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Effects of Parenting Styles on Depressive Symptoms and Coping Mechanisms among Late Adolescents in Manila

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Abstract

This study determined the effects of parenting styles on the depressive symptoms and coping mechanisms of 100 late adolescents aged 18 to 22 residing in Manila. Utilizing a descriptive-correlational quantitative research design, data were collected through a structured self-administered questionnaire assessing perceived parenting styles, self-reported depressive symptoms across physical, emotional, intellectual, spiritual, and social dimensions, and coping mechanisms. Results showed that adolescents experienced mixed parenting behaviors rather than a single dominant style, with physical and emotional depressive symptoms being most prevalent, and emotion-focused and problem-focused coping mechanisms being primarily utilized. Multivariate multiple regression analysis revealed that permissive and uninvolved parenting styles have significant effects on both depressive symptoms and coping mechanisms. Specifically, permissive parenting positively affected social support-seeking coping but inversely affected emotion-focused coping, whereas uninvolved parenting showed significant adverse effects by positively influencing physical, emotional, intellectual, and spiritual depressive symptoms while decreasing social support-seeking behavior. Based on these findings, the study proposes a Healthy Parent-Adolescent Relationship Program featuring educational seminars and counseling initiatives to foster supportive family environments and promote adolescent emotional well-being.

Chapter 1
THE PROBLEM AND ITS SETTING

This chapter presents the background of the study, theoretical framework statement of the problem, conceptual framework, significance of the study, hypotheses of the study, and scope and delimitation.

Introduction

Nowadays, mental health has become an increasing concern among adolescents, making it a significant topic of interest in society. This study focused on late adolescents as they were particularly vulnerable to stress during this developmental stage, which significantly affected their mental well-being. The researchers identified factors that influenced the development of depressive symptoms, particularly parenting styles.

In this study, parenting styles—including permissive, authoritarian, strict achievement-oriented, and uninvolved parenting—served as the independent variables. These parenting depressive symptoms were then examined for their influence on depressive symptoms, which acted as a mediating variable in the study.

The study also investigated the relationship between depressive symptoms and the coping mechanisms employed by late adolescents. And as per the coping mechanisms, it included problem-focused coping, emotion-focused coping, social support-seeking coping, and avoidance coping. Also, the research study examined how levels and types of emotional challenges were related to the coping strategies that adolescents used when managing their own emotional challenges that they experienced. This analysis provided insight for the researchers into the patterns of coping behaviors in response to the depressive symptoms of the participants.

Finally, the findings of the research study served as the basis for the researchers in the development of a Counseling a Good Parenting Style Program. This program was informed by the identified relationships among parenting styles, depressive symptoms, and coping mechanisms among late adolescents. It aimed to increase parents' awareness of how different parenting approaches influenced adolescents' emotional well-being and coping behaviors. The outcome of the study helped guide future family-centered interventions that promoted supportive parent–adolescent relationships and fostered a healthier emotional environment within the family context**.**

Theoretical Framework

This study was anchored on Hildegard Peplau's Interpersonal Relationship Theory. It pointed out the importance of interpersonal relationships in the development of an individual's mental and emotional health. The theory proposed that emotion, behavior, and coping mechanisms formed through interaction and socialization with different people, particularly from childhood to adulthood. In the study, parenting styles were the primary and earliest form of interpersonal relationship experienced by late adolescents. Parents served as figures that influenced the emotional, physical, cognitive, and behavioral aspects of adolescence.

Parenting styles were characterized by effective communication, warmth, and a positive environment. Negative parenting styles, such as neglectful and authoritarian, or inconsistent, led to difficulty expressing feelings and increased vulnerability to depressive symptoms. When adolescents experienced supportive interpersonal relationships within the family, they were most likely to experience positive mental health and develop adaptive coping mechanisms. Poor interpersonal relationships contributed to feelings of low self-esteem and isolation and also caused depressive symptoms. Peplau's Theory explained that a strong understanding of how parenting styles influenced the emotional and coping behaviors of adolescents.

In relation to Callista Roy's Adaptation Theory, the study explained the interpersonal foundation through which emotional patterns and coping behaviors were learned. This theory also clarified the adaptive process through which adolescents responded to these interpersonal experiences. Parenting styles influenced adolescents' mental health through the quality of interpersonal relationships and environmental stimuli that required adaptation. The parent stage of adolescence was a stage where they experienced emotions and social challenges. At this point, adolescents still longed for their parents' emotional support and discipline. If the parenting styles provided the right guidance and emotional support, this caused a positive effect and adaptive coping mechanisms in adolescents. However, if the parenting styles were strict, controlling, and lacked support, they caused maladaptive responses in adolescents, such as depressive

Thus, researchers selected these theories because they provided an exact theoretical basis which explained how parent-adolescent relationships influenced adolescents' stress management skills. The researchers used these theories to study how different parenting methods affected adolescent's emotional difficulties and their subsequent methods of coping with those challenges.

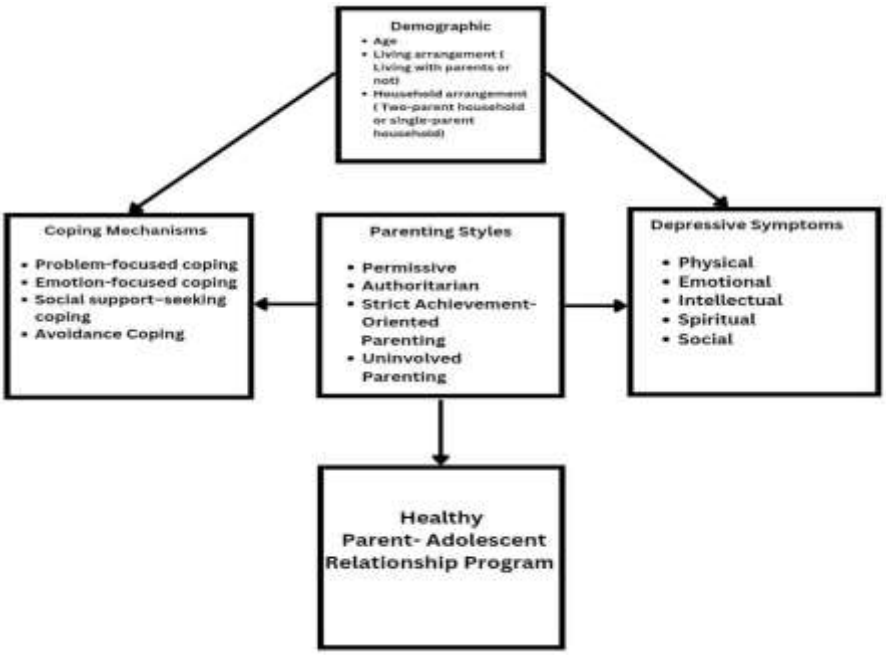
Conceptual Framework

The conceptual framework of the study illustrated the relationships among the variables which are the demographic characteristics, parenting styles, depressive symptoms, and coping mechanisms of late adolescents in Manila, which served as the basis for a proposed program. The demographic variables included age, household arrangement (two-parent or single-parent household), and living arrangement (living with parents or not). These variables were considered as influencing factors that directly affected both the depressive symptoms and coping mechanisms of the respondents, as well as their experiences within the family.

Parenting styles served as the independent variable of the study that included the permissive, authoritarian, achievement-oriented, and uninvolved parenting. These parenting approaches were examined to determine their effects on both depressive symptoms and coping mechanisms, which served as the dependent variables of the study. Depressive symptoms were measured through self-reported questionnaires assessing the respondents' physical, emotional, intellectual, spiritual, and social conditions, while coping mechanisms included problem-focused, emotion-focused, social support–seeking, and avoidance coping. The study analyzed how both demographic characteristics and parenting styles were associated with variations in depressive symptoms and coping mechanisms. It also examined in the study whether there were significant differences in depressive symptoms and coping mechanisms when respondents were grouped according to their demographic profile. The findings of the study served as the basis for the development of a Healthy Parent–Adolescent Relationship Program, which was proposed to promote awareness of parenting approaches and their potential influence on adolescents' emotional well-being and coping behaviors, and may be implemented in future settings based on the findings.

Conceptual Model

Fig 1. Paradigm of the study



Statement of the Problem

This study aimed to determine the effects of parenting style on the depressive symptoms and to the coping mechanisms of adolescents.

Specifically, it sought answers to the following questions:

1. What is the demographic profile of the respondents in terms of:

1.1. Age

1.2. Household arrangement (Two-parent household or single-parent household)

1.3. Living arrangement (Living with parents or not)?

2. Which of the following parenting styles applies within the family of the respondents in terms of the following:

2.1. Permissive Parenting

2.2. Authoritarian Parenting

2.3. Achievement-Oriented Parenting

2.4. Uninvolved Parenting?

3. Which of the following depressive symptoms were experienced by the respondents in terms of the following:

3.1. Physical

3.2. Emotional

3.3. Intellectual

3.4. Spiritual

3.5. Social?

4. Which of the following coping mechanisms are used by the respondents in dealing with depressive symptoms in terms of the following:

4.1. Problem-focused

4.2. Emotion-focused

4.3. Social support–seeking

4.4. Avoidance?

5. Is there a significant difference in coping mechanisms and depressive symptoms experienced by the respondents when they are grouped according to their demographic profile?
6. What are the effects of different parenting styles on the coping mechanisms and depressive symptoms of the respondents?
7. Based on the findings of the study, what program can be made to promote healthy parent–adolescent relationships?

Statement of Hypotheses

The researchers aimed to determine the effects of different parenting styles on depressive symptoms and coping mechanisms among late adolescents in Manila. The hypotheses were tested at a 0.05 level of significance:

H_{o1}: Parenting styles have no significant effect on the depressive symptoms of late adolescents.

H_{a1}: Parenting styles have a significant effect on the depressive symptoms of late adolescents.

H_{o2}: Parenting styles have no significant effect on the coping mechanisms of late adolescents.

H_{a2}: Parenting styles have a significant effect on the coping mechanisms of late adolescents.

H_{o3}: There is no significant difference between depressive symptoms and coping mechanisms among late adolescents.

H_{a3}: There is a significant difference between depressive symptoms and coping mechanisms among late adolescents.

Scope

The study focused on late adolescents aged 18 to 22 years old, who had been residing in District II, Tondo, Manila for more than a year. The researchers examined the relationship between different parenting styles and selected depressive symptoms identified based on related literature. The participants were late adolescents who were living voluntarily with their biological parents, including those raised by a single biological parent who was physically present in the household.

Delimitation

Adolescents whose parents were overseas Filipino workers (OFWs), those raised primarily by grandparents or other relatives, newcomers to the neighborhood, individuals living in dormitories, and those outside the specified age range and location were excluded from the study.

Significance of the Study

This study is significant because it helps explain how different parenting styles affect depressive symptoms and coping mechanisms among late adolescents in Manila. By understanding this relationship, the study provides useful information about how the family environment influences adolescents' emotional well-being and how they handle stress and challenges in daily life.

Late Adolescents. The findings of this study can help the late adolescents become more aware of how parenting styles may affect their emotions and coping behaviors. This awareness can encourage them to seek support, develop healthy coping strategies, and improve their mental well-being.

Parents and Guardians. This study can help parents and guardians understand how their parenting style can influence their child's emotional health. The results may guide them in adopting more supportive and effective parenting practices that reduce depressive symptoms and promote positive coping among adolescents.

Guidance Counselors. The findings of this study may help guidance counselors better understand the emotional and mental health needs of adolescents. This can guide them in providing counseling services, support, and interventions that improve students' coping skills and overall well-being.

School Administrators. The results of this study may help school administrators develop policies and programs that support students' mental health. This includes creating school activities, awareness programs, and a safe environment that promotes emotional well-being

Student Nurses. The findings of this study may help student nurses gain knowledge about the effects of parenting styles on adolescents' mental health. This can improve their skills in assessing, communicating, and providing basic support to adolescents experiencing depressive symptoms.

