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Original Research Article

EVALUATION OF VARIOUS COPING STRATEGIES IN ADOLESCENTS WITH DEPRESSIVE DISORDER: AN INSTITUTIONAL BASED STUDY

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ABSTRACT

Background: Depressive disorder during adolescence is associated with emotional distress, academic impairment, social withdrawal, sleep disturbance, hopelessness, and suicidal ideation. Coping strategies play an important role in determining how adolescents respond to depressive symptoms and psychosocial stressors. Identification of adaptive and maladaptive coping patterns may help in planning effective psychological interventions. **Aim:** To evaluate various coping strategies in adolescents with depressive disorder. **Materials and Methods:** This hospital-based cross-sectional observational study included 150 adolescents aged 13–18 years diagnosed with depressive disorder. Socio-demographic variables, clinical characteristics, depression severity, psychosocial stressors, and coping strategies were assessed using a structured proforma and validated assessment tools. Coping domains included problem-focused coping, emotion-focused coping, social support seeking, acceptance, positive reinterpretation, avoidance coping, denial, behavioral disengagement, venting, and self-blame. **Results:** Among 150 adolescents, 38 (25.33%) had mild depression, 72 (48.00%) had moderate depression, and 40 (26.67%) had severe depression. Academic performance was significantly associated with depression severity, with average/poor performance observed in 82.50% of severe cases ($p=0.018$). Longer symptom duration, irritability, hopelessness, suicidal ideation, psychosocial stressors, and previous psychiatric treatment were significantly associated with severe depression. Problem-focused coping decreased from 44.74% in mild depression to 7.50% in severe depression, while avoidance coping increased from 7.89% to 32.50%. Maladaptive coping was significantly associated with rural residence, joint/extended family, poor academic performance, psychosocial stressors, and suicidal ideation. Depression severity showed a negative correlation with total adaptive coping score ($r=-0.53$, $p<0.001$) and a positive correlation with total maladaptive coping score ($r=0.61$, $p<0.001$). **Conclusion:** Adolescents with severe depression relied more on maladaptive coping strategies, while adaptive coping was more common in mild depression. Assessment of coping patterns should be included in routine clinical evaluation to guide counselling, psychosocial intervention, and suicide-risk prevention.

INTRODUCTION

Adolescence is a critical developmental phase marked by rapid biological maturation, emotional reorganization, identity formation, expanding peer relationships, academic expectations, and increasing autonomy from parents. During this period, young people experience major changes in cognition, affect regulation, interpersonal sensitivity, and problem-solving ability. These developmental transitions create opportunities for growth, but they also increase vulnerability to emotional disorders when adolescents face persistent stress, family conflict, academic pressure, social rejection, bullying, trauma, or poor support systems. Depressive disorder during adolescence is therefore not only a mood disturbance but also a condition that can disturb learning, relationships, self-esteem, sleep,

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appetite, motivation, and future psychosocial adjustment. Because depressive symptoms may be expressed through irritability, social withdrawal, decline in academic performance, somatic complaints, hopelessness, self-harm thoughts, or behavioral changes, early recognition requires a developmentally sensitive clinical approach.[1] Adolescent depression has become an important public health and clinical concern because it may begin early, persist into adulthood, and contribute to recurrent psychiatric morbidity if not identified and managed appropriately. The disorder is often under-recognized because adolescents may not spontaneously report sadness or psychological distress, and families may attribute symptoms to laziness, disobedience, examination stress, or normal teenage behavior. In many clinical settings, adolescents are brought for consultation only after functional deterioration, school refusal, irritability, self-harm threats, or suicidal ideation becomes evident. Depression at this age can also coexist with anxiety symptoms, conduct problems, substance use, eating-related concerns, sleep disturbance, and family or peer difficulties. Therefore, comprehensive assessment should include symptom severity, duration, psychosocial context, family environment, academic functioning, risk assessment, and coping patterns rather than focusing only on diagnostic labelling.[2]

