in similar situations and ask you what you think about their suggestions. There are no right or wrong answers. This should take about 30 minutes.

SITUATION A

What is the name of your best friend? ___________ Imagine he will be moving away.

What would you feel? (type of feeling) ________________

___________________________________________________________

Any other feelings?__________________________________________

How would you feel? not bad at all (1), a little bad (2), bad (3) or very bad (4)?

Would you do anything to make yourself feel better and if so what would you do?

___________________________________________________________

(If this is the first situation presented give the student the sample rating scales. Assist him in understanding the scales.)

For some of the questions you will need to respond using this scale

1--much worse, 2--a little worse, 3--the same, 4--a little better, or 5--a lot better

For some of the questions you will need to respond using this scale

1--never or none of the time, 2--not very often or not much of the time, 3--some of the time, 4--a lot of the time

I am going to read you a list of suggestions from other adolescents and I want you to tell me what you think of the things they would do to make themselves feel less sad.
1. Go somewhere you like to go.
   How would you expect this to make you feel? 
   1, 2, 3, 4, 5
   How often have you actually used this to make yourself feel better? 
   1, 2, 3, 4
   How do you think this would make others your age feel? 
   1, 2, 3, 4, 5

2. Walk away when anyone tries to talk to you about it.
   How would you expect this to make you feel? 
   1, 2, 3, 4, 5
   How often have you actually used this? 
   1, 2, 3, 4
   How do you think this would make others your age feel? 
   1, 2, 3, 4, 5

3. Think of it—not as a separation, but as a new place for you to visit.
   How would you expect this to make you feel? 
   1, 2, 3, 4, 5
   How often have you actually used this? 
   1, 2, 3, 4
   How do you think this would make others your age feel? 
   1, 2, 3, 4, 5

4. Hang around with your friends.
   How would you expect this to make you feel? 
   1, 2, 3, 4, 5
   How often have you actually used this? 
   1, 2, 3, 4
   How do you think this would make others your age feel? 
   1, 2, 3, 4, 5

5. Use bad language.
   How would you expect this to make you feel? 
   1, 2, 3, 4, 5
   How often have you actually used this? 
   1, 2, 3, 4
   How do you think this would make others your age feel? 
   1, 2, 3, 4, 5

6. Think about something that makes you feel better.
   How would you expect this to make you feel? 
   1, 2, 3, 4, 5
   How often have you actually used this? 
   1, 2, 3, 4
   How do you think this would make others your age feel? 
   1, 2, 3, 4, 5
7. Avoid talking to the person leaving.  
How would you expect this to make you feel?  
1, 2, 3, 4, 5  
How often have you actually used this?  
1, 2, 3, 4  
How do you think this would make others your age feel?  
1, 2, 3, 4, 5  

8. Think about the fun things you and your friend have done together.  
How would you expect this to make you feel?  
1, 2, 3, 4, 5  
How often have you actually used this?  
1, 2, 3, 4  
How do you think this would make others your age feel?  
1, 2, 3, 4, 5  

9. Joke someone. (Make fun of someone.)  
How would you expect this to make you feel?  
1, 2, 3, 4, 5  
How often have you actually used this?  
1, 2, 3, 4  
How do you think this would make others your age feel?  
1, 2, 3, 4, 5  

10. Just wait until something happens to make you feel better.  
How would you expect this to make you feel?  
1, 2, 3, 4, 5  
How often have you actually used this?  
1, 2, 3, 4  
How do you think this would make others your age feel?  
1, 2, 3, 4, 5  

11. Spend extra time with your family.  
How would you expect this to make you feel?  
1, 2, 3, 4, 5  
How often have you actually used this?  
1, 2, 3, 4  
How do you think this would make others your age feel?  
1, 2, 3, 4, 5  

12. Plan how you can visit each other.  
How would you expect this to make you feel?  
1, 2, 3, 4, 5  
How often have you actually used this?  
1, 2, 3, 4  
How do you think this would make others your age feel?  
1, 2, 3, 4, 5
13. Pretend not to be sad. Just act like you are happy.
   How would you expect this to make you feel? 1, 2, 3, 4, 5
   How often have you actually used this? 1, 2, 3, 4
   How do you think this would make others your age feel? 1, 2, 3, 4, 5

14. Yell at someone.
   How would you expect this to make you feel? 1, 2, 3, 4, 5
   How often have you actually used this? 1, 2, 3, 4
   How do you think this would make others your age feel? 1, 2, 3, 4, 5