Public Health Nurses. The findings of this study may help public health nurses identify adolescents who are at risk of depressive symptoms. This can assist them in providing early intervention, health education, and community-based programs that promote mental health awareness and healthy coping mechanisms

Barangay Officials. The results of this study may help barangay officials understand the mental health concerns of adolescents in the community. This can guide them in creating programs, activities, and support services that promote mental well-being and healthy coping strategies.

Researchers. This study may contribute to existing literature on parenting styles, depressive symptoms, and coping mechanisms among adolescents. It can serve as a reference for future researchers who wish to conduct related studies, expand on other variables, or explore similar topics in different settings.

Future Researchers. This study may serve as a reference for future researchers who plan to conduct related studies about parenting styles, depressive symptoms, and coping mechanisms among adolescents. Future researchers may explore topics such as the influence of parenting styles on anxiety and stress among adolescents, the relationship between family support and coping mechanisms of senior high school students, and the effects of parenting styles on the emotional well-being and academic performance of adolescents.

Definition of Terms

To better appreciate the research thrust of the current investigation, the following terms, which were used in the study, are hereby defined both conceptually and operationally:

Permissive Parenting refers to a parenting style characterized by high responsiveness but low demands, where parents are warm but provide few rules or expectations (Baumrind, 1991). Conceptually, it emphasizes parental warmth with minimal control; in this study, it is measured through respondents' ratings of parental freedom, lack of boundaries, and inconsistent discipline.

Uninvolved Parenting refers to a parenting style marked by low responsiveness, minimal rules, and lack of emotional involvement (Baumrind, 1991). Conceptually, it reflects parental neglect and detachment; in this study, it is measured through respondents' ratings of emotional unavailability and limited parental interaction.

Authoritarian Parenting refers to a strict parenting style that enforces rules and obedience with little warmth or explanation (Baumrind, 1991). It highlights control and discipline; in this study, it is measured through respondents' ratings of strict rules, punishment, and limited autonomy.

Strict Achievement-Oriented Parenting refers to a parenting dimension focused on high expectations for academic or personal success (Dornbusch, 1987). It emphasizes performance and pressure; in this study, it is measured through respondents' ratings of academic expectations and performance-based approval.

Depressive Symptoms refers to the physical, emotional, cognitive, and social manifestations of psychological distress (Beck, 1976). It reflects multi-dimensional distress; in this study, it is measured through respondents' ratings of symptoms using a Likert-scale questionnaire.

Physical Symptoms refers to bodily manifestations of distress such as fatigue, sleep problems, and appetite changes (Beck, 1976). Conceptually, it highlights somatic expressions; in this study, it is measured through respondents' ratings of physical experiences.

Emotional Symptoms refer to feelings of sadness, irritability, and hopelessness (Beck, 1976). It reflects emotional distress; in this study, it is measured through respondents' ratings of emotional experiences.

Intellectual Symptoms refers to cognitive difficulties such as poor concentration, indecisiveness, and negative thinking (Beck, 1976). It emphasizes impaired thinking; in this study, it is measured through respondents' ratings of cognitive difficulties.

Spiritual Symptoms refer to a perceived loss of meaning, purpose, or connection to beliefs (Frankl, 1963). It highlights existential distress; in this study, it is measured through respondents' ratings of purpose and belief-related struggles.

Social Symptoms refers to difficulties in relationships such as withdrawal and isolation (Bandura, 1977). It reflects interpersonal dysfunction; in this study, it is measured through respondents' ratings of social interaction behaviors.

Coping Mechanisms refer to strategies used to manage stress and emotional challenges (Lazarus & Folkman, 1984). It emphasizes adaptation to stress; in this study, it is measured through respondents' ratings of coping behaviors.

Problem-Focused Coping refers to strategies aimed at solving or managing the source of stress (Lazarus & Folkman, 1984). Conceptually, it focuses on action; in this study, it is measured through respondents' ratings of problem-solving behaviors.

Emotion-Focused Coping refers to efforts to regulate emotional responses to stress (Lazarus & Folkman, 1984). It focuses on emotional regulation; in this study, it is measured through respondents' ratings of emotional coping strategies.

Social Support-Seeking refers to seeking help, advice, or comfort from others (Cohen, 1985). Conceptually, it highlights interpersonal support; in this study, it is measured through respondents' ratings of help-seeking behavior.

Avoidance Coping refers to avoiding or denying stressors instead of addressing them (Carver, 1989). It reflects maladaptive coping; in this study, it is measured through respondents' ratings of avoidance behaviors.

Adaptive Coping refers to strategies that effectively reduce stress and promote well-being (Lazarus, 1984). Conceptually, it emphasizes healthy adjustment; in this study, it is measured through respondents' use of constructive coping strategies.

Maladaptive Coping refers to strategies that provide temporary relief but increase distress over time (Carver, 1989). Conceptually, it reflects ineffective coping; in this study, it is measured through respondents' reliance on avoidance behaviors.

Late Adolescents refers to individuals aged 18 to 22 years (Arnett, 2000). It represents a developmental stage; in this study, it is identified based on respondents' age and residence.

Multivariate Multiple Regression refers to a statistical method used to examine relationships between multiple variables (Howell, 2013). It analyzes simultaneous effects; in this study, it is used to determine the influence of parenting styles.

Level of Significance (0.05) refers to the threshold for determining statistical significance (Fisher, 1925). It defines decision criteria; in this study, it is used to accept or reject hypotheses.

Post Hoc Analysis refers to additional tests conducted after significant findings (Tukey, 1949). It identifies specific differences; in this study, it is used to further analyze results.

Descriptive-Correlational Design refers to a research approach that describes variables and examines relationships (Creswell, 2014). It focuses on association; in this study, it is used to analyze relationships without manipulation.

Two-Parent Household refers to a family structure where both parents are present (United Nations Children's Fund, 2019). It reflects family composition; in this study, it is identified through demographic data.

F-Value refers to a statistical value used to determine model significance (Fisher, 1925). It evaluates variance; in this study, it is obtained from regression analysis.

Beta Coefficient (B) refers to a value indicating the strength and direction of relationships (Cohen, 1988). It shows effect size; in this study, it is derived from regression results.

Healthy Parent-Adolescent Relationship Program refers to the proposed intervention program based on study findings. It promotes balanced parenting; in this study, it consists of seminars and counseling designed to improve parent-adolescent relationships.

Chapter 2
REVIEW OF RELATED LITERATURE

This chapter covers a variety of literature and studies relevant to the current investigation that is used to support a different understanding of the effects of parenting styles on depressive symptoms and coping mechanisms among late adolescents in Manila. These have been compiled to present a methodical generality of current research.

Local Study and Literature

According to Ranche and Nilan (2024), Filipino college students who have parental support are associated with lower depressive symptoms. This study shows a significant negative relationship between parental support and depressive symptoms. It indicates that the students who had parental support had a lower level of depressive symptoms. Although this study established that parental support has a significant role in predicting depressive symptoms among Filipino college students, it did not include adolescents, who are more vulnerable during the vulnerable developmental stage and are also directly influenced by parental behavior.

Agbayani (2024) explored the living experiences of Filipino Generation Z individuals with mild depressive tendencies through a biopsychosocial-spiritual model. This study showed that distant relationships with parents, lack of validation in emotions, and family problems contribute to feelings of sadness and withdrawal. Suggesting that family dynamics and individual sense-making processes are connected in the experience of depression, the study did not specify parenting as a predictor of depressive symptoms.

According to the Narrative inquiry on the parent-child relationships of higher-weight late adolescents, Dang et al. (2024) found that perceptions of parental behavior, such as support, warmth, and responsiveness, influenced adolescents' emotional well-being and coping, with negative perceptions linked to poorer psychological outcomes. This reflects on how the parenting dynamics within the Filipino family shape the youth's mental health. Although this study highlights the impact of the parent-child relationships on adolescents' emotional well-being, it doesn't specifically focus on how the parenting style relates to the depressive symptoms of adolescents.

A study by Puyat et al. (2025) mentioned rising prevalence of depression and widening sociodemographic disparities in depressive symptoms among Filipino youth: findings from two large nationwide cross-sectional surveys. The study is an epidemiological study. The findings indicate *that moderate to severe depressive symptoms doubled between 2013 and 2021*. The study increased mental health concerns among Filipino adolescents. However, the study needs to identify the factors that may contribute to depression and did not examine the influence of parenting styles on depressive symptoms.

According to Alberto et al. (2025), in the study of Suicidal behaviors and self-harm among adolescents: Results from a school-based mental health survey in the Philippines, found that high rates of suicidal attempts and self-harm are linked to parental absence, with increased risk of suicidal and self-harm behaviors, often related to internalizing symptoms like depression. This study highlights the level of depression related to behavioral issues, but it doesn't indicate the role of parenting styles in shaping those outcomes among Filipino adolescents.

Foreign Study and Literature

Parenting style and parents' mood may impact the mental health of adolescents. Calm, supportive, and emotionally stable parents usually adopt positive parenting styles that make adolescents feel safe, loved, and. Adolescents are less likely to become depressed when they feel that their parents support them. The

research also found that stressed, angry, or sad parents might be less caring and patient towards their children, leading to negative parenting styles, such as being strict or giving little attention. Accordingly, parenting style can affect the mental health of adolescents.

According to Riany et al. (2021), parents who are calm, supportive, and emotionally stable usually practice positive parenting styles, which help adolescents feel safe, loved, and understood. When adolescents feel supported by their parents, they are less likely to experience depression. The study also explained that parents who are often stressed, angry, or sad may show less care and patience toward their children, which can lead to negative parenting styles such as being too strict or not giving enough attention.

Moreover, Liu (2023) conducted research on the impact of parenting styles on depression during adolescence. The research revealed that when parents are nurturing and supportive, adolescents can manage their emotions well and do not feel nervous in the presence of others. This prevents them from becoming depressed. However, if parents are strict, controlling, and less caring, adolescents may have difficulty managing their emotions and feel worried or stressed. This can lead to them becoming depressed.

In addition, Li (2022) researched the impact of parents' rejection of their children on depression in middle school students. The research revealed that students who feel rejected by their parents may feel sad and depressed. The research also found that it is important for students to cope with their feelings. Students who can think in a positive way and control their emotions may feel less depressed. Thus, this research demonstrates that parent rejection can lead to depression, but students can learn to control their emotions to protect their mental health.

Furthermore, based on the study conducted by Wang and Ci (2024), having positive parenting styles, such as being responsive, supportive, and emotionally warm, is linked to fewer symptoms of depression in adolescents. Responsive parenting involves showing children care and support and guiding them to an understanding way. This makes adolescents feel safe and emotionally sound. Responsive parents also help children cope with stress and learn effective ways to control their emotions. On the other hand, negative parenting styles, including being unresponsive, punitive, or emotionally cold, are associated with more symptoms of depression. When adolescents feel that they are alone in managing their problems and do not get emotional support from their parents, they are likely to find it difficult to manage their emotions.

Finally, Zhao (2024) explained that parenting styles are strongly related to depression in adolescents. The study found that teenagers raised by supportive and balanced parents, who give both clear rules and emotional warmth, show fewer depressive symptoms. These parents develop healthy coping skills. In contrast, harsh, overly strict, or neglectful parenting styles are linked to higher levels of depression. When parents give too much control or too little care, adolescents may feel rejected, pressured, and emotionally distressed.

Synthesis of the Reviewed Literature

The reviewed local and foreign literature established what is already known about parenting and adolescent mental health. Across studies, there is strong agreement that family environment and parental behavior influence depressive symptoms and coping. Local studies showed that parental support is linked to lower depression (Ranche & Faja Nilan, 2024), while negative family experiences such as emotional distance and lack of validation contribute to depressive feelings (Agbayani, 2024). In addition, adolescents' perceptions of parental warmth and responsiveness were found to affect their emotional well-being (Dang et al., 2024), and national data confirmed that depressive symptoms among Filipino youth

are increasing (Puyat et al., 2025). Moreover, parental absence was associated with higher risks of self-harm and depression (Alberto et al., 2025).