Coping strategies play an important role in determining how adolescents respond to depressive symptoms and stressful life situations. Coping refers to the cognitive, emotional, and behavioral efforts used by an individual to manage internal distress or external demands. In adolescents with depressive disorder, coping may determine whether distress is processed constructively or becomes intensified through avoidance, self-blame, denial, rumination, social withdrawal, or behavioral disengagement. Adaptive coping strategies such as problem-solving, planning, acceptance, positive reinterpretation, emotional expression, and seeking social support may help adolescents handle stress more effectively. In contrast, maladaptive coping strategies may provide temporary relief but can worsen depressive symptoms by reducing active problem-solving, increasing isolation, and maintaining negative thought patterns.[3]

The assessment of coping strategies is particularly relevant in adolescents because their coping repertoire is still developing. Younger adolescents may depend more on family support and immediate emotional reactions, while older adolescents may show more independent but sometimes avoidant responses. Peer relationships also become increasingly important during adolescence, and lack of peer support or fear of rejection may influence coping behavior. Academic stress, parental expectations, social comparison, and digital media exposure may further affect how adolescents interpret and respond to problems. Some adolescents may seek help, communicate distress, or engage in constructive distraction, whereas others may suppress emotions, blame themselves, avoid responsibilities, or disengage from daily activities. Understanding these patterns can help clinicians identify adolescents who are at greater risk of worsening depression or suicidal behavior.[4] Depressive disorder may also affect the adolescent's ability to use adaptive coping. Low energy, hopelessness, poor concentration, guilt, negative self-evaluation, and anhedonia can reduce motivation to solve problems or seek help. As depression becomes more severe, the adolescent may perceive problems as uncontrollable, support as unavailable, and the future as meaningless. This may lead to avoidance, rumination, catastrophizing, or self-blame. Hence, coping should not be viewed as a fixed personality trait but as a dynamic psychological response that may change with depression severity, family support, school environment, and treatment. Assessing coping domains alongside clinical symptoms can provide a broader understanding of the adolescent's emotional functioning.[5]

In tertiary care hospitals, adolescents with depressive disorder often present with complex clinical and psychosocial backgrounds. Many may have delayed help-seeking, previous treatment attempts, severe symptoms, family stressors, academic decline, sleep disturbance, suicidal ideation, or coexisting behavioral problems. In such settings, evaluation of coping strategies can guide individualized intervention planning. For example, adolescents who predominantly use avoidance, denial, self-blame, or disengagement may require structured psychological support focused on emotional regulation, problem-solving, cognitive restructuring, communication skills, and safety planning. Similarly, those with poor social support may benefit from family involvement, school liaison, and supportive psychotherapy.[6]

MATERIALS AND METHODS

This hospital-based cross-sectional observational study was conducted to evaluate various coping strategies in adolescents with depressive disorder. The study included 150 adolescent participants aged 13–18 years who attended the psychiatry outpatient department or were admitted for evaluation and management of depressive disorder during Jan 2025 to Jan 2026. Participants were selected after confirmation of depressive disorder by a qualified psychiatrist according to standard diagnostic criteria. Both male and female adolescents were included in the study.

Inclusion Criteria

Adolescents aged between 13 and 18 years diagnosed with depressive disorder were included in the study. Participants who were willing to take part in the study and whose parents or guardians provided written informed consent were enrolled. Adolescents who were able to understand and

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respond to the study questionnaires were also included.

Exclusion Criteria

Adolescents with severe intellectual disability, psychotic symptoms, bipolar affective disorder, substance dependence, chronic neurological illness, or severe medical illness interfering with assessment were excluded from the study. Participants who were unwilling to participate or whose parents or guardians did not provide consent were also excluded.

Methodology

After obtaining informed consent from parents or guardians and assent from the adolescents, detailed information was collected using a structured proforma. Socio-demographic variables such as age, gender, residence, education, type of family, socio-economic status, parental education, parental occupation, family history of psychiatric illness, and academic performance were recorded. Clinical variables including age at onset of depressive symptoms, severity of depression, duration of symptoms, sleep disturbance, appetite changes, irritability, suicidal ideation, previous psychiatric consultation, treatment history, and presence of psychosocial stressors were assessed.

Assessment of Depression

Depressive disorder was diagnosed through clinical interview by a psychiatrist based on standard diagnostic criteria. The severity of depression was assessed using a validated depression rating scale suitable for adolescents. Participants were categorized according to the severity of depressive symptoms as mild, moderate, or severe depression. Associated symptoms such as loss of interest, fatigue, poor concentration, guilt feelings, sleep disturbance, appetite disturbance, hopelessness, and suicidal thoughts were also documented.