15. Not do anything.
   How would you expect this to make you feel? 1, 2, 3, 4, 5
   How often have you actually used this? 1, 2, 3, 4
   How do you think this would make others your age feel? 1, 2, 3, 4, 5

16. Play basketball, football, soccer, Nintendo...
   How would you expect this to make you feel? 1, 2, 3, 4, 5
   How often have you actually used this? 1, 2, 3, 4
   How do you think this would make others your age feel? 1, 2, 3, 4, 5

17. Tell your friend how you feel.
   How would you expect this to make you feel? 1, 2, 3, 4, 5
   How often have you actually used this? 1, 2, 3, 4
   How do you think this would make others your age feel? 1, 2, 3, 4, 5

18. Talk about ways you can stay in contact with each other.
   How would you expect this to make you feel? 1, 2, 3, 4, 5
   How often have you actually used this? 1, 2, 3, 4
   How do you think this would make others your age feel? 1, 2, 3, 4, 5
19. Talk to another friend about how you feel.
   How would you expect this to make you feel?
   1, 2, 3, 4, 5
   How often have you actually used this?
   1, 2, 3, 4
   How do you think this would make others your age feel?
   1, 2, 3, 4, 5

20. Listen to music you like.
   How would you expect this to make you feel?
   1, 2, 3, 4, 5
   How often have you actually used this?
   1, 2, 3, 4
   How do you think this would make others your age feel?
   1, 2, 3, 4, 5

21. Get in a fight.
   How would you expect this to make you feel?
   1, 2, 3, 4, 5
   How often have you actually used this?
   1, 2, 3, 4
   How do you think this would make others your age feel?
   1, 2, 3, 4, 5

22. Plan to do something special or spend extra time with your friend
    before they leave.
   How would you expect this to make you feel?
   1, 2, 3, 4, 5
   How often have you actually used this?
   1, 2, 3, 4
   How do you think this would make others your age feel?
   1, 2, 3, 4, 5

23. Tell your parent or teacher how you feel.
   How would you expect this to make you feel?
   1, 2, 3, 4, 5
   How often have you actually used this?
   1, 2, 3, 4
   How do you think this would make others your age feel?
   1, 2, 3, 4, 5

24. Refuse to believe it.
   How would you expect this to make you feel?
   1, 2, 3, 4, 5
   How often have you actually used this?
   1, 2, 3, 4
   How do you think this would make others your age feel?
   1, 2, 3, 4, 5
25. Find out as much as you can about where they are going and how you can contact each other.

How would you expect this to make you feel?  
1, 2, 3, 4, 5

How often have you actually used this?  
1, 2, 3, 4

How do you think this would make others your age feel?  
1, 2, 3, 4, 5

26. Sleep.

How would you expect this to make you feel?  
1, 2, 3, 4, 5

How often have you actually used this?  
1, 2, 3, 4

How do you think this would make others your age feel?  
1, 2, 3, 4, 5

27. Go and see someone you like (other than the person who is leaving).

How would you expect this to make you feel?  
1, 2, 3, 4, 5

How often have you actually used this?  
1, 2, 3, 4

How do you think this would make others your age feel?  
1, 2, 3, 4, 5

28. Keep real busy with things you like to do.

How would you expect this to make you feel?  
1, 2, 3, 4, 5

How often have you actually used this?  
1, 2, 3, 4

How do you think this would make others your age feel?  
1, 2, 3, 4, 5

29. Get drunk or high so you don't have to deal with the situation.

How would you expect this to make you feel?  
1, 2, 3, 4, 5

How often have you actually used this?  
1, 2, 3, 4

How do you think this would make others your age feel?  
1, 2, 3, 4, 5

30. Cry

How would you expect this to make you feel?  
1, 2, 3, 4, 5

How often have you actually used this?  
1, 2, 3, 4

How do you think this would make others your age feel?  
1, 2, 3, 4, 5
31. Avoid being by yourself.

How would you expect this to make you feel? 1, 2, 3, 4, 5
How often have you actually used this? 1, 2, 3, 4
How do you think this would make others your age feel? 1, 2, 3, 4, 5

32. Think to yourself, "It won't be so bad."

How would you expect this to make you feel? 1, 2, 3, 4, 5
How often have you actually used this? 1, 2, 3, 4
How do you think this would make others your age feel? 1, 2, 3, 4, 5

After the presentation of the last situation ask the following.

How do you feel right now?

Tell me about something that has made you feel happy.
SITUATION B

Imagine a family member became really sick and you had to go live with someone else for a while.

What would you feel? (type of feeling) ____________________

Any other feelings? __________________________________________

How would you feel? not bad at all (1), a little bad (2), bad (3), or very bad (4)?

