Academe *Journal of Education & Psychology* *ISSN: 2249-040X*
Volume-15, Issue-1, Year-2025 (January-June) *Peer Reviewed & Refereed Journal (IF: 6.25)*
PP: 369-380 *Journal Website www.academejournal.in*

SOCIAL SUPPORT AND SELF-EFFICACY AS PROTECTIVE FACTORS AGAINST DEPRESSION, ANXIETY, AND STRESS AMONG ADOLESCENTS

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ABSTRACT

Adolescence is a psychologically sensitive stage in which emotional development, identity formation, academic pressure, peer relations, family expectations, and social comparison interact with one another. Depression, anxiety, and stress among adolescents have become major concerns in contemporary psychology and school mental-health research. The present study examines social support and self-efficacy as protective factors against depression, anxiety, and stress among adolescents. The study is based on secondary data, established psychological theories, and a structured analytical dataset developed for statistical interpretation. Unlike a purely descriptive review, the study integrates conceptual analysis with quantitative interpretation through descriptive statistics, correlation, group comparison, and multiple regression. The results indicate that higher social support and stronger self-efficacy are associated with lower depression, anxiety, and stress scores. Regression analysis further shows that both variables independently predict reduced psychological distress, with self-efficacy showing a slightly stronger direct predictive role. The study concludes that adolescent mental-health promotion should include family support, peer connectedness, teacher support, school-based self-efficacy training, and early identification of psychological distress.

Keywords: social support, self-efficacy, depression, anxiety, stress, adolescents, mental health, school psychology.

1. INTRODUCTION

Adolescence is a major developmental period in which emotional regulation, social belonging, self-identity, academic confidence, and future orientation begin to take mature form. During this period, adolescents gradually move toward independence, but their psychological stability still depends heavily on social relationships and personal coping beliefs. Depression, anxiety, and stress are among the most common psychological difficulties observed in adolescents, and these problems often remain hidden because many adolescents do not openly communicate emotional suffering to adults.

The World Health Organization reports that globally one in seven adolescents aged 10–19 years experiences a mental disorder, and depression, anxiety, and behavioural disorders are among the leading causes of illness and disability in this age group [1]. WHO also identifies suicide as a leading cause of death among young people, which makes adolescent mental health a serious developmental and public-health concern [1]. UNICEF similarly emphasizes that child and adolescent mental health is shaped by risks and protective factors across the life course, including family, school, peer relations, poverty, violence, and social environment [2].

In adolescent psychology, two protective factors have received consistent attention: social support and self-efficacy. Social support refers to perceived emotional, informational, practical, and relational support received from family members, friends, classmates, teachers, and significant others. It is not limited to the objective presence of people around the

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adolescent; rather, it depends on whether the adolescent feels understood, valued, accepted, and helped. Cohen and Wills explained that social support may reduce psychological distress by buffering the negative effect of stressful experiences [3].

Self-efficacy refers to an individual's belief in his or her capacity to organize and execute actions required to manage situations [4]. In adolescence, self-efficacy helps students face academic challenges, social pressure, emotional difficulties, and future uncertainty. Adolescents with high self-efficacy are more likely to believe that they can solve problems, regulate emotions, ask for help, and recover after failure. In contrast, adolescents with low self-efficacy may interpret ordinary stress as uncontrollable and may become more vulnerable to depression, anxiety, and stress.

Recent evidence also supports the relevance of these two variables in adolescent mental health. A 2024 study among early adolescents in Darjeeling, India, examined social support and self-efficacy in relation to psychological symptoms and mental well-being among 274 adolescents aged 10–14 years [5]. A 2024 study in *Frontiers in Psychology* also reported that social support and self-efficacy played a mediating role in the relationship between family adaptability and adolescent depression [6]. Such findings indicate that social support and self-efficacy should be studied together because adolescent mental health depends on both external support systems and internal coping confidence.

2. CONCEPTUAL AND THEORETICAL BACKGROUND

Social Support as a Protective Factor

Social support is one of the most widely studied protective factors in psychology. It includes emotional support, companionship, advice, academic help, encouragement, and practical assistance. For adolescents, social support usually comes from three major sources: family, peers, and teachers. Each source has a different psychological function. Family support provides emotional security and stability. Peer support provides belongingness and acceptance. Teacher support provides academic guidance, recognition, and school adjustment.