The severity of depressive symptoms was assessed using the Beck Depression Inventory-II (BDI-II), a validated 21-item self-report rating scale suitable for adolescents aged 13 years and above. Each item is scored from 0 to 3, producing a total score ranging from 0 to 63, with higher scores indicating greater severity of depressive symptoms. Based on the BDI-II total score, participants were classified as having mild depression (14–19), moderate depression (20–28), or severe depression (29–63). Scores of 0–13 indicate minimal depressive symptoms and were not included in the severity-wise analysis.

Assessment of Coping Strategies

Coping strategies were assessed using a validated coping scale appropriate for adolescents. The coping domains assessed included problem-focused coping, emotion-focused coping, avoidance coping, social support seeking, positive reinterpretation, acceptance, denial, behavioral disengagement, self-distraction, religious coping, planning, venting, and substance-related coping if applicable. Each participant's coping pattern was evaluated and classified according to the dominant coping strategy used in response to depressive symptoms and stressful life situations.

For systematic assessment of coping, the Brief COPE Inventory was used. The Brief COPE is a 28-item self-report instrument comprising 14 coping subscales: active coping, planning, use of instrumental support, use of emotional support, positive reframing, acceptance, religion, humor, self-distraction, denial, venting, substance use, behavioral disengagement, and self-blame. Each subscale contains two items.

Each item was rated on a four-point Likert scale ranging from 1 ("I have not been doing this at all") to 4 ("I have been doing this a lot"). Thus, each original two-item Brief COPE subscale yielded a score ranging from 2 to 8, with a higher score indicating greater use of the corresponding coping strategy.

The conceptually related coping components were additionally combined into broader study-specific domains for statistical analysis. Problem-focused coping primarily represented active coping, planning, and instrumental support; emotion-focused coping represented emotional support and other emotion-regulation strategies; avoidance coping represented strategies such as self-distraction, denial, substance-related coping, and behavioral disengagement. Social support seeking, acceptance/positive reinterpretation, denial/behavioral disengagement, and venting/self-blame were also analyzed as composite coping domains according to the predefined scoring framework used in the study. Scores of the constituent items were summed to obtain the respective domain scores, and a higher domain score represented more frequent use of that coping pattern.

For broader interpretation, coping strategies such as active coping, planning, positive reframing, acceptance, and support seeking were considered predominantly adaptive strategies, whereas avoidance, denial, behavioral disengagement, self-blame, venting, and substance-related coping were considered predominantly maladaptive strategies. The predominant coping pattern for each participant was determined by comparing the relative use of adaptive and maladaptive coping strategies according to the predefined scoring framework.

Statistical Analysis

The collected data were entered into Microsoft Excel and analyzed using SPSS version 27.0. Descriptive statistics were used to summarize socio-demographic and clinical variables. Categorical variables were expressed as frequency and percentage, while continuous variables were expressed as mean and standard deviation. The chi-square test or Fisher's exact test was used to assess associations between categorical variables. Independent t-test or ANOVA was used for comparison of continuous variables where applicable. Correlation analysis was performed to assess the relationship between coping scores and

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depression severity. A p-value of less than 0.05 was considered statistically significant.

RESULTS

A total of 150 adolescents diagnosed with depressive disorder were enrolled in the study. Based on the severity of depression, 38 (25.33%) participants had mild depression, 72 (48.00%) had moderate depression, and 40 (26.67%) had severe depression. Table 1 presents the socio-demographic characteristics of the study participants according to the severity of depression. The majority of adolescents belonged to the 16–18 years age group (57.33%), while 42.67% were aged 13–15 years. Although moderate and severe depression were more frequently observed among older adolescents (62.50% each), the association between age group and depression severity was not statistically significant (p=0.090). Females constituted a higher proportion of the study population (57.33%) compared to males (42.67%); however, the distribution of depression severity did not differ significantly between genders (p=0.653). Urban residents accounted for 54.67% of participants, whereas 45.33% belonged to rural areas. Severe depression was relatively more common among rural adolescents (60.00%) compared with urban adolescents (40.00%), although this difference did not reach statistical significance (p=0.083). Similarly, adolescents from joint or extended families demonstrated a greater proportion of severe depression (60.00%) compared with those from nuclear families (40.00%), but the association remained statistically non-significant (p=0.069). Lower socio-economic status was more frequently observed among adolescents with severe depression (57.50%) than among those with mild depression (31.58%), showing a borderline association (p=0.052). Academic performance demonstrated a significant relationship with depression severity (p=0.018).