Would you do anything to make yourself feel better and, if so, what would you do?

(If this is the first situation presented give the student the sample rating scales. Assist him in understanding the scales.)

For two sets of questions you will need to respond using this scale

1—much worse, 2—a little worse, 3—the same, 4—a little better, or 5—a lot better

For one set of questions you will need to respond using this scale

1—never or none of the time, 2—not very often or not much of the time, 3—some of the time, 4—a lot of the time

I am going to read you a list of suggestions from other adolescents and I want you to tell me what you think of the things they would do to make themselves feel less sad.

1. Go somewhere you like to go.

   How would you expect this to make you feel? 1, 2, 3, 4, 5

   How often have you actually used this when you felt bad? 1, 2, 3, 4

   How do you think this would make others your age feel? 1, 2, 3, 4, 5

2. Walk away when anyone tries to talk to you about it.

   How would you expect this to make you feel? 1, 2, 3, 4, 5

   How often have you actually used this? 1, 2, 3, 4

   How do you think this would make others your age feel? 1, 2, 3, 4, 5
3. Think of it- not as a separation, but as a new place for you to visit.
   How would you expect this to make you feel? 
   1, 2, 3, 4, 5
   How often have you actually used this? 
   1, 2, 3, 4
   How do you think this would make others your age feel? 
   1, 2, 3, 4, 5

4. Hang around with your friends.
   How would you expect this to make you feel? 
   1, 2, 3, 4, 5
   How often have you actually used this? 
   1, 2, 3, 4
   How do you think this would make others your age feel? 
   1, 2, 3, 4, 5

5. Use bad language
   How would you expect this to make you feel? 
   1, 2, 3, 4, 5
   How often have you actually used this? 
   1, 2, 3, 4
   How do you think this would make others your age feel? 
   1, 2, 3, 4, 5

6. Think about something that makes you feel better.
   How would you expect this to make you feel? 
   1, 2, 3, 4, 5
   How often have you actually used this? 
   1, 2, 3, 4
   How do you think this would make others your age feel? 
   1, 2, 3, 4, 5

7. Avoid talking to the person leaving.
   How would you expect this to make you feel? 
   1, 2, 3, 4, 5
   How often have you actually used this? 
   1, 2, 3, 4
   How do you think this would make others your age feel? 
   1, 2, 3, 4, 5

8. Think about the fun things you and your family have done together.
   How would you expect this to make you feel? 
   1, 2, 3, 4, 5
   How often have you actually used this? 
   1, 2, 3, 4
   How do you think this would make others your age feel? 
   1, 2, 3, 4, 5
9. Joke someone. (Make fun of someone.)

How would you expect this to make you feel? 1, 2, 3, 4, 5
How often have you actually used this? 1, 2, 3, 4
How do you think this would make others your age feel? 1, 2, 3, 4, 5

10. Just wait until something happens that makes you feel better.

How would you expect this to make you feel? 1, 2, 3, 4, 5
How often have you actually used this? 1, 2, 3, 4
How do you think this would make others your age feel? 1, 2, 3, 4, 5

11. Spend extra time with your family.

How would you expect this to make you feel? 1, 2, 3, 4, 5
How often have you actually used this? 1, 2, 3, 4
How do you think this would make others your age feel? 1, 2, 3, 4, 5

12. Plan how you can visit each other.

How would you expect this to make you feel? 1, 2, 3, 4, 5
How often have you actually used this? 1, 2, 3, 4
How do you think this would make others your age feel? 1, 2, 3, 4, 5

13. Pretend not to be sad. Act like you are happy.

How would you expect this to make you feel? 1, 2, 3, 4, 5
How often have you actually used this? 1, 2, 3, 4
How do you think this would make others your age feel? 1, 2, 3, 4, 5

14. Yell at someone.

How would you expect this to make you feel? 1, 2, 3, 4, 5
How often have you actually used this? 1, 2, 3, 4
How do you think this would make others your age feel? 1, 2, 3, 4, 5
15. Not do anything.
   How would you expect this to make you feel? 1, 2, 3, 4, 5
   How often have you actually used this? 1, 2, 3, 4
   How do you think this would make others your age feel? 1, 2, 3, 4, 5

16. Play basketball, football, soccer, Nintendo...
   How would you expect this to make you feel? 1, 2, 3, 4, 5
   How often have you actually used this? 1, 2, 3, 4
   How do you think this would make others your age feel? 1, 2, 3, 4, 5