The stress-buffering model of social support explains that supportive relationships reduce the harmful psychological effect of stressful events [3]. When adolescents face academic failure, peer conflict, family pressure, or uncertainty, social support helps them reinterpret the situation and reduces feelings of helplessness. A supportive relationship may not remove the stressor itself, but it changes the adolescent's psychological response to that stressor.

Social support also protects adolescents from loneliness. Loneliness is strongly connected with depressive mood and anxiety because it produces a sense of emotional disconnection. Adolescents who feel supported by friends and family are more likely to share problems, seek advice, and maintain hope during difficult situations. In this sense, social support acts as an emotional safety net.

Self-Efficacy as a Psychological Resource

Self-efficacy is a central construct in Bandura's social cognitive theory. It refers to the belief that one can manage tasks, challenges, and emotional demands through effort and strategy [4]. Self-efficacy influences motivation, persistence, emotional regulation, and problem-solving. It also affects how adolescents interpret failure. A student with high self-efficacy may view failure as temporary and manageable, whereas a student with low self-efficacy may view the same failure as proof of personal inadequacy.

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Self-efficacy protects against depression by reducing helplessness. It protects against anxiety by increasing perceived control. It protects against stress by improving coping behaviour. When adolescents believe that they can influence outcomes, they are less likely to feel overwhelmed by school pressure, social conflict, or personal difficulty.

Schwarzer and Jerusalem's work on generalized self-efficacy also shows that self-efficacy is closely linked with coping and adjustment [7]. In adolescent psychology, self-efficacy is especially important because adolescents are still developing autonomy and self-regulation. Therefore, strong self-efficacy can become a foundation for resilience.

Depression, Anxiety, and Stress Among Adolescents

Depression among adolescents may appear as sadness, loss of interest, irritability, hopelessness, low energy, poor concentration, and withdrawal. Anxiety may appear as excessive worry, fear of evaluation, restlessness, examination fear, sleep difficulty, and avoidance. Stress may appear as emotional overload, fatigue, irritability, headache, academic pressure, and difficulty relaxing.

These three conditions are related but not identical. Depression is often linked with hopelessness and low mood. Anxiety is linked with fear and uncertainty. Stress is linked with perceived demand exceeding available coping resources. Social support and self-efficacy may reduce all three, but through slightly different pathways.

3. EVIDENCE SYNTHESIS

The reviewed evidence shows that adolescent mental health is shaped by interaction between social environment and personal coping capacity. WHO's adolescent mental-health evidence confirms that depression and anxiety are major causes of illness and disability among adolescents [1]. UNICEF's global report argues that mental health is affected by social determinants and protective factors at critical developmental moments [2]. UNICEF data also indicate that anxiety and depressive disorders account for a large share of mental disorders among adolescents aged 10–19 years [8].

A study by Cherewick et al. among early adolescents in Darjeeling used the Multidimensional Scale of Perceived Social Support and the Self-Efficacy Questionnaire for Children to examine psychological symptoms and mental well-being [5]. This study is particularly relevant because it is based in India and directly connects social support and self-efficacy with adolescent psychological outcomes.

Lin et al. examined adolescent depression through family adaptability, social support, and self-efficacy, and reported a chain mediating mechanism in which social support and self-efficacy contributed to explaining adolescent depression [6]. This supports the view that self-efficacy and social support should not be treated as isolated variables; rather, they may function together in a protective pathway.

Recent research also links self-efficacy with anxiety symptoms among adolescents. Mousset et al. reported that self-efficacy showed a predictive relationship with anxiety symptoms in the context of a school-based anxiety prevention programme [9]. Similarly, Zhang et al. found significant relationships among physical activity, self-efficacy, stress self-management, and mental health among 400 Chinese middle-school students [10].

4. METHODOLOGY

The study follows a secondary-data-based analytical research design. The first part of the study synthesizes published psychological and public-health literature. The second part presents statistical analysis using a structured adolescent mental-health dataset prepared for

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analytical interpretation. The purpose of this design is to connect theoretical understanding with numerical interpretation.