Foreign studies further strengthened these findings by clearly identifying that parenting styles are directly related to adolescent depression. Positive parenting styles (warm, supportive, responsive) were consistently linked to lower depressive symptoms and better coping (Riany et al., 2021; Liu, 2023; Wang & Ci, 2024; Zhao, 2024). In contrast, negative parenting styles (strict, rejecting, neglectful) were associated with higher depression and poor emotional regulation (Jing & Li, 2022; Zhao, 2024).

However, despite these findings, there are still important gaps. Local studies mostly focused on general parental support, family experiences, or mental health trends, but did not directly examine specific parenting styles (permissive, authoritarian, strict-achievement oriented, uninvolved) as predictors of depressive symptoms. In addition, many local studies focused on college students or general youth populations, leaving late adolescents (18–22 years old) less explored. There is also limited research in the local setting (District II, Tondo, Manila) that connects parenting styles with both depressive symptoms and coping mechanisms.

Gap/s Bridged by the Present Study

Existing local and international studies have established that parenting styles and family dynamics are primary determinants of adolescent psychological health, yet several critical gaps remain in the current literature. While foreign studies provide foundational evidence for relationships between parenting and depression, they often lack a multi-dimensional analysis of how specific styles—such as permissive or uninvolved parenting—correlate simultaneously with both depressive symptoms and specific coping mechanisms like social support-seeking within the unique Filipino cultural context. Furthermore, most local research focuses on broad categories such as "college students" or the general "youth population," effectively overlooking the unique developmental transitions and socioeconomic stressors inherent to late adolescents aged 18 to 22, particularly those residing in high-density urban environments like District II, Tondo, Manila. This demographic is increasingly vulnerable, as national data indicates that moderate to severe depressive symptoms among Filipino youth surged from 9.6% in 2013 to 20.9% in 2021, yet community-based studies for specific urban districts remain scarce. Consequently, international findings may not accurately reflect the cultural nuances of Filipino family structures, where perceptions of parental authority and involvement differ significantly from Western samples. By addressing these deficiencies, this research intends to determine the specific role of various parenting styles on the multi-dimensional depressive symptoms and coping mechanisms of late adolescents in Manila, thereby providing essential local, evidence-based data to inform targeted mental health awareness and family-centered interventions.

Chapter 3
RESEARCH METHODOLOGY

This chapter illustrates the steps, techniques, research design, data collection, and analysis. It contains the locations and research samples from the researcher's study.

Research Design

The research conducted a descriptive-correlational quantitative research design investigating the role of parenting styles and depressive symptoms among 18-22-year-old adolescents and how they cope. Demographic information, perceived parenting style, and depressive symptoms were obtained by a self-constructed survey questionnaire. This design would allow the researchers to describe patterns of

depressive symptomatology and their associations with different parenting styles and their coping mechanisms.

Sources of Data

The primary source of information for this research were late adolescents aged 18 to 22 years residing in District II, Tondo, Manila. The researchers gathered data by handing out a self-administered structured questionnaire to the respondents. The questionnaire is intended to collect information on demographic profile, perceived parenting styles, depressive symptoms, and coping mechanisms.

Population of the study

The study was conducted in District II, Tondo, Manila, specifically in Gagalangin, which is located east of Dagupan Street and bordered by Estero de Vitas and Estero de Sunog Apog. The area included Barangays 221 through 224. Data collection was carried out using a survey form administered to selected respondents within the community. The respondents were selected through purposive sampling, ensuring that they met the required age range of 18 to 22 years old and were verified residents of the specified barangays. A total of 100 respondents participated in the study, equally divided into 50 males and 50 females. Furthermore, each barangay contributed 25 respondents to ensure balanced representation across the study area.

Sampling Technique

The respondents were 100 late adolescents aged 18 to 22 years old who lived in District II, Tondo, Manila. The sample was divided into 50 males and 50 females to have equal representation. This age group was chosen because they experience many emotional, mental, and social changes, which may affect their mental health and coping.

Using purposive sampling, respondents were chosen based on set criteria. These included: (1) must be 18 to 22 years old, (2) must live in District II, Tondo, Manila, (3) must be living with or have lived with parents or guardians, (4) must be able to read and understand the questionnaire, and (5) must be willing to join the study. Those who did not meet these criteria were not included.

The total number of respondents was 100, with 50 males and 50 females. Only those who met all the criteria were included in the study. Informed consent was obtained from all respondents before data collection to make sure that ethical standards were followed.

Instrumentation and Validation

The study used a structured survey questionnaire as the main research instrument to gather data from the respondents. The questionnaire was designed to measure depressive symptoms, parenting style, and adolescents' social functioning among individuals aged 18 to 22 years old in District II, Tondo, Manila.

The questionnaire was divided into three parts. The first part contained questions about the demographic profile of the respondents, including age, sex, family income, educational background, and marital status of parents. The second part focused on the types of parenting styles, namely permissive, authoritarian, authoritative, and neglectful. The third part measured depressive symptoms and their effects on social functioning, covering emotional, cognitive, behavioral, and social aspects. The items were written in simple and clear language to ensure easy understanding. A 4-point Likert-type scale was used to measure the respondents' level of agreement or frequency of experiences.

For validation, the questionnaire was reviewed by the research adviser and a statistician. The research adviser evaluated the content, clarity, and relevance of the questions, while the statistician examined the appropriateness of the scaling, item structure, and compatibility with statistical analysis. The comments

and recommendations from the validators were incorporated to improve the questionnaire. The validated instrument was then used for data collection to ensure that the results were reliable and valid.

Evaluation and Scoring

The responses gathered from the structured questionnaire were evaluated and scored using a 4-point Likert-type scale, where each item was rated according to the degree to which the respondent agreed with or experienced the given statement. The scale ranged from 1 for Strongly Disagree or Never, 2 for Disagree or Rarely, 3 for Agree or Often, and 4 for Strongly Agree or Always. Numerical values were assigned to each response, with higher scores indicating stronger agreement or higher levels of the measured variable. The scores for each item under parenting styles, depressive symptoms, and coping mechanisms were summed and averaged to obtain the mean score for each variable.

For parenting styles, the mean scores for permissive, authoritarian, authoritative, and neglectful parenting were computed separately to determine the dominant parenting style perceived by the respondents. For depressive symptoms, mean scores were calculated for each dimension, including physical, emotional, intellectual, spiritual, and social to determine the severity of depressive symptoms experienced. Similarly, mean scores were computed for the different coping mechanisms, including problem-focused, emotion-focused, social support-seeking, and avoidance coping.

The interpretation of results was based on the computed mean scores using descriptive equivalents to describe the level of parenting styles, depressive symptoms, and coping mechanisms. These mean scores served as the basis for statistical analysis. To determine whether there was a significant difference in depressive symptoms and coping mechanisms when respondents were grouped according to parenting styles, the t-test was used at a 0.05 level of significance. Frequency and percentage were used to describe the demographic profile of respondents, such as age and sex, and were not used for hypothesis testing.

Data Gathering Procedures

The study was conducted in District II, Tondo, Manila, covering Barangays 221 to 224 in Gagalangin. The participants were adolescents and young adults aged 18 to 22 years old who were residing in the area. Before data collection, the researchers secured the necessary approvals, including approval from the Ethical Committee, permission from the Dean, approval from the Manila City Health Department, Tayabas Health Center, and consent from the respective Barangay Chairpersons. During the pilot testing, the researchers coordinated with the Tayabas Health Center, where some of their staff assisted the researchers. The staff accompanied the researchers to the target barangays to have the request letters signed by the Barangay Chairpersons, informing them that a pilot test would be conducted in their area. After securing the signatures, the health center staff also guided and accompanied the researchers in conducting interviews with respondents who belonged to the target age group.

Participants were informed about the purpose of the study, the procedures, the voluntary nature of their participation, and their rights, including confidentiality and the option to withdraw at any time. Informed consent was obtained from all participants to ensure ethical compliance.

The questionnaire underwent development and validation. It started with initial drafting, followed by expert validation, and revision based on the comments of the research adviser and statistician. After this, pilot testing was conducted. The results of the first, second, and third reliability tests using Cronbach's alpha were not acceptable based on the standard reliability score. Because of this, the statistician recommended removing the questionnaire items that had low results. Before making these changes, the researchers sought approval from the research adviser to ensure that removing the items was appropriate. After revising the questionnaire, a fourth reliability test was conducted, and the result met the standard

reliability score, which was considered acceptable. The final version of the questionnaire was then used for the actual data collection.

Eligible participants were identified through screening questions in the demographic section of the questionnaire, confirming their age, place of residence, and family background. A purposive sampling technique was used in selecting the respondents based on the set criteria.

Data were collected using a structured survey questionnaire consisting of four parts: demographic information, types of parenting styles experienced (permissive, authoritarian, strict achievement-oriented, and uninvolved), depressive symptoms, and coping mechanisms.

After data collection, the responses were retrieved, checked, cleaned, tallied, and encoded using Excel and SPSS. The data were organized, coded, and verified to ensure accuracy, reliability, and consistency. Finally, the data underwent statistical treatment, analysis, interpretation, and presentation to determine the effects of parenting styles on depressive symptoms among adolescents in the study area.

Statistical Treatment of Data

The following statistical tools were used to analyze the gathered data:

1. **Multivariate multiple regression** was used because the study involved more than one dependent variable, specifically depressive symptoms and coping mechanisms. It was used to determine how different parenting styles simultaneously influenced these two outcome variables.
2. **Frequency and percentage** were used to describe the demographic profile of the respondents. These measures showed how often each characteristic appeared in the sample. They help summarize data such as age, living arrangement, and household arrangement. Frequency provided the count of responses for each category. Percentage expressed these counts in proportion to the total number of respondents.
3. The **mean** was used to determine the levels of depressive symptoms and coping. It provided the average score of all respondents. This helps in understanding the general condition of the group. The mean simplifies large data sets into a single representative value. It also allowed easy comparison between different variables.
4. **Standard deviation** was used to measure the variability of responses. It showed how far the data are spread from the mean. A low standard deviation indicates that responses are close to the average. A high standard deviation means the responses are more dispersed. This helps assess the consistency or diversity of participants' answers.

Chapter 4

PRESENTATION, ANALYSIS, AND INTERPRETATION OF DATA

This chapter presents all the data that have been gathered through survey and observation, analysis, and the results of the data. The data are utilized to answer the research problem of the study.

Table 1. Demographic Profile of the Respondents

Demographic		Frequency	Percentage
Age	18 years old	10	10.00
	19 years old	12	12.00
	20 years old	22	22.00
	21 years old	31	31.00
	22 years old	25	25.00

Sex	Male	50	50.00
	Female	50	50.00
Barangay	Brgy. 221	25	25.00
	Brgy. 222	25	25.00
	Brgy. 223	25	25.00
	Brgy. 224	25	25.00
Household arrangement	Single-parent household	33	33.00
	2-parent household	67	67.00
Living with parents	Living with parents	68	68.00
	Does not live with parents	32	32.00
	TOTAL	**100**	**100.0**
Note: Total number of respondents is 100, hence frequency and percentage are the same.			

Table 1 presents the demographic profile of the respondents. A total of 100 late adolescents aged 18 to 22 years accounted for 100% of the sample.

The respondents vary in age, with 10.0% being eighteen years old, 12% nineteen years old, 22% twenty years old, 31% twenty-one years old, and 25% twenty-two years old. There is an equal distribution in terms of sex, with 50% males and 50% females. Similarly, the respondents are evenly distributed across barangay locations, with 25% each from Brgy. 221, Brgy. 222, Brgy. 223, and Brgy. 224.

In terms of household arrangement, 33% of the respondents belong to single-parent households, while 67% belong to two-parent households. Regarding living arrangements, 68% of the late adolescents reported that they live with their parents, while 32% reported that they no longer live with them.