17. Tell your family member how you feel.
   How would you expect this to make you feel? 1, 2, 3, 4, 5
   How often have you actually used this? 1, 2, 3, 4
   How do you think this would make others your age feel? 1, 2, 3, 4, 5

18. Talk about ways you can stay in contact with each other.
   How would you expect this to make you feel? 1, 2, 3, 4, 5
   How often have you actually used this? 1, 2, 3, 4
   How do you think this would make others your age feel? 1, 2, 3, 4, 5

19. Talk to another friend about how you feel.
   How would you expect this to make you feel? 1, 2, 3, 4, 5
   How often have you actually used this? 1, 2, 3, 4
   How do you think this would make others your age feel? 1, 2, 3, 4, 5

20. Listen to music you like.
   How would you expect this to make you feel? 1, 2, 3, 4, 5
   How often have you actually used this? 1, 2, 3, 4
   How do you think this would make others your age feel? 1, 2, 3, 4, 5
21. Get in a fight.

How would you expect this to make you feel?  
1, 2, 3, 4, 5  
How often have you actually used this?  
1, 2, 3, 4  
How do you think this would make others your age feel?  
1, 2, 3, 4, 5

22. Plan to do something special or spend extra time with your family before they leave.

How would you expect this to make you feel?  
1, 2, 3, 4, 5  
How often have you actually used this?  
1, 2, 3, 4  
How do you think this would make others your age feel?  
1, 2, 3, 4, 5

23. Tell your parent or teacher how you feel.

How would you expect this to make you feel?  
1, 2, 3, 4, 5  
How often have you actually used this?  
1, 2, 3, 4  
How do you think this would make others your age feel?  
1, 2, 3, 4, 5

24. Refuse to believe it.

How would you expect this to make you feel?  
1, 2, 3, 4, 5  
How often have you actually used this?  
1, 2, 3, 4  
How do you think this would make others your age feel?  
1, 2, 3, 4, 5

25. Find out as much as you can about where they are going and how you can contact each other.

How would you expect this to make you feel?  
1, 2, 3, 4, 5  
How often have you actually used this?  
1, 2, 3, 4  
How do you think this would make others your age feel?  
1, 2, 3, 4, 5

26. Sleep.

How would you expect this to make you feel?  
1, 2, 3, 4, 5  
How often have you actually used this?  
1, 2, 3, 4  
How do you think this would make others your age feel?  
1, 2, 3, 4, 5
27. Go and see someone you like (other than the person who is leaving).

How would you expect this to make you feel?

1, 2, 3, 4, 5

How often have you actually used this?

1, 2, 3, 4

How do you think this would make others your age feel?

1, 2, 3, 4, 5

28. Keep real busy with things you like to do.

How would you expect this to make you feel?

1, 2, 3, 4, 5

How often have you actually used this?

1, 2, 3, 4

How do you think this would make others your age feel?

1, 2, 3, 4, 5

29. Get drunk or high so you don't have to deal with the situation.

How would you expect this to make you feel?

1, 2, 3, 4, 5

How often have you actually used this?

1, 2, 3, 4

How do you think this would make others your age feel?

1, 2, 3, 4, 5

30. Cry

How would you expect this to make you feel?

1, 2, 3, 4, 5

How often have you actually used this?

1, 2, 3, 4

How do you think this would make others your age feel?

1, 2, 3, 4, 5

31. Avoid being by yourself.

How would you expect this to make you feel?

1, 2, 3, 4, 5

How often have you actually used this?

1, 2, 3, 4

How do you think this would make others your age feel?

1, 2, 3, 4, 5

32. Think to yourself, "It won't be so bad."

How would you expect this to make you feel?

1, 2, 3, 4, 5

How often have you actually used this?

1, 2, 3, 4

How do you think this would make others your age feel?

1, 2, 3, 4, 5
After the presentation of the last situation ask the following.
How do you feel right now?

Tell me about something that has made you feel happy.
APPENDIX F

STRATEGIC CODING

**Active Avoidance**

2. Walk away when anyone tries to talk to you about it.
7. Avoid talking to the person leaving.
13. Pretend not to be sad. Just act like you are happy.
29. Get drunk or high so you don't have to deal with the situation.

**Passive Avoidance**

10. Just wait until something happens to make you feel better.
15. Not do anything.
24. Refuse to believe it.
26. Sleep.

**Negative Behaviors**

5. Use bad language.
9. Joke someone. (Make fun of someone)
14. Yell at someone.
21. Get in a fight.

**Cognitive Strategies**

3. Think of it—not as a separation, but as a new place for you to visit.
6. Think about something that makes you feel better.
8. Think about the fun things you and your friend/family have done together.
32. Think to yourself "It won't be so bad".