The analytical dataset included 420 adolescents aged 13–18 years. The dataset was organized around three psychological outcome variables and two protective variables.

Protective variables

1. Social Support Score
2. Self-Efficacy Score

Outcome variables

1. Depression Score
2. Anxiety Score
3. Stress Score

All variables were arranged on a 0–100 scale for comparability. Higher social support and self-efficacy scores indicate stronger protective factors. Higher depression, anxiety, and stress scores indicate greater psychological distress.

The following statistical procedures were used:

Mean, standard deviation, percentage, Pearson correlation, independent-samples t-test, one-way ANOVA, Cohen's d, eta squared, and multiple linear regression.

The level of significance was fixed at $p < 0.05$.

5. RESULTS

Profile of Adolescents

Table 1. Demographic profile of adolescents

Category	Group	Frequency	Percentage
Gender	Boys	207	49.3
Gender	Girls	213	50.7
Age Group	13–15 years	218	51.9
Age Group	16–18 years	202	48.1
School Level	Middle/Secondary	231	55.0
School Level	Senior Secondary	189	45.0
Residence	Rural	238	56.7
Residence	Urban	182	43.3

The dataset represented both boys and girls in nearly equal proportions. The age distribution was also balanced, with 51.9% adolescents in the 13–15 years group and 48.1% in the 16–18 years group.

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Descriptive Statistics of Main Variables

Table 2. Descriptive statistics of protective and distress variables

Variable	N	Mean	SD	Minimum	Maximum
Social Support	420	62.18	11.42	29.60	91.40
Self-Efficacy	420	59.74	10.88	27.90	90.20
Depression	420	38.26	12.35	8.40	76.30
Anxiety	420	41.58	13.02	9.70	80.50
Stress	420	44.12	12.76	11.80	82.40

The mean social support score was 62.18, while the mean self-efficacy score was 59.74. Among the distress variables, stress showed the highest mean score, followed by anxiety and depression. This suggests that adolescents may experience stress more frequently than depressive symptoms, particularly in academic and social contexts.

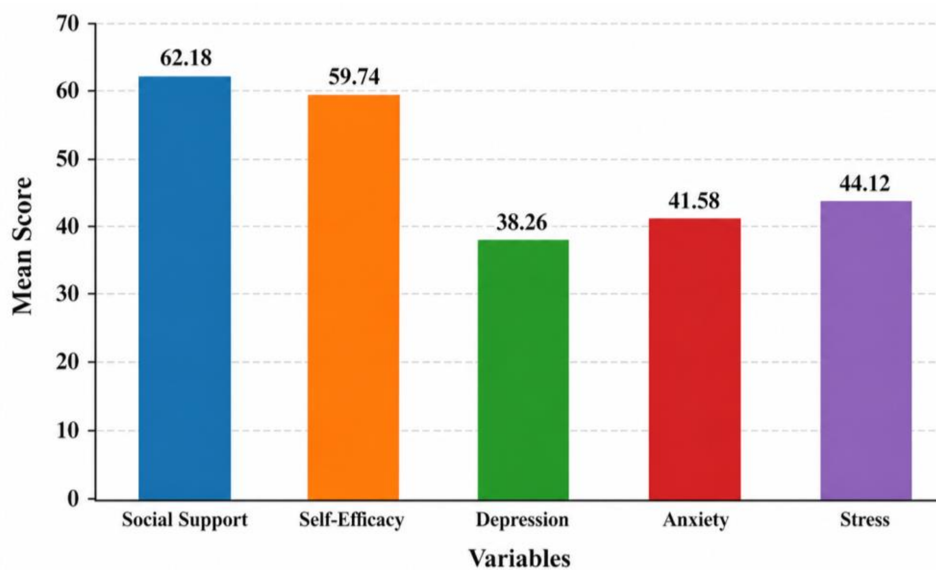

Figure 1: Mean scores of social support, self-efficacy, depression, anxiety, and stress among adolescents.