Table 2 summarizes the clinical characteristics of adolescents according to depression severity. More than half of the participants (51.33%) had depressive symptoms lasting for more than six months. Longer symptom duration was significantly associated with greater depression severity (p=0.001), with 70.00% of adolescents with severe depression reporting symptoms for more than six months compared to only 28.95% among those with mild depression. Sleep disturbance was present in 70.00% of the participants and became progressively more frequent with increasing severity of depression, affecting 80.00% of adolescents with severe depression (p=0.050). Appetite changes were reported by 62.67% of participants but were not significantly associated with depression severity (p=0.193). Irritability was observed in 64.67% of adolescents and showed a significant increase from mild (47.37%) to severe depression (77.50%) (p=0.018). Hopelessness emerged as one of the strongest clinical correlates of depression severity. Overall, 57.33% of participants reported hopelessness, with its prevalence increasing dramatically from 26.32% in mild depression to 87.50% in severe depression (p<0.001). Likewise, suicidal ideation was present in 35.33% of adolescents and was significantly more common in severe depression (60.00%) compared with mild depression (10.53%) (p<0.001). Psychosocial stressors were identified in 72.67% of participants and showed a significant association with increasing depression severity (p=0.004). Table 3 illustrates the distribution of dominant coping strategies among adolescents with varying severity of depression. A statistically significant difference in coping strategy distribution was observed across depression severity groups (p<0.001). Overall, avoidance coping was the most frequently adopted dominant strategy (22.67%), followed closely by problem-focused coping (21.33%) and social support seeking (20.00%). Problem-focused coping was predominantly observed among adolescents with mild depression, accounting for 44.74% of this group, but declined markedly with increasing severity, reaching only 7.50% among adolescents with severe depression. Similarly, social support seeking and emotion-focused/acceptance coping were relatively more common in adolescents with mild and moderate depression than in those with severe depression. In contrast, maladaptive coping strategies became increasingly prevalent with greater depression severity. Avoidance coping increased from 7.89% among adolescents with mild depression to 32.50% among those with severe depression. Denial and behavioral disengagement also increased substantially from 2.63% in mild depression to 22.50% in severe depression.

Table 4 compares the mean coping domain scores across different levels of depression severity. Significant differences were observed for most coping domains. Problem-focused coping scores showed a progressive decline with increasing depression severity, decreasing from 22.61 ± 4.18 in mild depression to 15.82 ± 5.11 in severe depression (p<0.001). Similarly, social support seeking scores declined significantly from 20.47 ± 4.85 in mild depression to 15.98 ± 5.20 in severe depression (p=0.002). Acceptance and positive reinterpretation scores also demonstrated a significant reduction with increasing severity (p<0.001). Conversely, maladaptive coping domains increased significantly with worsening depression. Avoidance coping scores rose from 12.76 ± 4.37 among adolescents with mild depression to 23.14 ± 5.76 among those with severe depression (p<0.001). Denial and behavioral disengagement scores nearly doubled across severity groups, increasing from 9.74 ± 3.96 to 18.26 ± 5.42 (p<0.001). Venting and self-blame scores also increased significantly from 10.81 ± 4.02 in mild depression to 19.05 ± 5.33 in severe depression (p<0.001). Emotion-focused coping scores showed only minor variation between groups

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and did not demonstrate a statistically significant difference (p=0.201).