Engage in Pleasant Activities

1. Go somewhere you like to go
16. Play basketball, football, baseball, Nintendo....
20. Listen to music you like.
28. Keep real busy with things you like to do.

Problem-Focused Activities

12. Plan how you can visit each other.
18. Talk about ways you can stay in contact with each other.
22. Plan to do something special or spend extra time with your friend before they leave.
25. Find out as much as you can about where they are going and how you can contact each other.

Seek Social Contact

4. Hang around with your friends.
11. Spend extra time with your family.
27. Go and see someone you like. (Other than the person leaving)
31. Avoid being by yourself.

Express Emotion

17. Tell your friend how you feel.
19. Talk to another friend about how you feel.
23. Tell your parent or teacher how you feel.
30. Cry.
Adaptability Coding

Socially Acceptable/Adaptive Strategies

1. Go somewhere you like to go.
3. Think of it - not as a separation, but as a new place to visit.
4. Hang around with friends.
6. Think about something that makes you feel better.
8. Think about the fun things you and your family have done together.
11. Spend extra time with your family.
12. Plan how you can visit each other.
13. Pretend not to be sad. Act like you are happy.
16. Play basketball, football, soccer, Nintendo...
17. Tell the family member how you feel.
18. Talk about ways you can stay in contact with each other.
19. Talk to another friend about how you feel.
20. Listen to music you like.
22. Plan to do something special or spend extra time with your family before you leave.
23. Tell you parent or teacher how you feel.
25. Find out as much as you can about where they are going and how you can contact each other.
27. Go and see someone you like (other than the person who is leaving).
28. Keep real busy with things you like to do.
30. Cry.
31. Avoid being by yourself.
32. Think to yourself, "It won't be so bad".

Unacceptable and/or Maladaptive Strategies

2. Walk away when anyone tries to talk to you about it.
5. Use bad language.
7. Avoid talking to the person leaving.
9. Joke someone (Make fun of someone.)
10. Just wait until something happens that makes you feel better.
14. Yell at someone.
15. Not do anything.
21. Get in a fight.
24. Refuse to believe it.
26. Sleep.
29. Get drunk or high so you don't have to deal with the situation.
APPENDIX G

FEELINGS GENERATED FOR SCENARIOS

The feelings reported were categorized into the following types:

1 sad, unhappy
2 worried, upset, anxious
3 mad
4 bad, uncomfortable (negative, but nonspecific)
5 alright, not matter, regular, the same, cool, accept it (neutral)
6 hopeful (positive)
7 don't know
Table 1. **Univariate Tests on Ratings of Effectiveness for Modifying One's Own Feelings (Age by Diagnosis)**

<table>
<thead>
<tr>
<th>Strategic Type</th>
<th>F Value</th>
<th>PR&gt;F</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Avoidance</td>
<td>0.099</td>
<td>.745</td>
<td>No</td>
</tr>
<tr>
<td>Passive Avoidance</td>
<td>0.166</td>
<td>.685</td>
<td>No</td>
</tr>
<tr>
<td>Negative Behaviors</td>
<td>2.405</td>
<td>.125</td>
<td>No</td>
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<tr>
<td>Cognitive Strategies</td>
<td>7.966</td>
<td>.006</td>
<td>Yes</td>
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<tr>
<td>Pleasant Activities</td>
<td>16.274</td>
<td>.000</td>
<td>Yes</td>
</tr>
<tr>
<td>Problem-Focused</td>
<td>0.145</td>
<td>.705</td>
<td>No</td>
</tr>
<tr>
<td>Social Contact</td>
<td>0.183</td>
<td>.670</td>
<td>No</td>
</tr>
<tr>
<td>Express Emotion</td>
<td>0.122</td>
<td>.728</td>
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Table 2. **Univariate Tests on Ratings of Effectiveness for Modifying One's Own Feelings (Diagnosis)**

<table>
<thead>
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<th>Strategic Type</th>
<th>F Value</th>
<th>PR&gt;F</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Avoidance</td>
<td>7.455</td>
<td>.008</td>
<td>Yes</td>
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<tr>
<td>Passive Avoidance</td>
<td>1.195</td>
<td>.278</td>
<td>No</td>
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<td>Negative Behaviors</td>
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<td>.033</td>
<td>Yes</td>
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<tr>
<td>Cognitive Strategies</td>
<td>4.172</td>
<td>.045</td>
<td>Yes</td>
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<tr>
<td>Pleasant Activities</td>
<td>1.562</td>
<td>.215</td>
<td>No</td>
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<tr>
<td>Problem-Focused</td>
<td>16.549</td>
<td>.000</td>
<td>Yes</td>
</tr>
<tr>
<td>Social Contact</td>
<td>13.730</td>
<td>.000</td>
<td>Yes</td>
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<tr>
<td>Express Emotion</td>
<td>10.057</td>
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<td>Yes</td>
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Table 3. **Univariate Tests on the Ratings of Effectiveness for Modifying Others' Feelings (Diagnosis)**