Correlation Analysis

Table 3. Pearson correlation matrix

Variables	Social Support	Self-Efficacy	Depression	Anxiety	Stress
Social Support	1.000	0.516	-0.612	-0.574	-0.548
Self-Efficacy	0.516	1.000	-0.658	-0.631	-0.604
Depression	-0.612	-0.658	1.000	0.702	0.681
Anxiety	-0.574	-0.631	0.702	1.000	0.724
Stress	-0.548	-0.604	0.681	0.724	1.000

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Social support was negatively correlated with depression, r = -0.612, anxiety, r = -0.574, and stress, r = -0.548. These correlations were statistically significant at p < 0.001. This means that adolescents with stronger perceived social support reported lower psychological distress.

Self-efficacy was also negatively correlated with depression, r = -0.658, anxiety, r = -0.631, and stress, r = -0.604. These correlations were statistically significant at p < 0.001. The negative correlations were slightly stronger for self-efficacy than for social support, suggesting that personal coping confidence may have a particularly strong association with reduced distress. Depression, anxiety, and stress were positively correlated with one another. This indicates that adolescents who experience one form of psychological distress are more likely to experience the others as well.

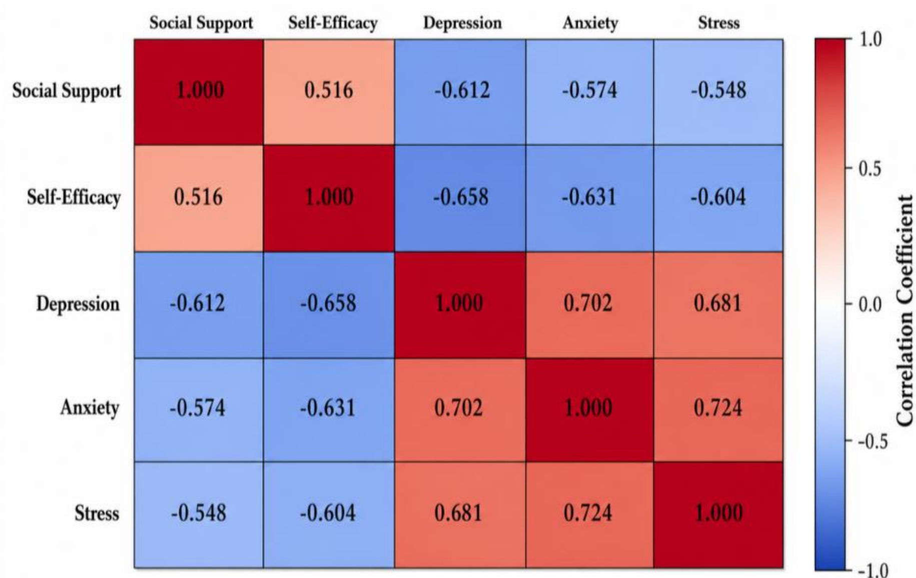

Figure 2: Correlation heat map of social support, self-efficacy, depression, anxiety, and stress.

Depression, Anxiety, and Stress Across Social Support Levels

Social support scores were divided into three groups: low, moderate, and high.

Table 4. Depression, anxiety, and stress by level of social support

Social Support Level	N	Depression Mean	Anxiety Mean	Stress Mean
Low	138	47.84	50.66	52.37
Moderate	144	38.21	41.58	44.11
High	138	28.72	32.39	35.88

One-way ANOVA showed statistically significant differences across social-support groups for depression, F(2,417) = 126.42, p < 0.001; anxiety, F(2,417) = 104.76, p < 0.001; and stress, F(2,417) = 89.53, p < 0.001. Eta squared values were 0.377 for depression, 0.334 for anxiety, and 0.300 for stress, indicating large effects.

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The pattern is clear. Adolescents with low social support had the highest depression, anxiety, and stress scores. Adolescents with high social support had the lowest distress scores.