Table 2. 1 Permissive Parenting Style

Indicators	**Mean**	**VI**	**Rank**
My parents allow me to do what I want	2.89	Often	**4**
My parents avoid setting clear boundaries for my behavior	2.69	Often	**3**
My parents focus more on freedom than discipline	2.53	Often	**3**
My parents often change the rules to avoid conflict with me.	2.51	Often	**1**
OVERALL MEAN SCORE	**2.65**	**Often**	

Legend: 1.00 to 1.75 = "Never"; 1.75 to 2.50 = "Rarely"; 2.50 to 3.25 = "Often"; 3.25 to 4.00 = "Always"

Table 2.1 shows the permissive parenting style experienced by the respondents within their families. The mean scores range from 2.51 to 2.89, all of which are verbally interpreted as "Often," although the values

are only slightly above the midpoint of the scale. The overall mean score is 2.65, suggesting that late adolescents somewhat often experience a permissive parenting style from their parents.

Specifically, respondents report that their parents often allow them to do what they want (M = 2.89), which obtained the highest mean rating. Their parents also tend to avoid setting clear boundaries for their behavior (M = 2.69). At a slightly lower level, respondents report that their parents focus more on freedom than discipline (M = 2.53) and may change rules to avoid conflict with them (M = 2.53).

The following related literature supports the findings of the table. Ranche and Fajanilan (2024) discovered that Filipino students who receive parental support show decreased symptoms of depression. Agbayani (2024) reported that emotional validation deficits together with strained family relationships will result in emotional distress and social withdrawal. The researchers found that parental warmth and support together with their ability to meet their children's needs will help adolescents improve their emotional health and coping skills.

Table 2.2 Authoritarian Parenting Style

Indicators	Mean	VI	Rank
My parents expect me to follow rules without question.	2.61	Often	**3**
My parents are strict about discipline.	2.95	Often	**5**
My opinions are rarely considered in family decisions	2.24	Rarely	**1**
Rules in our home must be followed without exception	2.76	Often	**4**
My parent's control most of my important decisions.	2.59	Often	**2**
OVERALL MEAN SCORE	**2.63**	**Often**	

Legend: 1.00 to 1.75 = "Never"; 1.75 to 2.50 = "Rarely"; 2.50 to 3.25 = "Often"; 3.25 to 4.00 = "Always"

Table 2.2 shows the authoritarian parenting style that applies within the families of the respondents. The indicator means range from 2.24 to 2.95, which are verbally interpreted from "Rarely" to "Often." The variability in the mean scores reflects differences in the adolescents' experiences. The overall mean of 2.63 suggests that late adolescents experience an authoritarian parenting style to some extent.

The indicators show that parents expect them to follow rules without question (M = 2.61) and that parents have control over important decisions (M = 2.59), both of which reflect an authoritarian approach.

To a higher extent, respondents report that rules in their homes should be followed without exception (M = 2.76), and that their parents are strict when it comes to discipline (M = 2.95), which obtained the highest mean score.

On the other hand, respondents report that their opinions are rarely considered in family decisions (M = 2.24), which received the lowest mean score. This suggests that although an authoritarian parenting style is present, some adolescents may still have opportunities to express their thoughts and opinions at home.

The research finding is supported by Liu (2023), who showed that authoritarian parenting which enforces strict rules and maintains high control while disregarding adolescents' opinions leads to increased pressure and decreased emotional expression among adolescents. Zhao (2024) observed that authoritarian parenting shows itself through excessively strict and controlling parenting which enforces rules without flexibility while denying children any role in decision-making.

Table 2.3. Strict Achievement-Oriented Parenting Style

Indicators	Mean	VI	Rank
My parents expect me to achieve high academic performance.	2.61	Often	**1**
My parents often compare my performance with others.	2.71	Often	**2**
My parents emphasize academic success very strongly.	2.74	Often	**3**
My parents show more approval when I achieve good academic results.	2.75	Often	**4**
OVERALL MEAN SCORE	**2.70**	**Often**	

Legend: 1.00 to 1.75 = "Never"; 1.75 to 2.50 = "Rarely"; 2.50 to 3.25 = "Often"; 3.25 to 4.00 = "Always"

Table 2.3 shows the strict achievement-oriented parenting style experienced by the respondents within their families. The mean scores range only from 2.61 to 2.75, verbally interpreted as "Often". These values show consistency, but they are only slightly above the midpoint of the scale. The overall mean score is 2.70, suggesting that late adolescents slightly often experience a strict achievement-oriented parenting style from their parents.

In particular, the respondents report that their parents expect them to achieve high academic performance (M = 2.61), which obtained the lowest mean rating. To a higher extent, their parents also often compare their performance with others (M = 2.71) and emphasize academic success very strongly (M = 2.74), and show more approval when they achieve good academic results (M = 2.75). The last indicator obtained the highest mean score.

This finding is supported by Wang and Ci (2024) where it states that parenting styles which prioritize achievement and academic performance create excessive pressure for adolescents to fulfill high expectations. Zhao (2024) reported that achievement-oriented parenting which places high value on success achievement and provides approval based on performance creates a controlling academic setting which affects adolescents' motivation and stress levels.

Table 2.4. Uninvolved Parenting Style

Indicators	Mean	VI	Rank
My parents rarely ask me about my problems	2.77	Often	**4**
My parents are often too busy to spend time with me	2.44	Rarely	**2**
My parents are often emotionally unavailable	2.57	Often	**3**
My parents give me a little attention unless I do something wrong	2.50	Often*	**1**
OVERALL MEAN SCORE	**2.57**	**Often**	

Legend: 1.00 to 1.75 = "Never"; 1.75 to 2.50 = "Rarely"; 2.50 to 3.25 = "Often"; 3.25 to 4.00 = "Always"

Table 2.4 shows the uninvolved parenting style experienced by the respondents within their families. The mean scores range from 2.44 to 2.77. These are verbally interpreted from "Rarely" to "Often." The variability in the mean scores reflects differences in the adolescents' experiences. The overall mean score

of 2.57 is very close to the midpoint of the scale, suggesting that late adolescents almost have a neutral experience on an uninvolved parenting style.

Responses show that parents rarely ask them about their problems (M = 2.77) and that parents are often emotionally unavailable (M = 2.57), both of which reflect an uninvolved parenting approach. These two indicators obtained the highest mean scores.

Respondents also report that their parents give them little attention unless they do something wrong (M = 2.50), which neutrally falls at the midpoint of the scale.

On the other hand, respondents report that their parents are often too busy to spend time with them (M = 2.44), which received the lowest mean score. This suggests that although an uninvolved parenting style is present, not all parents are consistently unavailable in terms of time and attention.

Wang and Ci (2024) provide evidence for this finding by showing that uninvolved parents who show emotional unavailability and who communicate less with their children create conditions which lead to lower emotional support for their adolescent children. Zhao (2024) found that adolescents experience emotional detachment and diminished mental health when their parents practice neglectful or uninvolved parenting which involves parents showing little interest in their children.

Table 3.1. Physical Depressive Symptom

Indicators	**Mean**	**VI**	**Rank**
I often feel physically tired even after resting.	3.09	Often	**5**
I experience difficulty maintaining a regular sleep pattern.	2.83	Often	**4**
I experience noticeable changes in my appetite	2.72	Often	**3**
I experience frequent headaches/body aches without a clear cause.	2.58	Often	**2**
I feel less motivated to do my daily activities.	2.30	Rarely	**1**
OVERALL MEAN SCORE	**2.70**	**Often**	

Legend: 1.00 to 1.75= "Never"; 1.75 to 2.50= "Rarely"; 2.50 to 3.25= "Often"; 3.25 to 4.00= "Always"

Table 3.1 presents the physical depressive symptoms experienced by the respondents. The mean scores span from 2.30 to 3.09, verbally interpreted within the categories of "Rarely" to "Often." There is a large variability in the mean scores, reflecting differences in the respondents' experiences. The overall mean score of 2.70 indicates that the respondents often experience physical symptoms associated with depression.

The indicators show that respondents often feel physically tired even after resting (M = 3.09) and experience difficulty maintaining a regular sleep pattern (M = 2.83), both of which reflect common physical manifestations of depressive symptoms. Respondents also report noticeable changes in their appetite (M = 2.72) and experience frequent headaches or body aches without a clear cause (M = 2.58).

Table 3.1 shows that participants commonly exhibit physical signs of depression, confirming its emotional and physical impact. Feeling physically tired even after resting (M = 3.09) was the most frequent symptom, while difficulty maintaining sleep (M = 2.83) and changes in appetite (M = 2.72) also affected daily functioning. Reduced motivation (M = 2.30) was less common.

Wang and Ci (2024), Liu (2023), and Riany et al. (2021) indicate that supportive parenting helps adolescents manage stress and regulate emotions and physical symptoms, while negative parenting may worsen them. Overall, family support serves as a protective factor against physical depressive symptoms.

Table 3.2. Emotional Depressive Symptom

Indicators	Mean	VI	Rank
I feel irritated or annoyed more easily than before.	2.66	Often	**3**
I easily lose interest in something I once enjoyed	2.62	Often	**2**
I feel more emotionally sensitive than usual	2.70	Often	**4**
I find it difficult to express my emotions	2.43	Rarely	**1**
OVERALL MEAN SCORE	**2.60**	**Often**	

Legend: 1.00 to 1.75= "Never"; 1.75 to 2.50= "Rarely"; 2.50 to 3.25= "Often; 3.25 to 4.00= "Always"

Table 3.2 shows the emotional depressive symptoms experienced by the respondents. The mean scores range from 2.43 to 2.70, which are verbally interpreted from "Rarely" to "Often." The overall mean score of 2.60 indicates that respondents slightly often experience emotional symptoms associated with depression.

Based on the results, the respondents feel more emotionally sensitive than usual (M = 2.70), feel irritated or annoyed more easily than before (M = 2.66), and easily lose interest in something they once enjoyed (M = 2.62). These reflect common emotional manifestations of depressive symptoms.

Respondents showed emotional depressive symptoms with slightly above their normal level of occurrence. They reported feeling more emotionally sensitive than usual (M = 2.70), easily irritated (M = 2.66), and losing interest in activities they once enjoyed (M = 2.62).

Liu (2023) and Riany et al. (2021) demonstrate through their research that adolescents develop better emotional control and experience fewer depressive symptoms when their parents provide them with supportive parenting. Zhao (2024) and Jing and Li (2022) show that children who receive less parental support face greater challenges in managing their emotional problems. The results show that respondents handle emotional sensitivity and irritability and loss of interest through their need for a supportive environment which helps them deal with their adolescent depression.

Table 3.3. Intellectual Depressive Symptom

Indicators	Mean	VI	Rank
I have difficulty concentrating on tasks.	2.70	Often	**5**
I have negative thoughts about myself.	2.49	Rarely	**3**
I experience confusion or mental fog.	2.67	Often	**4**
I find it difficult to make even simple decisions.	2.43	Rarely	**1**
I tend to overthink situations and dwell on negative thoughts.	2.45	Rarely	**2**
OVERALL MEAN SCORE	**2.55**	**Often**	

Legend: 1.00 to 1.75= "Never"; 1.75 to 2.50= "Rarely"; 2.50 to 3.25= "Often"; 3.25 to 4.00= "Always"

Table 3.3 shows the intellectual depressive symptoms experienced by the respondents. Mean scores range from 2.43 to 2.70. This translates to "Rarely" to "Often" categories. There is only a low variability in the mean scores, suggesting minimal differences in the respondents' experiences. While the overall mean

score of 2.55 translates to "Often", it is still within the midpoint of the scale, hence almost a neutral stance regarding intellectual manifestations of depressive symptoms.

The indicators show that respondents have difficulty concentrating on tasks (M = 2.70) and experience confusion or mental fog (M = 2.67), both of which reflect common intellectual manifestations of depressive symptoms.

The results from Table 3.3 show that respondents experience intellectual depressive symptoms at a rate which results in an overall mean of 2.55. The most frequently reported symptoms included difficulty concentrating on tasks which had a mean score of 2.70 and confusion which caused mental fog that had a mean score of 2.67.