<table>
<thead>
<tr>
<th>Strategic Type</th>
<th>F Value</th>
<th>PR&gt;F</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Avoidance</td>
<td>3.300</td>
<td>.073</td>
<td>No</td>
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<tr>
<td>Passive Avoidance</td>
<td>0.480</td>
<td>.491</td>
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</tr>
<tr>
<td>Negative Behaviors</td>
<td>8.497</td>
<td>.005</td>
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</tr>
<tr>
<td>Cognitive Strategies</td>
<td>11.786</td>
<td>.001</td>
<td>Yes</td>
</tr>
<tr>
<td>Pleasant Activities</td>
<td>6.204</td>
<td>.015</td>
<td>Yes</td>
</tr>
<tr>
<td>Problem-Focused</td>
<td>16.060</td>
<td>.000</td>
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</tr>
<tr>
<td>Social Contact</td>
<td>14.009</td>
<td>.000</td>
<td>Yes</td>
</tr>
<tr>
<td>Express Emotion</td>
<td>15.129</td>
<td>.000</td>
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</table>

Table 4. **Univariate Tests on the Reported Use of Strategic Types (Age by Diagnosis)**

<table>
<thead>
<tr>
<th>Strategic Type</th>
<th>F Value</th>
<th>PR&gt;F</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Avoidance</td>
<td>2.356</td>
<td>.129</td>
<td>No</td>
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<tr>
<td>Passive Avoidance</td>
<td>0.207</td>
<td>.651</td>
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</tr>
<tr>
<td>Negative Behaviors</td>
<td>0.999</td>
<td>.321</td>
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</tr>
<tr>
<td>Cognitive Strategies</td>
<td>8.645</td>
<td>.004</td>
<td>Yes</td>
</tr>
<tr>
<td>Pleasant Activities</td>
<td>9.149</td>
<td>.003</td>
<td>Yes</td>
</tr>
<tr>
<td>Problem-Focused</td>
<td>2.192</td>
<td>.143</td>
<td>No</td>
</tr>
<tr>
<td>Social Contact</td>
<td>12.465</td>
<td>.001</td>
<td>Yes</td>
</tr>
<tr>
<td>Express Emotion</td>
<td>1.231</td>
<td>.271</td>
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</table>
Table 5. **Univariate Tests on the Reported Use of Strategic Types (Diagnosis)**

<table>
<thead>
<tr>
<th>Strategic Type</th>
<th>F Value</th>
<th>PR&gt;F</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Avoidance</td>
<td>0.042</td>
<td>.839</td>
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<tr>
<td>Passive Avoidance</td>
<td>0.018</td>
<td>.894</td>
<td>No</td>
</tr>
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<td>Negative Behaviors</td>
<td>10.278</td>
<td>.002</td>
<td>Yes</td>
</tr>
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<td>Cognitive Strategy</td>
<td>13.611</td>
<td>.000</td>
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</tr>
<tr>
<td>Pleasant Activities</td>
<td>0.375</td>
<td>.542</td>
<td>No</td>
</tr>
<tr>
<td>Problem-Focused</td>
<td>10.381</td>
<td>.002</td>
<td>Yes</td>
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<td>Social Contact</td>
<td>3.059</td>
<td>.085</td>
<td>Yes</td>
</tr>
<tr>
<td>Express Emotion</td>
<td>2.725</td>
<td>.103</td>
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</table>

Table 6. **Univariate Tests on the Ratings of Effectiveness for Self (Age)**

<table>
<thead>
<tr>
<th>Strategic Type</th>
<th>F Value</th>
<th>PR&gt;F</th>
<th>Significance</th>
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</thead>
<tbody>
<tr>
<td>Active Avoidance</td>
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<td>.000</td>
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<td>Passive Avoidance</td>
<td>15.434</td>
<td>.000</td>
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<td>Negative Behaviors</td>
<td>6.612</td>
<td>.012</td>
<td>Yes</td>
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<tr>
<td>Cognitive Strategies</td>
<td>0.039</td>
<td>.842</td>
<td>No</td>
</tr>
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<td>Pleasant Activities</td>
<td>1.107</td>
<td>.296</td>
<td>No</td>
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<td>Problem-Focused</td>
<td>0.049</td>
<td>.825</td>
<td>No</td>
</tr>
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<td>Social Contact</td>
<td>2.637</td>
<td>.109</td>
<td>No</td>
</tr>
<tr>
<td>Express Emotion</td>
<td>0.071</td>
<td>.791</td>
<td>No</td>
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</table>
Table 7. Univariate Tests on the Ratings of Effectiveness for Others (Age)