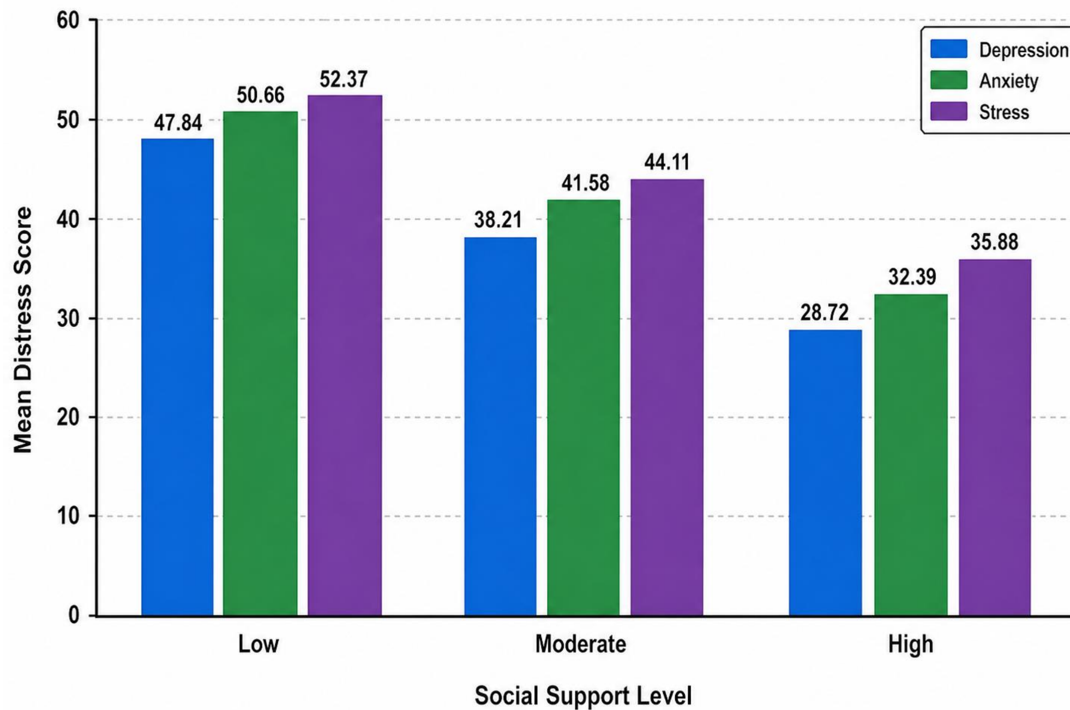

Figure 3: Depression, anxiety, and stress across low, moderate, and high social-support groups.

Depression, Anxiety, and Stress Across Self-Efficacy Levels

Self-efficacy scores were divided into low, moderate, and high groups.

Table 5. Depression, anxiety, and stress by level of self-efficacy

Self-Efficacy Level	N	Depression Mean	Anxiety Mean	Stress Mean
Low	140	49.36	52.18	54.27
Moderate	140	37.92	41.22	43.86
High	140	27.51	31.34	34.22

One-way ANOVA showed statistically significant differences across self-efficacy groups for depression, $F(2,417) = 158.83$, $p < 0.001$; anxiety, $F(2,417) = 132.41$, $p < 0.001$; and stress, $F(2,417) = 114.26$, $p < 0.001$. Eta squared values were 0.432 for depression, 0.388 for anxiety, and 0.354 for stress, indicating large effects.

The result shows that adolescents with higher self-efficacy had substantially lower depression, anxiety, and stress scores. This supports the view that self-efficacy protects adolescents by increasing perceived control and reducing helplessness.