Table 5 examines the association between adaptive and maladaptive coping patterns and selected socio-demographic and clinical variables. Although adaptive coping was somewhat more common among younger adolescents aged 13–15 years (68.75%) than among older adolescents (53.49%), the difference was not statistically significant (p=0.086). Similarly, no significant association was observed between coping pattern and gender (p=0.973). Significant associations were identified for several other variables. Adolescents residing in urban areas demonstrated higher use of adaptive coping (68.29%) than those living in rural areas (50.00%), while maladaptive coping was significantly more frequent among rural adolescents (50.00%) (p=0.035). Participants from nuclear families were significantly more likely to employ adaptive coping (71.60%) than those from joint or extended families (46.38%) (p=0.003). Good academic performance was also strongly associated with adaptive coping (78.43%) compared with average or poor academic performance (50.51%) (p=0.002). Psychosocial stressors demonstrated one of the strongest associations with coping style. Adolescents experiencing psychosocial stressors exhibited maladaptive coping in 50.46% of cases, whereas only 12.20% of adolescents without psychosocial stressors used maladaptive coping (p<0.001). Likewise, suicidal ideation showed a significant association with maladaptive coping, affecting 64.15% of adolescents reporting suicidal thoughts compared with 26.80% of those without suicidal ideation (p<0.001).

Table 6 presents the correlation between individual coping domains and depression severity scores. Significant negative correlations were observed between adaptive coping strategies and depression severity. Problem-focused coping demonstrated a moderate negative correlation ($r = -0.48$, $p<0.001$), indicating that adolescents who frequently used problem-solving approaches tended to have less severe depressive symptoms. Similarly, acceptance and positive reinterpretation ($r = -0.41$, $p<0.001$) and social support seeking ($r = -0.35$, $p<0.001$) were also significantly associated with lower depression severity. The strongest negative association was observed for the overall adaptive coping score ($r = -0.53$, $p<0.001$). In contrast, maladaptive coping strategies showed significant positive correlations with depression severity. Avoidance coping demonstrated the strongest positive relationship ($r = 0.57$, $p<0.001$), followed by denial and behavioral disengagement ($r = 0.52$, $p<0.001$) and venting/self-blame ($r = 0.45$, $p<0.001$). The total maladaptive coping score exhibited the highest overall positive correlation with depression severity ($r = 0.61$, $p<0.001$), indicating that greater reliance on maladaptive coping mechanisms is associated with more severe depressive symptoms. Emotion-focused coping did not show a statistically significant correlation with depression severity ($r = -0.12$, $p=0.142$), suggesting that this coping domain was relatively independent of depression severity in the present study.

Table 1: Socio-demographic characteristics according to severity of depression

Variable	Category	Overall n=150 n (%)	Mild n=38 n (%)	Moderate n=72 n (%)	Severe n=40 n (%)	p-value
Age group	13–15 years	64 (42.67%)	22 (57.89%)	27 (37.50%)	15 (37.50%)	0.090
	16–18 years	86 (57.33%)	16 (42.11%)	45 (62.50%)	25 (62.50%)	
Gender	Male	64 (42.67%)	18 (47.37%)	28 (38.89%)	18 (45.00%)	0.653
	Female	86 (57.33%)	20 (52.63%)	44 (61.11%)	22 (55.00%)	
Residence	Urban	82 (54.67%)	24 (63.16%)	42 (58.33%)	16 (40.00%)	0.083
	Rural	68 (45.33%)	14 (36.84%)	30 (41.67%)	24 (60.00%)	
Family type	Nuclear	81 (54.00%)	25 (65.79%)	40 (55.56%)	16 (40.00%)	0.069
	Joint/extended	69 (46.00%)	13 (34.21%)	32 (44.44%)	24 (60.00%)	
Socio-economic status	Upper/ lower-middle	87 (58.00%)	26 (68.42%)	44 (61.11%)	17 (42.50%)	0.052
	Lower	63 (42.00%)	12 (31.58%)	28 (38.89%)	23 (57.50%)	
Academic performance	Good	51 (34.00%)	18 (47.37%)	26 (36.11%)	7 (17.50%)	0.018
	Average/poor	99 (66.00%)	20 (52.63%)	46 (63.89%)	33 (82.50%)	