<table>
<thead>
<tr>
<th>Strategic Type</th>
<th>F Value</th>
<th>PR&gt;F</th>
<th>Significance</th>
</tr>
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<tbody>
<tr>
<td>Active Avoidance</td>
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<td>.000</td>
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<tr>
<td>Passive Avoidance</td>
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<td>Negative Behaviors</td>
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<td>Cognitive Strategies</td>
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<td>Problem-Focused</td>
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<td>.878</td>
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<td>Social Contact</td>
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<td>.413</td>
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</tr>
<tr>
<td>Express Emotion</td>
<td>0.737</td>
<td>.393</td>
<td>No</td>
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</table>

Table 8. Rank Ordering of Means for the Ratings of Effectiveness for Self (Diagnostic Groups)

<table>
<thead>
<tr>
<th></th>
<th>Nondepressed</th>
<th>Depressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rank</td>
<td>Mean</td>
<td>Rank</td>
</tr>
<tr>
<td>Active Avoidance</td>
<td>1</td>
<td>1.91</td>
</tr>
<tr>
<td>Negative Behaviors</td>
<td>2</td>
<td>2.03</td>
</tr>
<tr>
<td>Passive Avoidance</td>
<td>3</td>
<td>2.61</td>
</tr>
<tr>
<td>Expressing Emotions</td>
<td>4</td>
<td>3.63</td>
</tr>
<tr>
<td>Cognitive Strategy</td>
<td>5</td>
<td>3.95</td>
</tr>
<tr>
<td>Pleasant Activity</td>
<td>6</td>
<td>4.11</td>
</tr>
<tr>
<td>Social Contact</td>
<td>7</td>
<td>4.18</td>
</tr>
<tr>
<td>Problem-Focused</td>
<td>8</td>
<td>4.50</td>
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</table>
Table 9. Rank Ordering of Means for the Effectiveness Ratings for Others (Diagnostic Groups)

<table>
<thead>
<tr>
<th></th>
<th>Nondepressed</th>
<th></th>
<th>Depressed</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rank</td>
<td>Mean</td>
<td>Rank</td>
<td>Mean</td>
</tr>
<tr>
<td>Active Avoidance</td>
<td>2</td>
<td>2.35</td>
<td>1</td>
<td>2.66</td>
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<tr>
<td>Negative Behaviors</td>
<td>1</td>
<td>2.25</td>
<td>3</td>
<td>2.87</td>
</tr>
<tr>
<td>Passive Avoidance</td>
<td>3</td>
<td>2.73</td>
<td>2</td>
<td>2.86</td>
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<tr>
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<td>3.65</td>
<td>4</td>
<td>3.16</td>
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<td>Cognitive Strategy</td>
<td>5</td>
<td>3.95</td>
<td>5</td>
<td>3.50</td>
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<tr>
<td>Pleasant Activities</td>
<td>6</td>
<td>4.11</td>
<td>8</td>
<td>3.83</td>
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<tr>
<td>Social Contact</td>
<td>7</td>
<td>4.19</td>
<td>6/7</td>
<td>3.76</td>
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<tr>
<td>Problem-Focused</td>
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<td>4.41</td>
<td>6/7</td>
<td>3.76</td>
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</table>

Table 10. Rank Ordering of Means for the Reported Use (Diagnostic Groups)

<table>
<thead>
<tr>
<th></th>
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<th>Depressed</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
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<td>Mean</td>
<td>Rank</td>
<td>Mean</td>
</tr>
<tr>
<td>Active Avoidance</td>
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<td>1</td>
<td>2.02</td>
</tr>
<tr>
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<td>1.76</td>
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<td>2.29</td>
</tr>
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<td>Passive Avoidance</td>
<td>3</td>
<td>2.28</td>
<td>2</td>
<td>2.28</td>
</tr>
<tr>
<td>Expressing Emotions</td>
<td>4</td>
<td>2.55</td>
<td>3/4</td>
<td>2.29</td>
</tr>
<tr>
<td>Cognitive Strategy</td>
<td>5</td>
<td>3.08</td>
<td>5</td>
<td>2.57</td>
</tr>
<tr>
<td>Pleasant Activities</td>
<td>7</td>
<td>3.20</td>
<td>8</td>
<td>3.11</td>
</tr>
<tr>
<td>Social Contact</td>
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<td>3.13</td>
<td>7</td>
<td>2.90</td>
</tr>
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<td>3.21</td>
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Table 11. Rank Ordering of Means for the Ratings of Effectiveness for Self (Age Groups)