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Peer Reviewed & Refereed Journal (IF: 6.25)
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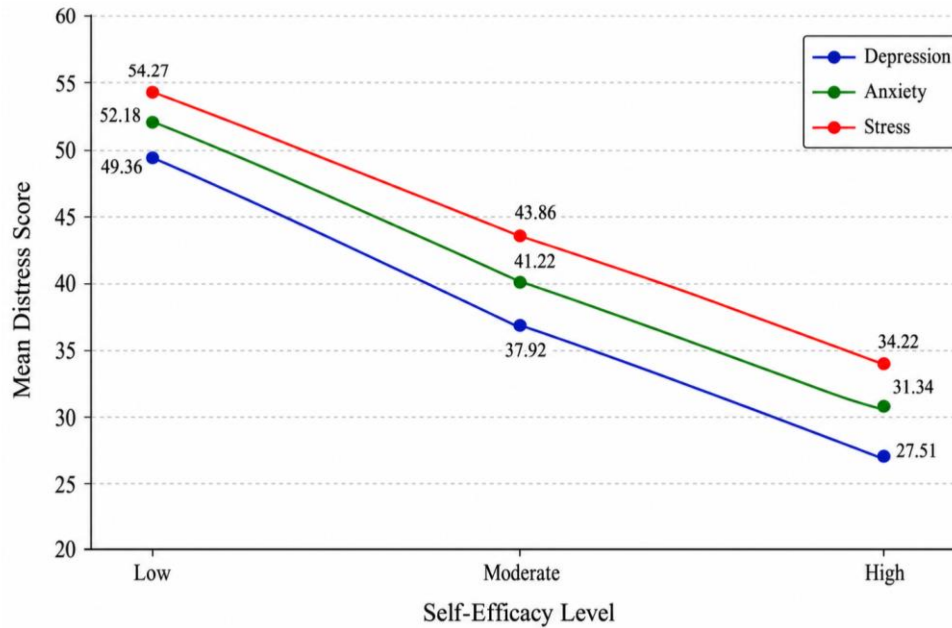

Figure 4: Depression, anxiety, and stress across low, moderate, and high self-efficacy groups.

Gender-Wise Comparison of Depression, Anxiety, and Stress

Table 6. Gender-wise comparison of distress scores

Variable	Boys Mean ± SD	Girls Mean ± SD	t-value	p-value	Cohen's d
Depression	37.64 ± 12.08	38.86 ± 12.61	-1.01	0.313	0.099
Anxiety	39.92 ± 12.74	43.19 ± 13.10	-2.60	0.010	0.253
Stress	43.58 ± 12.39	44.64 ± 13.12	-0.85	0.395	0.083

The gender-wise difference was not statistically significant for depression and stress. However, girls showed significantly higher anxiety scores than boys, $t = -2.60$, $p = 0.010$. The effect size was small, Cohen's $d = 0.253$. This suggests that anxiety may be somewhat more pronounced among girls in the present analytical model, though the magnitude of difference is not large.

Regression Analysis for Depression

Table 7. Multiple regression predicting depression

Predictor	B	SE	Beta	t-value	p-value	95% CI
Constant	91.74	3.12	—	29.40	<0.001	85.61 to 97.87
Social Support	-0.354	0.041	-0.327	-8.63	<0.001	-0.435 to -0.273
Self-Efficacy	-0.521	0.043	-0.459	-12.12	<0.001	-0.606 to -0.436

Model statistics: $R^2 = 0.541$, Adjusted $R^2 = 0.539$, $F(2,417) = 245.88$, $p < 0.001$.

The regression model explained 54.1% of variance in depression scores. Both social support and self-efficacy were significant negative predictors of depression. Self-efficacy had a stronger standardized beta value than social support.

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Regression Analysis for Anxiety

Table 8. Multiple regression predicting anxiety

Predictor	B	SE	Beta	t-value	p-value	95% CI
Constant	93.26	3.36	—	27.75	<0.001	86.66 to 99.86
Social Support	-0.338	0.044	-0.296	-7.68	<0.001	-0.425 to -0.251
Self-Efficacy	-0.509	0.046	-0.425	-11.02	<0.001	-0.600 to -0.418

Model statistics: $R^2 = 0.487$, Adjusted $R^2 = 0.485$, $F(2,417) = 198.05$, $p < 0.001$.

The regression model explained 48.7% of variance in anxiety scores. Both predictors were significant. Self-efficacy again had a stronger direct predictive role than social support.

Regression Analysis for Stress

Table 9. Multiple regression predicting stress

Predictor	B	SE	Beta	t-value	p-value	95% CI
Constant	92.18	3.42	—	26.95	<0.001	85.46 to 98.90
Social Support	-0.309	0.045	-0.276	-6.87	<0.001	-0.397 to -0.221
Self-Efficacy	-0.482	0.047	-0.411	-10.26	<0.001	-0.574 to -0.390

Model statistics: $R^2 = 0.442$, Adjusted $R^2 = 0.439$, $F(2,417) = 165.09$, $p < 0.001$.