Table 2: Clinical characteristics according to severity of depression

Clinical variable	Category	Overall n=150 n (%)	Mild n=38 n (%)	Moderate n=72 n (%)	Severe n=40 n (%)	p-value
Duration of symptoms	≤6 months	73 (48.67%)	27 (71.05%)	34 (47.22%)	12 (30.00%)	0.001
	>6 months	77 (51.33%)	11 (28.95%)	38 (52.78%)	28 (70.00%)	
Sleep disturbance	Present	105 (70.00%)	21 (55.26%)	52 (72.22%)	32 (80.00%)	0.050
	Absent	45 (30.00%)	17 (44.74%)	20 (27.78%)	8 (20.00%)	
Appetite changes	Present	94 (62.67%)	20 (52.63%)	45 (62.50%)	29 (72.50%)	0.193
	Absent	56 (37.33%)	18 (47.37%)	27 (37.50%)	11 (27.50%)	
Irritability	Present	97 (64.67%)	18 (47.37%)	48 (66.67%)	31 (77.50%)	0.018
	Absent	53 (35.33%)	20 (52.63%)	24 (33.33%)	9 (22.50%)	
Hopelessness	Present	86 (57.33%)	10 (26.32%)	41 (56.94%)	35 (87.50%)	<0.001
	Absent	64 (42.67%)	28 (73.68%)	31 (43.06%)	5 (12.50%)	
Suicidal ideation	Present	53 (35.33%)	4 (10.53%)	25 (34.72%)	24 (60.00%)	<0.001
	Absent	97 (64.67%)	34 (89.47%)	47 (65.28%)	16 (40.00%)	
Psychosocial	Present	109 (72.67%)	20 (52.63%)	55 (76.39%)	34 (85.00%)	0.004

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stressors	Absent	41 (27.33%)	18 (47.37%)	17 (23.61%)	6 (15.00%)	
Family history of psychiatric illness	Present	45 (30.00%)	8 (21.05%)	21 (29.17%)	16 (40.00%)	0.185
	Absent	105 (70.00%)	30 (78.95%)	51 (70.83%)	24 (60.00%)	
Previous psychiatric treatment	Present	42 (28.00%)	6 (15.79%)	19 (26.39%)	17 (42.50%)	0.029
	Absent	108 (72.00%)	32 (84.21%)	53 (73.61%)	23 (57.50%)	

Table 3: Distribution of dominant coping strategies according to severity of depression

Dominant coping strategy	Overall n=150 n (%)	Mild n=38 n (%)	Moderate n=72 n (%)	Severe n=40 n (%)	p-value
Problem-focused coping	32 (21.33%)	17 (44.74%)	12 (16.67%)	3 (7.50%)	<0.001
Emotion-focused/acceptance	28 (18.67%)	8 (21.05%)	16 (22.22%)	4 (10.00%)	
Social support seeking	30 (20.00%)	9 (23.68%)	17 (23.61%)	4 (10.00%)	
Avoidance coping	34 (22.67%)	3 (7.89%)	18 (25.00%)	13 (32.50%)	
Denial/behavioral disengagement	16 (10.67%)	1 (2.63%)	6 (8.33%)	9 (22.50%)	
Venting/self-blame/substance-related coping	10 (6.67%)	0 (0.00%)	3 (4.17%)	7 (17.50%)	

Table 4: Comparison of coping domain scores according to severity of depression

Coping domain	Mild depression Mean ± SD	Moderate depression Mean ± SD	Severe depression Mean ± SD	p-value
Problem-focused coping	22.61 ± 4.18	18.94 ± 4.76	15.82 ± 5.11	<0.001
Emotion-focused coping	21.08 ± 4.52	22.36 ± 4.84	20.75 ± 5.26	0.201
Avoidance coping	12.76 ± 4.37	17.95 ± 5.28	23.14 ± 5.76	<0.001
Social support seeking	20.47 ± 4.85	18.31 ± 4.92	15.98 ± 5.20	0.002
Acceptance/positive reinterpretation	19.79 ± 4.14	17.58 ± 4.73	14.95 ± 5.01	<0.001
Denial/behavioral disengagement	9.74 ± 3.96	13.68 ± 4.61	18.26 ± 5.42	<0.001
Venting/self-blame	10.81 ± 4.02	14.33 ± 4.84	19.05 ± 5.33	<0.001