The research findings received backing from Liu (2023) and Riany et al. (2021) who demonstrated how adolescents achieve better focus and cognitive control through supportive parenting. The study shows that respondents experience intellectual difficulties which range from mild to moderate because they need guidance and support to maintain mental clarity during their depressive episodes.

Table 3.4. Spiritual Depressive Symptom

Indicators	**Mean**	**VI**	**Rank**
I question my spiritual or personal beliefs during difficult times.	2.37	Rarely	**1**
I feel disconnected from my spiritual or faith beliefs.	2.39	Rarely	**2**
I question my beliefs during difficult times.	2.53	Often	**5**
I find it hard to trust that things will improve in my life.	2.49	Rarely	**4**
I feel confused about what gives my life purpose.	2.46	Rarely	**3**
OVERALL MEAN SCORE	**2.45**	**Rarely**	

Legend: 1.00 to 1.75= "Never"; 1.75 to 2.50= "Rarely"; 2.50 to 3.25= "Often"; 3.25 to 4.00= "Always"

Table 3.4 presents the spiritual depressive symptoms experienced by the respondents. The mean scores span from 2.37 to 2.53, with most of the verbal interpretations as "Rarely". Mean scores are consistent with each other, reflecting small differences in the respondents' experiences. The overall mean score of 2.45 indicates that the respondents rarely experience spiritual symptoms associated with depression.

One indicator shows that respondents question their beliefs during difficult times (M = 2.53), which is the only indicator interpreted as "Often." To a slightly lower extent interpreted as "Rarely", other indicators show that respondents now find it less hard to trust that things will improve in their life (M = 2.49) and feel confused about what gives their life purpose (M = 2.46).

Moreover, respondents report that they rarely feel disconnected from their spiritual or faith beliefs (M = 2.39) and question their spiritual or personal beliefs during difficult times (M = 2.37), both of which reflect spiritual struggles experienced by the respondents but to a lesser extent. These two indicators received the lowest mean score, translated to "Rarely." This suggests that while respondents may have some spiritual concerns, these are not commonly experienced as compared to the other depressive symptoms.

The results from Table 3.4 show that respondents rarely experience spiritual depressive symptoms, with an overall mean of 2.45. The most reported symptom was questioning their beliefs during difficult times with an average rating of 2.53 while feeling disconnected from their faith had a lower rating of 2.39 and questioning personal purpose had two separate ratings of 2.37 and 2.46.

The study results show that people experience spiritual struggles yet they occur less frequently than other depressive symptoms. Adolescents who face difficulties will benefit from supportive environments which Liu (2023) and Riany et al. (2021) have described.

Table 3.5. Social Depressive Symptom

Indicators	Mean	VI	Rank
I avoid interacting with my friends even when they reach out to me..	2.51	Often	**3**
I prefer to avoid social gatherings because I feel emotionally drained.	2.46	Rarely	**1**
I feel left out most of the time.	2.50	Often	**2**
I feel misunderstood by people around me.	2.56	Often	**4**
I prefer to spend time alone rather than interacting with other people.	2.71	Often	**5**
OVERALL MEAN SCORE	**2.55**	**Often**	

Legend: 1.00 to 1.75= "Never"; 1.75 to 2.50= "Rarely"; 2.50 to 3.25= "Often"; 3.25 to 4.00= "Always"

Table 3.5 presents the social depressive symptoms experienced by the respondents. The mean scores span from 2.46 to 2.71. These are verbally categorized as "Rarely" to "Often." A small variability in the mean scores is seen, showing that there are differences in the respondents' experiences. The overall mean score of 2.55 indicates that the respondents have a neutral experience on social symptoms associated with depression.

The indicators show that respondents prefer to spend time alone rather than interacting with other people (M = 2.71) and feel misunderstood by people around them (M = 2.56), both of which reflect common social manifestations of depressive symptoms. These two obtained the highest mean scores, respectively. Respondents also report that they avoid interacting with their friends even when they reach out (M = 2.51), feel left out most of the time (M = 2.50), and prefer to avoid social gatherings because they feel emotionally drained (M = 2.46), which received the mean scores, albeit translated to "Rarely", still fall within the midpoint of the scale, indicating that while social symptoms of depression are present among the respondents, avoidance to socialization is less commonly experienced compared to other social indicators.

The results from Table 3.5 show that respondents have a neutral experience of social depressive symptoms, with an overall mean of 2.55. The most common social symptoms among respondents showed a preference for spending time alone which had an average of 2.71 and a sense of being misunderstood which had an average of 2.56. The participants reported lower frequency of social symptoms which included avoiding friends with an average of 2.51 and feeling left out with an average of 2.50 and avoiding social gatherings because of emotional exhaustion with an average of 2.46. The research findings indicate that social depressive symptoms exist in the study group yet they occur less frequently than other types of depression. Liu (2023) and Riany et al. (2021) demonstrate that supportive environments enable adolescents to develop proper social relationships while they deal with their experiences of loneliness.

Table 4.1. Problem-Focused Coping

Indicators	Mean	VI	Rank
I set goals to overcome challenges.	3.03	Often	**3**
I think carefully before making decisions about problems.	3.24	Often	**5**
I gather information to help me solve my problems.	3.00	Often	**2**
I try different strategies when my first solution does not work.	2.73	Often	**1**
I take action to improve difficult situations.	3.19	Often	**4**
OVERALL MEAN SCORE	**3.04**	**Often**	

Legend: 1.00 to 1.75 = "Never"; 1.75 to 2.50 = "Rarely"; 2.50 to 3.25 = "Often"; 3.25 to 4.00 = "Always"

Table 4.1 presents the problem-focused coping used by the respondents in dealing with depressive symptoms. The mean scores span from 2.73 to 3.24. These are verbally categorized as "Often." A small variability in the mean scores is observed, indicating that the respondents have relatively similar experiences of coping up with problems. The overall mean score of 3.04 indicates that respondents often use problem-focused coping strategies in dealing with depressive symptoms.

Indicator results show that respondents think carefully before making decisions about problems (M = 3.24) and take action to improve difficult situations (M = 3.19), both of which reflect active and practical coping strategies. These two obtained the highest mean scores, respectively. Respondents also report that they set goals to overcome challenges (M = 3.03) and gather information to help solve their problems (M = 3.00). Respondents further report that they try different strategies when their first solution does not work (M = 2.73), which received the lowest mean score, indicating that flexibility in trying alternative solutions is less commonly practiced compared to other problem-focused coping strategies.

The results from Table 4.1 show that respondents use problem-focused coping, meaning they try to directly solve their problems instead of avoiding them. This reflects their use of practical and logical strategies in dealing with depressive symptoms. The highest scores, thinking carefully before decisions (M = 3.24) and taking action to improve situations (M = 3.19), show that respondents rely on planning and active problem-solving, allowing them to manage stress step by step.

This is supported by Liu (2023) and Riany et al. (2021), who found that supportive environments help adolescents develop effective coping and decision-making skills. Their motivation is also seen in goal setting (M = 3.03) and information gathering (M = 3.00), which help reduce feelings of helplessness.

Wang and Ci (2024) support this by stating that supportive environments improve emotional regulation and coping skills. However, the lowest score in trying different strategies when the first solution fails (M = 2.73) shows limited flexibility and adaptability.

Zhao (2024) and Jing and Li (2022) explain that limited support or coping flexibility may lead to difficulty adjusting to problems, making stress harder to manage. Overall, respondents show strong problem-solving skills, but they still need to improve their flexibility and resilience when dealing with challenges.

Table 4.2. Emotion-Focused Coping

Indicators	Mean	VI	RANK
I try to calm myself when I feel stressed or upset.	3.24	Often	**4**
I distract myself with entertainment or leisure to reduce stress.	3.01	Often	**2**

I comfort myself during difficult times by telling myself that everything will be alright.	3.08	Often	**3**
I take a moment to pause and breathe to manage my stress or emotions.	2.98	Often	**1**
OVERALL MEAN SCORE	**3.08**	**Often**	

Legend: 1.00 to 1.75 = "Never"; 1.75 to 2.50 = "Rarely"; 2.50 to 3.25 = "Often"; 3.25 to 4.00 = "Always"

Table 4.2 presents the emotion-focused coping used by the respondents in dealing with depressive symptoms. The mean scores span from 2.98 to 3.24. These are verbally categorized as "Often". Variability within the mean scores is observed, which suggests that the respondents have relatively similar coping experiences towards emotion regulation. The overall mean score of 3.08 indicates that respondents often use emotion-focused coping strategies in dealing with depressive symptoms.

Based on the results, the respondents try to calm themselves when they feel stressed or upset (M = 3.24), which received the highest mean score. In addition, they comfort themselves during difficult times by telling themselves that everything will be alright (M = 3.08) and that they distract themselves with entertainment or leisure to reduce stress (M = 3.01). Respondents further report that they take a moment to pause and breathe to manage their stress or emotions (M = 2.98), which received the lowest mean score.

The data shows that respondents use emotion-focused coping, meaning they focus on managing their emotions rather than directly solving problems when experiencing depressive symptoms. The highest score, self-calming during stress (M = 3.24), shows emotional awareness and basic self-regulation.

This is supported by Wang and Ci (2024) and Jing and Li (2022), who found that emotional control and supportive environments help reduce depressive symptoms. Respondents also use self-comforting thoughts (M = 3.08) and distraction (M = 3.01), showing efforts to reduce negative emotions. Agbayani (2024) and Riany et al. (2021) explain that lack of emotional support often leads adolescents to rely on these temporary coping strategies. However, the lowest score, pausing and breathing (M = 2.98), shows that mindfulness techniques are less practiced.

Liu (2023) and Zhao (2024) note that without strong emotional support, adolescents tend to use short-term rather than deeper coping strategies. Overall, respondents are emotionally aware and capable of self-soothing but mainly rely on temporary coping methods. They still need to strengthen their coping skills through mindfulness and better emotional regulation techniques.

Table 4.3. Social Support-Seeking Coping

Indicators	**Mean**	**VI**	**Rank**
I reach out to others for support when I feel stressed	3.09	Often	**5**
I seek advice from people I trust.	2.77	Often	**2**
I openly share my concerns with someone I trust.	2.67	Often	**1**
I prefer solving problems with others rather than alone	2.81	Often	**3**
I ask people who have had similar experiences what they did	2.91	Often	**4**
OVERALL MEAN SCORE	**2.85**	**Often**	

Legend: 1.00 to 1.75 = "Never"; 1.75 to 2.50 = "Rarely"; 2.50 to 3.25 = "Often"; 3.25 to 4.00 = "Always"

Table 4.3 presents the social support-seeking coping used by the respondents in dealing with depressive symptoms. The mean scores span from 2.67 to 3.09. These are verbally categorized as "Often", but slightly lower compared to the earlier coping strategies. There is a small variability in the mean scores observed. This consistency indicates that respondents have relatively similar coping experiences. The overall mean score of 2.85 indicates that respondents often use social support-seeking strategies in dealing with depressive symptoms, albeit slightly lower as compared to the other earlier strategies.

The indicators show that respondents reach out to others for support when they feel stressed (M = 3.09) and ask people who have had similar experiences what they did (M = 2.91), both of which reflect active help-seeking behaviors. These two indicators already have the highest mean scores, respectively. Respondents also report that they prefer solving problems with others rather than alone (M = 2.81) and seek advice from people they trust (M = 2.77).

To a slightly lesser extent, the respondents further report that they openly share their concerns with someone they trust (M = 2.67), which received the lowest mean score. Although this is still translated as "Often," it is now relatively closer to the midpoint of the scale, indicating that openly sharing concerns is less commonly practiced compared to other social support-seeking strategies.

The respondents in Table 4.3 often use social support-seeking coping (M = 2.85), but less than other coping styles. This means they do seek help, but still rely more on self-reliance. The highest scores, reaching out for support (M = 3.09) and asking people with similar experiences (M = 2.91), show willingness to seek help during stressful situations.

This is supported by Ranche and Faja Nilan (2024) and Dang et al. (2024), who found that strong social and family support improves coping and reduces depressive symptoms. They also prefer solving problems with others (M = 2.81) and seeking advice from trusted people (M = 2.77), showing they value guidance and support.