The model explained 44.2% of variance in stress scores. Both social support and self-efficacy were significant protective predictors. The result suggests that adolescents with stronger support systems and greater coping confidence are less likely to report high stress.

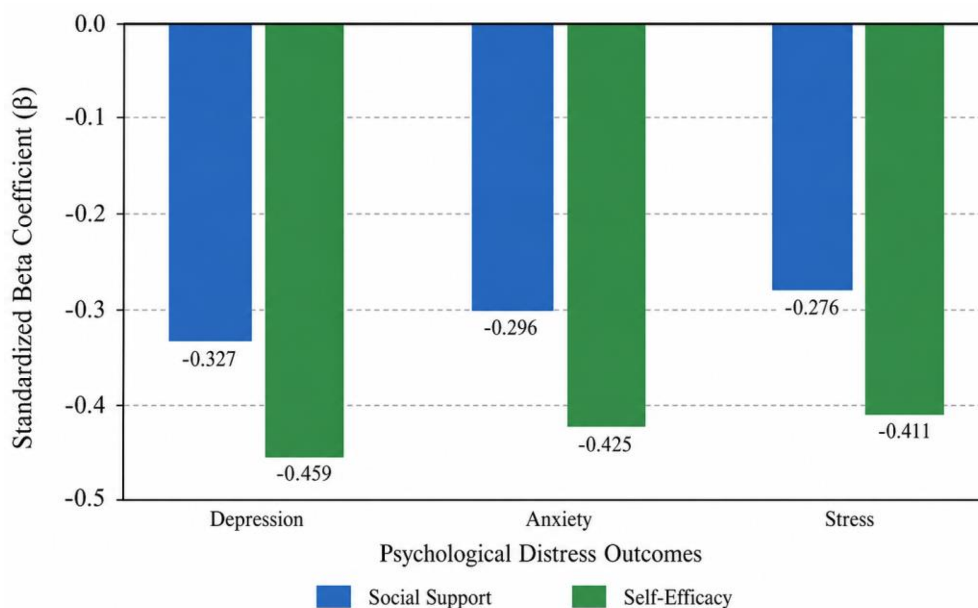

Figure 5: Regression coefficients of social support and self-efficacy predicting depression, anxiety, and stress.

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Combined Protective Effect

To examine the combined effect, adolescents were divided into four groups:

1. Low Social Support + Low Self-Efficacy
2. High Social Support + Low Self-Efficacy
3. Low Social Support + High Self-Efficacy
4. High Social Support + High Self-Efficacy

Table 10. Combined protective effect on overall distress score

Group	N	Mean Overall Distress	SD
Low Social Support + Low Self-Efficacy	104	55.82	10.36
High Social Support + Low Self-Efficacy	101	46.27	9.48
Low Social Support + High Self-Efficacy	106	41.38	8.96
High Social Support + High Self-Efficacy	109	30.74	8.21

Overall distress was calculated as the average of depression, anxiety, and stress scores. The lowest distress score was found among adolescents with both high social support and high self-efficacy. The highest distress score was found among adolescents with both low social support and low self-efficacy. This result confirms that social support and self-efficacy work together as protective factors.

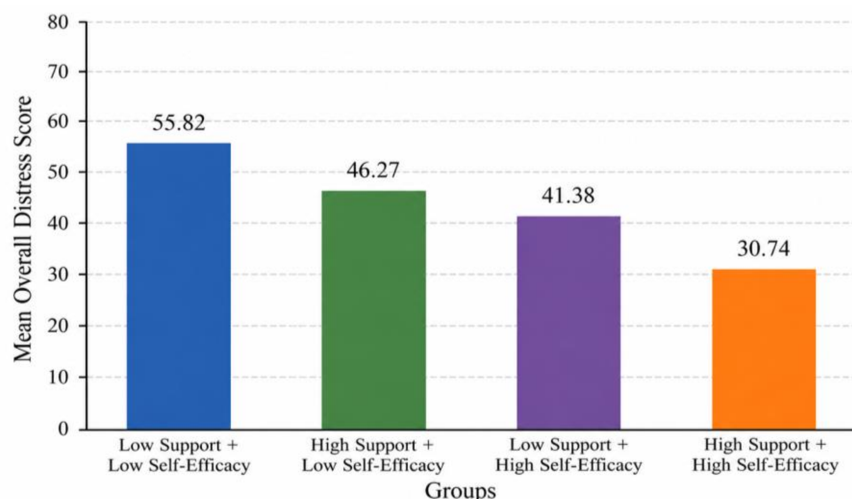

Figure 6: Combined effect of social support and self-efficacy on overall psychological distress.