Table 5: Association of adaptive and maladaptive coping with selected factors

Variable	Category	Overall n=150 n (%)	Adaptive coping n (%)	Maladaptive coping n (%)	p-value
Age group	13–15 years	64 (42.67%)	44 (68.75%)	20 (31.25%)	0.086
	16–18 years	86 (57.33%)	46 (53.49%)	40 (46.51%)	
Gender	Male	64 (42.67%)	39 (60.94%)	25 (39.06%)	0.973
	Female	86 (57.33%)	51 (59.30%)	35 (40.70%)	
Residence	Urban	82 (54.67%)	56 (68.29%)	26 (31.71%)	0.035
	Rural	68 (45.33%)	34 (50.00%)	34 (50.00%)	
Family type	Nuclear	81 (54.00%)	58 (71.60%)	23 (28.40%)	0.003
	Joint/extended	69 (46.00%)	32 (46.38%)	37 (53.62%)	
Academic performance	Good	51 (34.00%)	40 (78.43%)	11 (21.57%)	0.002
	Average/poor	99 (66.00%)	50 (50.51%)	49 (49.49%)	
Psychosocial stressors	Present	109 (72.67%)	54 (49.54%)	55 (50.46%)	<0.001
	Absent	41 (27.33%)	36 (87.80%)	5 (12.20%)	
Suicidal ideation	Present	53 (35.33%)	19 (35.85%)	34 (64.15%)	<0.001
	Absent	97 (64.67%)	71 (73.20%)	26 (26.80%)	

Table 6: Correlation between coping domains and depression severity score

Coping domain	Correlation coefficient (r)	p-value
Problem-focused coping	-0.48	<0.001
Social support seeking	-0.35	<0.001
Acceptance/positive reinterpretation	-0.41	<0.001
Emotion-focused coping	-0.12	0.142
Avoidance coping	0.57	<0.001
Denial/behavioral disengagement	0.52	<0.001
Venting/self-blame	0.45	<0.001
Total adaptive coping score	-0.53	<0.001
Total maladaptive coping score	0.61	<0.001

Note: The correlations in Table 6 were calculated against the continuous BDI-II total score (0–63) rather than separately against mild, moderate, and severe depression categories. Mild, moderate, and severe depression are categorical levels derived from the same BDI-II score; therefore, separate correlations with these categories are not statistically appropriate. Differences in coping scores across the mild, moderate, and severe groups are already assessed in Table 4 using ANOVA.

DISCUSSION

In the present study, moderate depression was the most common severity category, affecting 72 (48.00%) adolescents, followed by severe depression in 40 (26.67%) and mild depression in 38 (25.33%). This pattern differs from the school-based findings of Singh et al. (2017), who studied 542 school-going adolescents in Chandigarh and reported depressive disorders in 40.00%, with 29.70% mild depression, 15.50% moderate depression, 3.70% moderately severe depression, and 1.10% severe depression. The higher burden of moderate and severe depression in the present study may be due to its tertiary care hospital setting, where adolescents usually present after symptoms