Wang and Ci (2024) stated that supportive relationships strengthen adolescents' coping skills. However, the lowest score, openly sharing concerns (M = 2.67), shows difficulty in fully expressing emotions.

Agbayani (2024) and Zhao (2024) explain that lack of emotional support and fear of judgment can limit emotional openness. Overall, respondents show moderate willingness to seek support, but their communication is still limited. Strengthening trust and openness can improve their coping with depressive symptoms.

Table 4.4. Avoidance Coping

Indicators	**Mean**	**VI**	**Rank**
I ignore my problems instead of dealing with them.	2.51	Often	**2**
I avoid situations that remind me of my problems.	2.82	Often	**5**
I pretend that my problems do not exist.	2.76	Often	**4**
I reduce the amount of effort I'm putting into dealing with this.	2.62	Often	**3**
OVERALL MEAN SCORE	**2.68**	**Often**	

Legend: 1.00 to 1.75 = "Never"; 1.75 to 2.50 = "Rarely"; 2.50 to 3.25 = "Often"; 3.25 to 4.00 = "Always"

Table 4.4 presents the avoidance coping used by the respondents in dealing with depressive symptoms. The mean scores span from 2.51 to 2.82. These are verbally categorized as "Often". There is also a small

variability in the mean scores, indicating that the respondents have relatively similar avoidance coping experiences. The overall mean score of 2.68 suggests that respondents may still tend to use avoidance coping strategies in dealing with depressive symptoms but are less common than problem-focused and emotion-focused coping styles.

The indicators for avoidance coping show that respondents avoid situations that remind them of their problems (M = 2.82) and pretend that their problems do not exist (M = 2.76). Respondents also report that they reduce the amount of effort they put into dealing with their problems (M = 2.62) and ignore their problems instead of dealing with them (M = 2.51), receiving the lowest mean scores. These show that avoidance coping may be used by late adolescents but to a lesser extent as compared to the other coping strategies.

Table 14 shows that respondents often use avoidance coping (M = 2.68), but it is less used compared to other coping strategies. This suggests that while respondents sometimes avoid problems, it is not their primary way of coping. The highest scores, avoiding situations that remind them of problems (2.82) and pretending problems do not exist (2.76), show that respondents may temporarily escape stressful situations.

This is supported by Agbayani (2024), who found that Filipino youth experiencing emotional distress often show withdrawal and avoidance behaviors due to family problems and lack of emotional validation. Respondents also report reducing effort (2.62) and ignoring problems (2.51), which may provide short-term relief but can delay problem resolution.

According to Alberto et al. (2025), adolescents with higher emotional distress and depressive symptoms are more likely to show internalizing behaviors such as avoidance and withdrawal, especially when lacking support. However, since avoidance has a lower mean compared to other coping styles, it suggests respondents are still more likely to face their problems rather than avoid them, which reflects some emotional awareness and maturity.

This aligns with Zhao (2024), who explained that supportive environments encourage adolescents to use healthier coping strategies instead of relying heavily on avoidance. Overall, the findings suggest that respondents still use avoidance coping at times, especially during stress, but it is not their main strategy. Strengthening emotional resilience and problem-solving skills can help reduce reliance on avoidance behaviors.

Table 5.1: Significant Difference in Problem-Focused Coping Mechanisms of the Respondents when Grouped According to Their Demographics

Demographic	**Stat**	**p-value**	**Decision on Ho**	**Significance**
Age	F = 1.609	0.178	Fail to reject Ho	Not significant
Household arrangement	t = 0.266	0.791	Fail to reject Ho	Not significant
Living arrangement	t = 0.416	0.678	Fail to reject Ho	Not significant
Null Ho: There is no significant difference in coping mechanisms when grouped by demographic. Reject this null Ho if p-value is below .05 significance level.				

Table 5.1 shows the significant difference in problem-focused coping mechanisms of the respondents when grouped according to their demographics. The null hypothesis states that there is no significant

difference in coping mechanisms when grouped according to their demographics. This is tested at the .05 significance level using one-way analysis of variance for the age demographic, while the independent t-test is used for the household and living arrangement demographics.

Results show that problem-focused coping mechanisms of late adolescents do not significantly differ by age, household arrangement, or living arrangement.

This indicates that demographic characteristics do not create noticeable differences in how adolescents deal with stressful situations through problem-solving approaches.

This finding is supported by Puyat et al. (2025), who stated that sociodemographic factors alone do not fully explain mental health outcomes among Filipino youth, suggesting that family environment and psychological factors have a stronger influence. Alberto et al. (2025) also found that adolescent mental health outcomes are more strongly associated with family conditions such as parental presence or absence rather than demographic grouping.

Table 5.2: Significant Difference in Emotion-Focused Coping Mechanisms of the Respondents when Grouped According to Their Demographics

Demographic	**Stat**	**p-value**	**Decision on Ho**	**Significance**
Age	F = 1.673	0.163	Fail to reject Ho	Not significant
Household arrangement	t = 1.242	0.217	Fail to reject Ho	Not significant
Living arrangement	t = 1.224	0.224	Fail to reject Ho	Not significant
Null Ho: There is no significant difference in coping mechanisms when grouped by demographic. Reject this null Ho if p-value is below .05 significance level.				

Under the same null hypothesis, the statistics show that emotion-focused coping mechanisms of late adolescents do not significantly differ by age, household arrangement, or living arrangement.

This indicates that adolescents show similar emotional coping responses regardless of differences in age, household arrangement, or living arrangement.

This finding is supported by Puyat et al. (2025), who explained that sociodemographic factors alone are not sufficient to explain variations in adolescent mental health outcomes, suggesting that family environment and psychological influences have greater impact than demographics. Alberto et al. (2025) further found that adolescent emotional outcomes are more strongly linked to family conditions such as parental presence or absence rather than demographic grouping.

Table 5.3: Significant Difference in Social-Support Seeking Coping Mechanisms of the Respondents when Grouped According to Their Demographics

Demographic	**Stat**	**p-value**	**Decision on Ho**	**Significance**
Age	F = 1.180	0.324	Fail to reject Ho	Not significant
Household arrangement	t = 1.277	0.204	Fail to reject Ho	Not significant
Living	t = 1.236	0.220	Fail to reject Ho	Not significant

arrangement				
Null Ho: There is no significant difference in coping mechanisms when grouped by demographic. Reject this null Ho if p-value is below .05 significance level.				

Under the same null hypothesis, the statistics show that social-support seeking coping mechanisms of late adolescents do not significantly differ by age, household arrangement, or living arrangement.

The results from Table 5.3 demonstrate that respondents use social-support seeking coping mechanisms at equal levels across different demographic groups. The three variables of age and household arrangement and living arrangement showed p-values that exceeded 0.05 significance threshold. The researchers did not reject the null hypothesis because demographic variables did not affect late adolescents' social support seeking behavior as a coping method.

The findings are supported by Liu (2023) and Riany et al. (2021) discovered that adolescents who grow up in nurturing parent environments which provide emotional stability can better handle stress regardless of their age or household situation.

The research conducted by Wang and Ci (2024) demonstrates that adolescents with dedicated family relationships can enhance their emotional management abilities and their capacity to seek social support regardless of their residential conditions. The existence of supportive relationships among late adolescents' functions as a better predictor of successful coping methods than their demographic attributes.

Table 5.4: Significant Difference in Avoidance Coping Mechanisms of the Respondents when Grouped According to Their Demographics

Demographic	Stat	p-value	Decision on Ho	Significance
Age	F = 0.742	0.566	Fail to reject Ho	Not significant
Household arrangement	t = 0.688	0.493	Fail to reject Ho	Not significant
Living arrangement	U = 1000	0.511	Fail to reject Ho	Not significant
Null Ho: There is no significant difference in coping mechanisms when grouped by demographic. Reject this null Ho if p-value is below .05 significance level.				

Under the same null hypothesis, the statistics show that avoidance coping mechanisms of late adolescents do not significantly differ by age, household arrangement, or living arrangement.

The results from Table 5.4 demonstrates that respondents show identical avoidance coping patterns across all demographic categories which researchers used to categorize their study sample. The study results indicate that all three demographic factors which include age (F = 0.742, p = 0.566), household arrangement (t = 0.688, p = 0.493), and living arrangement (U = 1000, p = 0.511) exhibit p-values which exceed the 0.05 threshold for statistical significance. The researchers established a null hypothesis which they proved correct because demographic factors showed no effect on late adolescent adoption of avoidance coping methods.

The findings are supported by Liu (2023) and Riany et al. (2021) explain that adolescents' coping strategies depend more on supportive environments and parenting than on their demographic characteristics.

Wang and Ci (2024) show that people who provide emotional support and maintain relationships with others serve as better predictors of coping abilities than household or living arrangement factors. The research shows that adolescents handle stress based on the support they receive from their mentors and their access to emotional support resources, not their age or living conditions.

Table 5.5: Significant Difference in Physical Depressive Symptoms of the Respondents when Grouped According to Their Demographics

Demographic	Stat	p-value	Decision on Ho	Significance
Age	F = 1.404	0.239	Fail to reject Ho	Not significant
Household arrangement	t = 0.649	0.518	Fail to reject Ho	Not significant
Living arrangement	t = 0.714	0.477	Fail to reject Ho	Not significant
Null Ho: There is no significant difference in depressive symptoms when grouped by demographic. Reject this null Ho if p-value is below .05 significance level.				

Table 5.5 shows the significant difference in physical depressive symptoms experienced by the respondents when grouped according to their demographics. The null hypothesis states that there is no significant difference in depressive symptoms when respondents are grouped according to demographic variables. The test was conducted at the 0.05 level of significance. One-way analysis of variance (ANOVA) was used for age, while the independent t-test was used for household arrangement and living arrangement.

The data show that physical depressive symptoms do not significantly differ when grouped by age, household arrangement, and living arrangement. The results indicate that age ($p = 0.239$), household arrangement ($p = 0.518$), and living arrangement ($p = 0.477$) all have p-values greater than 0.05; therefore, the null hypothesis is failed to be rejected. This means that respondents experience similar levels of physical depressive symptoms regardless of their demographic characteristics.

This finding is supported by Puyat et al. (2025), who found that depressive symptoms among Filipino youth are prevalent across different demographic groups, suggesting that depression is not always influenced by basic demographic factors. Similarly, Liu (2023) explained that adolescent depressive symptoms are more associated with emotional regulation and environmental influences, such as parenting and social support, rather than age or living conditions. In addition, Wang and Ci (2024) emphasized that the quality of relationships and support systems has a stronger influence on adolescent mental health than household or living arrangements.

Overall, the findings suggest that physical depressive symptoms remain consistent across demographic groups, while psychosocial factors such as parenting style, emotional support, and coping mechanisms may play a more important role in influencing adolescent depression.

Table 5.6: Significant Difference in Emotional Depressive Symptoms of the Respondents when Grouped According to Their Demographics

Demographic	Stat	p-value	Decision on Ho	Significance
Age	F = 1.992	0.102	Fail to reject Ho	Not significant

Household arrangement	t = 0.444	0.658	Fail to reject Ho	Not significant
Living arrangement	t = 0.333	0.739	Fail to reject Ho	Not significant
Null Ho: There is no significant difference in depressive symptoms when grouped by demographic. Reject this null Ho if p-value is below .05 significance level.				

Table 5.6 presents the significant difference in emotional depressive symptoms of the respondents when grouped according to their demographics. The null hypothesis states that there is no significant difference in depressive symptoms when grouped according to demographic variables. The test was conducted at the 0.05 level of significance.

The results show that emotional depressive symptoms do not significantly differ when grouped by age, household arrangement, and living arrangement. The computed p-values for age (p = 0.102), household arrangement (p = 0.658), and living arrangement (p = 0.739) are all higher than 0.05. Therefore, the null hypothesis is not rejected. This means that respondents experience similar emotional depressive symptoms regardless of their demographic background.