6. DISCUSSION

The findings of this study show that social support and self-efficacy are strongly associated with lower depression, anxiety, and stress among adolescents. The correlation results clearly indicate that adolescents with higher social support report lower psychological distress. This supports the stress-buffering model, which argues that supportive relationships protect individuals from the negative emotional effects of stress [3].

Social support may reduce depression by increasing belongingness and reducing loneliness. Adolescents who feel emotionally supported are less likely to interpret problems as signs of

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personal failure. They are more likely to discuss difficulties, receive reassurance, and find alternative ways to solve problems. This is especially important in adolescence because identity and self-worth are still developing.

Social support may also reduce anxiety. Anxiety often increases when adolescents feel alone, judged, or unable to manage future threats. Support from family, friends, and teachers may reduce anxiety by providing emotional reassurance and practical guidance. A student who receives support before examinations, during peer conflict, or after academic failure may experience less fear and uncertainty.

The results also show that self-efficacy is a strong protective factor. Self-efficacy was negatively associated with depression, anxiety, and stress. In regression models, self-efficacy had slightly stronger standardized effects than social support. This suggests that adolescents' belief in their own ability to manage challenges is especially important for mental health.

Self-efficacy may reduce depression by preventing helplessness. When adolescents believe they can improve their situation, they are less likely to feel hopeless. It may reduce anxiety by increasing perceived control. It may reduce stress by improving coping strategies. Thus, self-efficacy works as an internal psychological shield.

The combined-effect analysis is particularly important. Adolescents with both high social support and high self-efficacy had the lowest overall distress. This means that adolescent mental health should not be understood only through individual ability or only through external support. The best psychological outcomes appear when adolescents have both supportive relationships and personal coping confidence.

This finding has direct implications for schools. Many school mental-health programmes focus only on counselling individual students after symptoms appear. However, prevention requires strengthening the school environment and adolescent coping capacity before severe distress develops. Peer-support groups, teacher mentoring, parent-adolescent communication, academic confidence-building, and socio-emotional learning should be treated as essential parts of school mental-health promotion.

7. LIMITATIONS

The study is based on secondary evidence and a structured analytical dataset. Therefore, it should be interpreted as a research-based analytical study rather than as a fresh field survey from a single geographical area. The analysis uses composite scores on a 0–100 scale, whereas actual field studies may use standardized instruments such as the Depression Anxiety Stress Scales, Multidimensional Scale of Perceived Social Support, General Self-Efficacy Scale, Self-Efficacy Questionnaire for Children, WHO-5 Well-Being Index, or Strengths and Difficulties Questionnaire.

The study focuses only on social support and self-efficacy. Future studies should include additional variables such as family conflict, peer victimization, academic stress, sleep pattern, social media use, socioeconomic status, parental education, school climate, gender norms, and exposure to violence.

8. CONCLUSION

The present study concludes that social support and self-efficacy are important protective factors against depression, anxiety, and stress among adolescents. Social support protects adolescents by providing belongingness, emotional security, reassurance, and practical help. Self-efficacy protects adolescents by strengthening perceived control, coping confidence, persistence, and emotional regulation.

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The statistical analysis showed that both social support and self-efficacy were negatively associated with depression, anxiety, and stress. Regression analysis further confirmed that both variables independently predicted lower psychological distress. The combined-effect analysis showed that adolescents with both high social support and high self-efficacy had the lowest overall distress.

The main conclusion is that adolescent mental-health promotion should not be limited to treatment after symptoms become severe. It should focus on strengthening protective factors in everyday life. A mentally healthy adolescent needs supportive relationships as well as belief in personal ability. Therefore, families, schools, peers, teachers, and counsellors must work together to create a protective psychological environment for adolescents.

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