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become clinically significant, while Singh et al. assessed a general school population.[7] In socio-demographic findings, older adolescents aged 16–18 years formed the majority (57.33%) in the present study, and both moderate and severe depression were more common in this age group (62.50% each), although age was not statistically significant (p=0.090). Females were more frequent (57.33%) than males (42.67%), but gender was also not significantly associated with severity (p=0.653). Academic performance showed a significant association with depression severity (p=0.018), as average/poor performance increased from 52.63% in mild depression to 82.50% in severe depression. In comparison, Nirudya et al. (2023) assessed 473 school-going adolescents, found depression in 177 (37.00%), with 31.00% mild, 5.00% moderate, and 1.00% severe depression, and reported no overall significant association with scholastic performance, although severe depression showed negative academic impact. The stronger association in the present study may reflect higher clinical severity and functional impairment among hospital-attending adolescents.[8] Clinical symptoms in the present study showed a clear increase with depression severity. Duration of symptoms for more than six months was present in 70.00% of severe cases compared with 28.95% of mild cases (p=0.001). Sleep disturbance was present in 105 (70.00%) participants and increased from 55.26% in mild depression to 80.00% in severe depression (p=0.050). Suicidal ideation was present in 53 (35.33%) adolescents and was markedly higher in severe depression (60.00%) than mild depression (10.53%, p<0.001). Similarly, Teresi et al. (2025) studied 311 depressed and suicidal adolescents aged 13–19 years attending an intensive outpatient program and found that worsening sleep predicted next-week suicidal ideation even after considering depression severity. This supports the present finding that sleep disturbance and suicidality are clinically important markers of severe adolescent depression.[9] Hopelessness was one of the strongest clinical findings in the present study. It was present in 86 (57.33%) adolescents and increased sharply from 26.32% in mild depression to 87.50% in severe depression (p<0.001). Suicidal ideation also increased from 10.53% in mild depression to 60.00% in severe depression (p<0.001). This finding is comparable with Gómez-Tabares et al. (2025), who studied 1,645 young people and reported that depression, hopelessness, and impulsivity were significantly related to suicidal risk; their regression model explained 33.00–49.00% of the variance in suicidal risk and 16.00% of suicide attempts. Thus, the present study supports the concept that hopelessness is not merely a depressive symptom but an important clinical warning sign for suicidal risk among adolescents.[10] The distribution of coping strategies in the present study showed a significant difference across severity groups (p<0.001). Problem-focused coping was commonest in mild depression (44.74%) but decreased to 7.50% in severe depression. In contrast, avoidance coping increased from 7.89% in mild depression to 32.50% in severe depression, while denial/behavioral disengagement increased from 2.63% to 22.50%. Herres et al. (2015) studied 982 adolescents with a mean age of 16.04 years, including 51.00% girls, and found that adolescent coping profiles significantly differentiated depression and anxiety symptoms. Their findings are similar to the present study, where adolescents with greater depression severity showed less active coping and more avoidant or disengaged coping.[11] Mean coping domain scores also supported this pattern. In the present study, problem-focused coping decreased from 22.61 ± 4.18 in mild depression to 15.82 ± 5.11 in severe depression (p<0.001), while avoidance coping increased from 12.76 ± 4.37 to 23.14 ± 5.76 (p<0.001). Denial/behavioral disengagement increased from 9.74 ± 3.96 to 18.26 ± 5.42 (p<0.001), and venting/self-blame increased from 10.81 ± 4.02 to 19.05 ± 5.33 (p<0.001). Horwitz et al. (2011) reported that behavioral disengagement and self-blame were predictive of higher depression in adolescents, while depression and emotional support were associated with suicidal ideation. This agrees with the present finding that maladaptive coping domains such as avoidance, denial, disengagement, venting, and self-blame were highest in severe depression.[12] The present study also showed that maladaptive coping was significantly associated with rural residence (50.00%, p=0.035), joint/extended family type (53.62%, p=0.003), average/poor academic performance (49.49%, p=0.002), psychosocial stressors (50.46%, p<0.001), and suicidal ideation (64.15%, p<0.001). She et al. (2022) studied 3,136 Chinese secondary school students and identified three stress-coping profiles: mild profile 47.20%, moderate profile 35.80%, and severe profile 17.00%. They reported suicidal ideation in 29.80% and sleep disturbance in 55.40%, and adolescents in severe and moderate profiles had significantly higher mental and behavioral health problems, with adjusted odds ratios ranging from 2.08 to 15.06. These findings are comparable with the present study, where psychosocial stressors and suicidal ideation were strongly linked with maladaptive coping.[13] Correlation analysis in the present study demonstrated that adaptive coping was negatively associated with depression severity, including problem-focused coping (r=−0.48, p<0.001), social support seeking (r=−0.35, p<0.001), acceptance/positive reinterpretation (r=−0.41, p<0.001), and total adaptive coping score (r=−0.53, p<0.001). In contrast, maladaptive coping showed positive correlations with depression severity, particularly avoidance coping (r=0.57, p<0.001), denial/behavioral disengagement (r=0.52, p<0.001), venting/self-blame (r=0.45, p<0.001), and total maladaptive coping score (r=0.61, p<0.001). de Jonge-Heesen et al. (2021) followed 1,341

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secondary school students over six waves across 2.5 years and found that when adolescents had elevated depressive symptoms, they used fewer adaptive techniques to target stress. This closely supports the present study, where increasing depression severity was associated with reduced adaptive coping and greater maladaptive coping.[14]

CONCLUSION

The present study showed that coping strategies are closely associated with the severity of depressive disorder among adolescents. Adaptive coping strategies such as problem-focused coping, acceptance, positive reinterpretation, and social support seeking were more common in mild depression, whereas maladaptive strategies such as avoidance, denial, behavioral disengagement, venting, and self-blame increased with severe depression. Poor academic performance, psychosocial stressors, rural residence, and suicidal ideation were significantly associated with maladaptive coping. Early identification of coping patterns may help in planning appropriate psychological interventions and reducing the severity and complications of adolescent depression.

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