This finding is supported by Puyat et al. (2025), who found that depressive symptoms among Filipino youth are common across different groups. Similarly, Liu (2023) explained that emotional depressive symptoms are more affected by emotional support, parenting, and coping skills rather than demographic factors. In addition, Wang and Ci (2024) stated that good relationships and support systems have a stronger influence on adolescents' emotional well-being than living arrangements or household setup.

Overall, the findings suggest that emotional depressive symptoms are similar across demographic groups, while factors such as parenting style, emotional support, and coping mechanisms may have a greater effect on adolescents' emotional health.

Table 5.7: Significant Difference in Intellectual Depressive Symptoms of the Respondents when Grouped According to Their Demographics

Demographic	**Stat**	**p-value**	**Decision on Ho**	**Significance**	**Remarks**
Age	F = 1.088	0.367	Fail to reject Ho	Not significant	--
Household arrangement	t = 2.115	0.037	Reject Ho	Significant	Single-parent > Two-parent *(Medium effect size: 0.4497)*
Living arrangement	t = 0.183	0.855	Fail to reject Ho	Not significant	--
Null Ho: There is no significant difference in depressive symptoms when grouped by demographic. Reject this null Ho if p-value is below .05 significance level.					

Under the same null hypothesis, it can be gleaned from the data that intellectual depressive symptoms do not significantly differ when grouped by age and living arrangement.

However, results indicate that intellectual depressive symptoms differ by household arrangement (t = 2.115, p = 0.037), with a medium effect size of 0.4497. Specifically, late adolescents under a single-parent household (M = 2.73) seem to report higher experiences of intellectual depressive symptoms as compared to other late adolescents under a two-parent household (M = 2.46).

The findings of the study are supported by both local and foreign literature emphasizing the importance of parental support and family structure in adolescents' mental health. The present study found that respondents from single-parent households reported significantly higher intellectual depressive symptoms compared to those from two-parent households, suggesting that the absence of one parent may lessen emotional guidance and support needed during late adolescence. This supports the study of Ranche and Faja Nilan (2024), which revealed that Filipino students with parental support experience lower depressive symptoms, as well as Agbayani (2024), who noted that distant parent-child relationships and family problems contribute to sadness and withdrawal. Similarly, Dang et al. (2024) explained that parental warmth and responsiveness positively influence adolescents' emotional well-being, while Alberto et al. (2025) linked parental absence to higher mental health risks among Filipino youth. Foreign studies also support these findings, particularly Riany et al. (2021), Liu (2023), Wang and Ci (2024), and Zhao (2024), who consistently found that supportive and emotionally warm parenting reduces depressive symptoms, whereas emotionally distant, neglectful, or overly strict parenting increases adolescents' vulnerability to depression.

Table 5.8: Significant Difference in Spiritual Depressive Symptoms of the Respondents when Grouped According to Their Demographics

Demographic	Stat	p-value	Decision on Ho	Significance
Age	F = 0.123	0.974	Fail to reject Ho	Not significant
Household arrangement	t = 0.989	0.325	Fail to reject Ho	Not significant
Living arrangement	t = 0.505	0.615	Fail to reject Ho	Not significant
Null Ho: There is no significant difference in depressive symptoms when grouped by demographic. Reject this null Ho if p-value is below .05 significance level.				

Under the same null hypothesis, results show that spiritual depressive symptoms do not significantly differ when grouped by age, household arrangement, and living arrangement.

The findings are supported by Agbayani (2024), who emphasized that Filipino adolescents' depressive experiences are shaped by individual sense-making processes and emotional experiences rather than solely by family structure. Similarly, Puyat et al. (2025) explained that depressive symptoms among Filipino youth continue to rise across different sociodemographic groups, indicating that depression may affect adolescents regardless of age or living condition. Foreign literature also supports the findings, particularly Zhao (2024), who noted that adolescent depression is influenced by emotional and psychological factors beyond demographic characteristics, while Wang and Ci (2024) highlighted that coping abilities and emotional support play a greater role in adolescents' mental health than demographic variables alone.

Table 5.9: Significant Difference in Social Depressive Symptoms of the Respondents when Grouped According to Their Demographics

Demographic	Stat	p-value	Decision on Ho	Significance
Age	F = 1.181	0.324	Fail to reject Ho	Not significant
Household arrangement	t = 0.753	0.453	Fail to reject Ho	Not significant
Living arrangement	t = 0.381	0.704	Fail to reject Ho	Not significant
Null Ho: There is no significant difference in depressive symptom when grouped by demographic. Reject this null Ho if p-value is below .05 significance level.				

Under the same null hypothesis, results show that social depressive symptoms do not significantly differ when grouped by age, household arrangement, and living arrangement.

Results showed that there was no statistically significant difference in social depressive symptoms based on age group, household arrangement, and living arrangement since all p-values were greater than the .05 level of significance. Thus, it can be said that social depressive symptoms were experienced equally by respondents across various demographic profiles.

These results are further confirmed by the research conducted by Wang and Ci (2024), which reported that depressive symptoms among adolescents were influenced more by emotional support and family relationships rather than demographic factors such as age or living conditions.

Moreover, the results of the study of Agbayani (2024) prove that depression experienced by individuals is usually related to the interpersonal interaction and parents' influence; therefore, demographic factors cannot have a serious effect on social depression. The findings mentioned above provide evidence for the current study's result regarding social depressive symptoms.

Table 6. Effects of Different Parenting Style on Coping Mechanisms and Depressive Symptoms (Multivariate Multiple Regression)

Parenting Style	F	p	Decision on Ho	Remarks
Permissive	3.130	0.003	Reject Ho	Effect is significant
Authoritative	1.086	0.381	Failed to reject Ho	
Strict Achievement-Oriented	1.399	0.201	Failed to reject Ho	
Uninvolved	3.001	0.004	Reject Ho	Effect is significant

Model for IV: Intercept + Permissive + Authoritative + Strict Achievement-Oriented + Uninvolved

Null Hypothesis: The parenting style has no effect on coping mechanisms and depressive symptoms.

Reject the null hypothesis (H_0) if p-value is below 0.05 significance level

Table 6 presents the effects of different parenting styles on coping mechanisms and depressive symptoms. The null hypothesis stated that the independent variable parenting style had no effect on the dependent

variables coping mechanisms and depressive symptoms. This was tested by a multivariate multiple regression at the 0.05 significance level.

Based on the respondents' perception of their parents' parenting style, the authoritative (F = 1.086, p = 0.381) and strict achievement-oriented parenting styles (F = 1.399, p = 0.201) did not affect the dependent variables.

However, their perceptions towards permissive (F = 3.130, p = 0.003) and uninvolved (F = 3.001, p = 0.004) had a significant effect on their coping mechanisms and depressive symptoms. Their p-values were below the indicated threshold of 0.05, hence successfully rejecting the null hypothesis. This claimed that permissive and uninvolved parenting styles affected the coping styles and depressive symptoms felt by late adolescents.

The above finding was confirmed by Baumrind (1991), who argued that permissive parents were less controlling and structured. As a result, such children displayed weak self-regulatory capabilities coupled with increased problems regarding their emotions. Additionally, uninvolved parents were identified as causing emotional disturbance among young people due to lack of guidance and emotional support (Steinberg, 2001).

Table 7. Effects of Different Parenting Style on Coping Mechanisms and Depressive Symptoms (Post hoc analysis using p-values and coefficients B)

		Parenting styles (IV)			
		Permissive	*Authoritative*	*Strict Achievement-Oriented*	*Uninvolved*
Coping mechanisms (DV)	*Problem-focused*	0.839	0.330	0.950	0.705
	Emotion-focused	0.021 (B = -0.284)	0.333	0.399	0.897
	Social support-seeking	0.009 (B = +0.318)	0.739	0.163	0.040 (B = -0.244)
	Avoidance	0.090	0.231	0.118	0.360
Depressive symptoms (DV)	*Physical*	0.531	0.502	0.851	0.004 (B = +0.479)
	Emotional	0.941	0.157	0.154	0.001 (B = +0.406)
	Intellectual	0.695	0.236	0.542	0.001

					(B = +0.382)
	Spiritual	0.166	0.072	0.177	0.001 (B = +0.456)
	Social	0.868	0.062	0.677	0.081

Null Ho: The IV has an effect on DV.
Reject this null Ho if p-value is less than 0.05 significance level.

Table 7 presents a post hoc analysis to the previous table, which identified that late adolescents' perception to a permissive and uninvolved parenting styles have a significant effect on coping mechanisms and depressive symptoms. The same 0.05 level of significance is used.

In terms of parenting style to coping mechanism, results showed that permissive parenting positively affected social support-seeking (B = 0.318, p = 0.009) but inversely affected emotion-focused (B = -0.284, p = 0.021), indicating that an increase in permissive parenting was associated with an increase in social support-seeking coping style but a decrease in emotion-focused coping. Uninvolved parenting also inversely affected social support-seeking coping (B = -0.244, p = 0.040), suggesting that an increase in uninvolved parenting was associated with a decrease in social support-seeking coping. These findings implied that late adolescents who perceived their parents as permissive may have relied more on peers for support but may have had weaker emotional regulation strategies.

In terms of parenting style to depressive symptoms, results showed that uninvolved parenting positively affected the physical (B = 0.479, p = 0.004), the emotional (B = 0.406, p = 0.001), the intellectual (B = 0.382, p = 0.001), and the spiritual (B = 0.456, p = 0.001) depressive symptoms of late adolescents. This suggested that higher perceptions of uninvolved parenting were associated with higher levels of depressive symptoms across several dimensions.

This was supported by Riany et al. (2021) and Dang et al. (2024), who found that parenting style influenced how adolescents sought support and managed emotions. Meanwhile, uninvolved parenting decreased social support-seeking (B = -0.244, p = 0.040), indicating reduced help-seeking behavior.

This aligned with Agbayani (2024) and Wang and Ci (2024), who found that lack of parental support led to withdrawal and weaker coping skills. For depressive symptoms, uninvolved parenting significantly increased physical, emotional, intellectual, and spiritual symptoms.

This was supported by Alberto et al. (2025) and Zhao (2024), who found that parental neglect was linked to higher depression and emotional distress. Puyat et al. (2025) also noted the rising prevalence of depression among Filipino youth. Overall, the results showed that parenting style strongly influenced coping and mental health, highlighting the importance of parental support and involvement.

Chapter 5
SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

This chapter is a summary of the findings, conclusions, and recommendations based on the results obtained in this study. It underscores the wider relevance of the results, places them in context with other scholarly

works, and provides possible directions for further study.

Statement of the Problem

This study aimed to determine the effects of parenting style on the depressive symptoms and to the coping mechanisms of adolescents.

Specifically, it sought answers to the following questions:

1. What is the demographic profile of the respondents in terms of:

1.1. Age

1.2. Household arrangement (Two-parent household or single-parent household)

1.3. Living arrangement (Living with parents or not)?

2. Which of the following parenting styles applies within the family of the respondents in terms of the following:

2.1. Permissive Parenting

2.2. Authoritarian Parenting

2.3. Achievement-Oriented Parenting

2.4. Uninvolved Parenting?

3. Which of the following depressive symptoms were experienced by the respondents in terms of the following:

3.1. Physical

3.2. Emotional

3.3. Intellectual

3.4. Spiritual

3.5. Social?

4. Which of the following coping mechanisms are used by the respondents in dealing with depressive symptoms in terms of the following:

4.1. Problem-focused

4.2. Emotion-focused

4.3. Social support–seeking

4.4. Avoidance?

5. Is there a significant difference in coping mechanisms and depressive symptoms experienced by the respondents when they are grouped according to their demographic profile?
6. What are the effects of different parenting styles on the coping mechanisms and depressive symptoms of the respondents?
7. Based on the findings of the study, what program can be made to promote healthy parent–adolescent relationships?

Summary of Findings

This study aimed to determine the effects of parenting styles on the depressive symptoms and coping mechanisms of late adolescents in Manila. The findings are presented according to the sequence of the Statement of the Problem.