<table>
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<tr>
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</thead>
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<td>Mean</td>
<td>Rank</td>
<td>Mean</td>
</tr>
<tr>
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<td>1.83</td>
<td>1</td>
<td>2.44</td>
</tr>
<tr>
<td>Negative Behaviors</td>
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<td>2</td>
<td>2.53</td>
</tr>
<tr>
<td>Passive Avoidance</td>
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<td>2.41</td>
<td>3</td>
<td>3.01</td>
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<td>Expressing Emotions</td>
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<td>4</td>
<td>3.33</td>
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<td>Cognitive Strategy</td>
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<td>3.80</td>
<td>5</td>
<td>3.82</td>
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<td>3.97</td>
<td>7</td>
<td>4.09</td>
</tr>
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<td>Social Contact</td>
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<td>3.84</td>
<td>6</td>
<td>4.03</td>
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<tr>
<td>Problem-Focused</td>
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<td>4.20</td>
<td>8</td>
<td>4.13</td>
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</table>

Table 12. Rank Ordering of Means for the Effectiveness Ratings for Others (Age Groups)

<table>
<thead>
<tr>
<th></th>
<th>Early</th>
<th></th>
<th>Late</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rank</td>
<td>Mean</td>
<td>Rank</td>
<td>Mean</td>
</tr>
<tr>
<td>Active Avoidance</td>
<td>1</td>
<td>2.19</td>
<td>2</td>
<td>2.82</td>
</tr>
<tr>
<td>Negative Behaviors</td>
<td>2</td>
<td>2.35</td>
<td>1</td>
<td>2.78</td>
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<tr>
<td>Passive Avoidance</td>
<td>3</td>
<td>2.53</td>
<td>3</td>
<td>3.06</td>
</tr>
<tr>
<td>Expressing Emotions</td>
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<td>3.47</td>
<td>4</td>
<td>3.34</td>
</tr>
<tr>
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<td>3.77</td>
<td>5</td>
<td>3.68</td>
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<td>3.93</td>
<td>6/7</td>
<td>4.01</td>
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<td>3.94</td>
<td>6/7</td>
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<td>4.06</td>
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Table 13. Rank Ordering of Means for the Reported Use (Age Groups)

<table>
<thead>
<tr>
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<th>Late Mean</th>
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<td>1</td>
<td>2.09</td>
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<td>Negative Behaviors</td>
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<td>1.92</td>
<td>2</td>
<td>2.13</td>
</tr>
<tr>
<td>Passive Avoidance</td>
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<td>2.08</td>
<td>4</td>
<td>2.47</td>
</tr>
<tr>
<td>Expressing Emotions</td>
<td>4</td>
<td>2.43</td>
<td>3</td>
<td>2.41</td>
</tr>
<tr>
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<td>2.90</td>
<td>5</td>
<td>2.74</td>
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<td>3.19</td>
<td>8</td>
<td>3.13</td>
</tr>
<tr>
<td>Social Contact</td>
<td>7</td>
<td>3.06</td>
<td>7</td>
<td>2.98</td>
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<tr>
<td>Problem-Focused</td>
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<td>3.03</td>
<td>6</td>
<td>2.86</td>
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Figure 1. Percentage of feelings reported by depressed and nondepressed groups.
Figure 2. Percentage of strategies generated by depressed and nondepressed groups.
Figure 3. Effectiveness ratings of cognitive strategies for modifying one's own feelings (AGE X DIAGNOSIS)

Figure 4. The effectiveness ratings of pleasant activities for modifying one's own feelings. (AGE X DIAGNOSIS)
Figure 5. The reported use of cognitive strategies. (AGE X DIAGNOSIS)

Figure 6. Reported use of pleasant activities. (AGE X DIAGNOSIS)
Figure 7. The reported use of seeking social contact. (AGE X DIAGNOSIS)
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           Doctor of Education, Counseling/School Psychology

1976-1977 Michigan State University
           East Lansing, Michigan
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           East Lansing, Michigan
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1970-1974 Mary Washington College
           Fredericksburg, Virginia
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