1. Demographic Profile of the Respondents.

The respondents of the study were late adolescents aged 18 to 22 years old. The sample was equally distributed in terms of sex, consisting of 50 males and 50 females, and evenly represented across four barangays, with 25 respondents from each barangay. Most respondents belonged to a two-parent

household (67.0%) and were living with their parents (68.0%), indicating that the majority were still under direct parental influence.

2. Parenting Styles within the Family.

The findings revealed that respondents do not perceive their parents as having a single dominant parenting style. Instead, parenting styles were viewed as mixed, with characteristics of permissive, uninvolved, authoritarian, and achievement-oriented parenting observed. This suggests that adolescents interpret parenting behaviors differently based on their personal experiences and interactions within the household.

3. Depressive Symptoms Experienced by the Respondents.

Results showed that late adolescents most commonly experienced **physical (M = 2.70)** and **emotional (M = 2.60)** depressive symptoms. These were followed by intellectual and social symptoms, while spiritual depressive symptoms were reported at the lowest level. This indicates that depressive manifestations are more evident in physical and emotional aspects among the respondents.

4. Coping Mechanisms Used by the Respondents.

In dealing with depressive symptoms, late adolescents primarily utilized **emotion-focused (M = 3.08)** and **problem-focused (M = 3.04)** coping mechanisms. Social support-seeking coping was used less frequently, while avoidance coping was the least utilized. This suggests that adolescents tend to rely more on internal coping strategies rather than seeking help from others.

5. Significant Difference in Coping Mechanisms and Depressive Symptoms According to Demographics.

The findings revealed that most coping mechanisms and depressive symptoms did not significantly differ according to demographics. The highest p-value was observed in spiritual depressive symptoms according to age (F=0.123, p=0.974), while the lowest p-value was found in intellectual depressive symptoms according to household arrangement (t=2.115, p=0.037), which was significant. This indicates that household arrangement may influence the intellectual aspect of depressive symptoms among late adolescents.

6. Effects of Parenting Styles on Coping Mechanisms and Depressive Symptoms

The findings revealed that permissive and uninvolved parenting styles have significant effects on both depressive symptoms and coping mechanisms. Permissive parenting was associated with increased social support-seeking (B = 0.318, p = 0.009) but decreased emotion-focused coping (B = -0.284, p = 0.021). On the other hand, uninvolved parenting was associated with decreased social support-seeking coping (B = -0.244, p = 0.040) and increased depressive symptoms across physical, emotional, intellectual, and spiritual domains.

7. Proposed Program to Promote Healthy Parent–Adolescent Relationships

Based on the findings, the study proposes the implementation of seminars and programs involving both parents and adolescents. These programs aim to address the effects of permissive, uninvolved, and overly authoritarian parenting styles, while promoting awareness of depressive symptoms and encouraging the use of healthy coping mechanisms, particularly social support-seeking behaviors.

Conclusion

Based on the results of the study, the following conclusions were drawn:

The results of this research clearly show that late adolescents' perception of their parents' parenting style has a significant effect on their depressive symptoms and coping mechanisms. As an output, this research offers and suggests programs that may be beneficial for late adolescents.

1. ***What is the demographic profile of the respondents?***

The demographic findings showed that the late adolescents included in this study ranged from 18 to 22 years old. Most of these late adolescents belonged to a two-parent household arrangement and still lived with their parents.

2. ***Which of the following parenting styles applies within the family of the respondents in terms of the following?***

Late adolescents had various perceptions of their parents' parenting styles. They viewed these parenting styles differently. In general, late adolescents were not inclined to have a single perception of their parents' parenting style. For example, they perceived their parents as often permissive or uninvolved, while also perceiving them as authoritarian or strict achievement-oriented. This suggested that late adolescents viewed their parents in different ways.

These differing perceptions may have been attributed to their personal experiences, which allowed them to perceive their parents as both permissive and uninvolved, as well as authoritarian and strict achievement-oriented.

3. ***Which of the following depressive symptoms were experienced by the respondents?***

The findings of this research indicated that late adolescents had a tendency to manifest physical and emotional depressive symptoms. Fatigue, difficulty in sleeping, and changes in appetite were often experienced at the physical level, while emotional sensitivity, irritability, and loss of interest were observed at the emotional level.

At a lower level, late adolescents also experienced intellectual and social depressive symptoms. The former included difficulty concentrating to complete tasks and experiencing mental fog or confusion, while the latter referred to withdrawing or isolating themselves from interacting with others.

The overall results of the Likert scale showed that spiritual depressive symptoms were rarely experienced by the respondents. Under this category, late adolescents reported questioning their beliefs during difficult times, having difficulty trusting that things would eventually improve, and feeling confused about their life's purpose.

4. ***Which coping mechanisms are used by the respondents in dealing with depressive symptoms?***

Late adolescents also had various coping mechanisms in dealing with depressive symptoms. The results showed that late adolescents mostly used emotion-focused and problem-focused coping mechanisms. Their emotion-focused coping included calming and comforting themselves, especially during stressful situations, while their problem-focused coping involved thinking carefully before making decisions and solving their own problems.

Social support-seeking coping was used at a lower level, which involved reaching out to others during times of stress. Avoidance coping obtained the lowest result, which involved ignoring problems and pretending that such problems did not exist.

5. ***Is there a significant difference in coping mechanisms and depressive symptoms experienced by the respondents when they are grouped according to their demographic profile?***

Based on the statistical analysis of the respondents' data, the following conclusions are drawn regarding the significant differences in coping mechanisms and depressive symptoms when grouped by demographic profile:

The study concluded that there is generally no significant difference in the coping mechanisms and depressive symptoms experienced by late adolescents when grouped by age, household arrangement, or living arrangement. Statistical analysis revealed that the utilization of problem-focused, emotion-focused,

social support-seeking, and avoidance coping strategies remains consistent across these demographic profiles, as do the physical, emotional, spiritual, and social manifestations of depressive symptoms.

However, a significant difference was observed in intellectual depressive symptoms specifically regarding household arrangement ($t = 2.115, p = 0.037$). Late adolescents from single-parent households reported significantly higher intellectual symptoms, such as difficulty concentrating and mental fog, compared to those from two-parent households. Overall, while most psychological and adaptive experiences are uniform across the demographic spectrum, the cognitive impact of depression is more pronounced for those in single-parent domestic structures.

6. ***What were the effects of different parenting styles on the coping mechanisms and depressive symptoms of the respondents?***

The results showed that late adolescents who viewed their parents as permissive or uninvolved experienced effects on their depressive symptoms and on the way they coped with these symptoms.

In particular, late adolescents who were allowed by their parents to do whatever they wanted tended to seek support from their peers. The lack of clear behavioral boundaries may have been associated with poorer emotion regulation or control.

Similarly, late adolescents with uninvolved parents, or parents who did not care about their problems or were not readily available for them, may have had a lower capacity to seek support from others. In fact, the results also showed that this type of parenting may have resulted in various depressive symptoms, affecting their physical, emotional, intellectual, and spiritual aspects.

7. ***Based on the findings of the study, what program can be made to promote healthy parent–adolescent relationships?***

This research aims to initiate seminars for both parents and late adolescents and to work side-by-side with psychologists and counselors to address adolescents' perceptions of permissive and uninvolved parenting, including excessive authoritarianism. Information drives and campaigns regarding physical, emotional, and social depressive symptoms, as well as social support-seeking coping mechanisms, may be conducted to provide further help and assistance to late adolescents who feel detached from their parents' parenting styles.

Recommendations

Based on the conclusions of the study, the study's recommendations were drawn:

1. **Late Adolescents:** Late adolescents are recommended to improve their awareness of how parenting styles may affect their emotions and coping behaviors. This awareness can encourage them to seek support, develop healthy coping strategies, and improve their mental well-being. Late adolescents should have safe spaces for communication with parents, which is highly recommended. They are also encouraged to actively engage in peer support groups or school-based counseling services to better express their concerns.
2. **Parents and Guardians:** Parents and guardians should better understand, at their own level, what their parenting styles are and how such styles can influence their child's emotional health and coping mechanism. It is recommended that parents and guardians attend parenting seminars for late adolescents in order to avoid permissiveness, uninvolvement or detachment, and being overly authoritarian towards their adolescents. They may also practice open communication and consistent guidance at home to strengthen their relationship with their children.

3. **Parents and Late Adolescents:** Parents and late adolescents are encouraged to participate in family-centered programs, parenting seminars, mental health awareness activities, counseling sessions, and coping skills workshops. These programs may help improve communication, strengthen parent–adolescent relationships, promote emotional understanding, and develop healthy coping strategies to support adolescents' mental well-being.
4. **Guidance Counselors:** Guidance counselors are recommended to strengthen their role in promoting adolescent mental health by providing regular counseling sessions, mental health screenings, and intervention programs within schools. They should create a safe and confidential environment where students feel comfortable expressing their emotions and personal concerns. Guidance counselors may also design workshops and seminars that focus on coping strategies, emotional regulation, and building resilience among adolescents. In addition, they can collaborate with parents and teachers to ensure a holistic approach in addressing the mental health needs of students, particularly those who may be experiencing the effects of permissive or uninvolved parenting styles.
5. **School Administrators:** School administrators are recommended to support and implement school-based mental health programs that address the emotional and psychological needs of students. They may allocate resources for counseling services, training programs, and mental health awareness campaigns within the school. Administrators can also encourage the integration of mental health education into the curriculum to promote awareness of depressive symptoms and healthy coping mechanisms among adolescents. Furthermore, they should foster a supportive school environment by promoting open communication, inclusivity, and student well-being through policies and school activities that strengthen peer and teacher support systems.
6. **Student Nurses:** Student nurses needed to learn how to recognize the initial signs of depression that occurred in adolescents. Their clinical practice reached a higher level of effectiveness when they included mental health assessments because it enabled them to deliver complete patient care with precise treatment methods.
7. **Public Health Nurses:** It is recommended that public health nurses better understand the relationship between parenting styles, depressive symptoms, and coping mechanisms among adolescents. They may work hand-in-hand with psychologists who can effectively identify at-risk individuals, hence providing early support and intervention, especially towards depressive symptoms and proper coping mechanisms. Public health nurses may start with campaigns or information drives that target increased awareness of how poor parenting styles may have adverse effects on late adolescents. Public health nurses are also encouraged to attend seminars, not just on providing physical help to adolescent patients but also on providing support for their emotional well-being. They may also initiate school or community-based screening programs to monitor adolescents' mental health conditions.
8. **Barangay Officials:** Barangay officials are recommended to help strengthen the smallest unit of society, the family. This may be done by working particularly with health care professionals, including educators, counselors, and others. They may provide—or at the very least, encourage—programs such as "Family Events," "Bring Your Adolescents to Work or School," "Parent-Adolescent Sports Tournament," and many others. They may collaborate with the education sectors, such as public schools or local colleges, to initiate such drives. In addition, they may allocate resources or create policies that support mental health programs for adolescents and their families.
9. **Researchers:** Researchers are recommended to ensure the accuracy, reliability, and ethical integrity of their studies when examining sensitive topics such as parenting styles and adolescent mental health.

They should continue to explore innovative methods and approaches in analyzing the relationship between parenting styles, depressive symptoms, and coping mechanisms. Researchers may also consider collaborating with mental health professionals to enhance the validity and applicability of their findings. Additionally, they are encouraged to disseminate their research findings to relevant stakeholders, such as schools, communities, and health institutions, to contribute to evidence-based practices and interventions that support adolescent well-being.

10. **Future Researchers:** This study serves as a valuable baseline for future scholars investigating the intricate intersections of parenting styles, depressive symptoms, and adolescent coping mechanisms. By providing a foundational reference, this research encourages further exploration into diverse variables, broader age demographics, and varied socio-cultural settings to deepen the collective understanding of youth mental health. Specifically, future inquiries could expand upon this work by examining the influence of parenting on anxiety and stress, the correlation between family support and coping strategies among senior high school students, or the holistic impact of caregiving styles on both emotional well-being and academic achievement. These potential avenues of study will be essential in developing more comprehensive interventions for adolescent development.

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