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Exploring The Tendency Of Depression As A Consequence Of Tolerance To Frustration In Children Of Marginalized Socio-Economic Status

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Abstract

Nowadays psychological worries like depression, frustration and ways of coping with them are concerns which are often encountered in daily life. The most affected target group remain children and social contexts of high vulnerability. They often have to deal with stressors that can be potential threats to their well-being and healthy development.

The sample of this study is composed of a group of 100 children from vulnerable groups of families in need and with socio-economic assistance at the age of 9-12 years (M = 11.08; SD = 1.25) of which 64 girls and 36 boys . The sample was selected in a non-probabilistic manner due to the access of the participant. Significant variables of Frustration Tolerance and Depressive Symptomatology were measured with valid and reliable instruments as the Infantile Depression Inventory (CDI) and the Frustration Tolerance Scale (ETF).

The results showed that there is a positive, strong and stable relationship between the two variables (r_w = .. 91) of frustration and depression tolerance and a moderate relationship in dysphoria (rë = .67) and negative self-esteem ($r_ë$ =. .47). The Pearson indices also showed that girls exhibited higher scores on all group variables compared to boys. The differences in depressive symptomatology and gender-related frustration tolerance are not significant enough to influence their specific weigh scale (PSest> .56).

Although genuine Albanian studies on the depressive tendencies of low socio-economic status children are lacking, other studies have shown that children experience depression, anxiety and stress at moderately high levels today compared to previous years.

Keywords: depression, tolerance, frustration, children, socio-economic status

Introduction

Del Barrio (2013) defined depression as a state of mood characterized by the presence of sadness and lack of getting pleasure from life. From a descriptive point of view, the individual with this diagnosis exhibits an affective framework of fatigue, despair, melancholy, inability to concentrate, lack of enthusiasm and fulfillment of his executive duties as thoughts of inadequacy and the belief that everything goes wrong and there is no solution (Del Barrio, 2013; Abello, Cortés, Barro, Mercado & Solano, 2014). Based on the definition of the depressive construct according to the DSM-V (American Psychiatric Publishing, 2021) on Depression, an individual is considered such when he exhibits at least 5 symptoms during the last two weeks: depressed mood, loss of interest, increase or loss of weight

gain, hypersomnia or insomnia, motor slowdown or agitation, fatigue, feelings of guilt or worthlessness, decreased ability to concentrate, and occasional thoughts of death. If these symptoms appear in lesser duration, then they are associated with transient emotional disorders that are differential from depressive disorder (Del Barrio, 2000). In populations of children or adolescents who also have behavioral and social difficulties, they exhibit characteristic symptoms of depression such as loneliness, boredom, hopelessness, withdrawal, despair, opposition, disobedience, anger, anxiety, and school performance problems (López, et al. et al. 2010; Del Barrio, 2013).

It is very important to note that childhood depression carries a polymorphic manifestation and can be masked by various psychopathological conditions (Tochoy & Chaskel, 2013). Studies have shown that childhood depression can be categorized according to course (unipolar and bipolar), severity, causes, onset and duration, age and diagnostic difficulty (Del Barrio, 2013). Considering the course of the problem, a distinction is made between depression with unipolar and bipolar episode; the first is regular, of medium duration, in case a good intervention has been made on the issue. Bipolarity represents a course of change from the pole of depression on the one hand and another mania alternating between time (Garre et al., 2010; Del Barrio, 2013). Based on the severity ,a distinction is made between dysthymic disorder and major depression, where the symptoms, although milder, last longer; while in the case of major infantile depression they are present and with more numerous and more intense symptoms (idem). The causality of depression is divided into exogenous or endogenous, where, in exogenous depressions, the cause is related to negative psychosocial events; while in the endogenous ones there is no apparent reason for the occurrence of the disorder and it is often thought of as idiopathic typology. Depending on the mode and frequency of occurrence, the symptoms of depression can be divided into acute and chronic (idem).

Depression is generally exogenous, and when it begins, the individual perceives a change, which is evident and easily detected (Del Barrio, 2013). The most frequent changes are in the form of being (identity), in bodily and mental functions. In the changes of being, a child can go from a state of joy and pleasure to insecure and doubtful, seek to be alone, avoid expressing love, and be rebellious and nervous. In changes in bodily functions, the child exhibits changes in sleep, food routine, complains of pain, is tired, and experiences marked weight loss. Relating the changes in mental functions, the child often forgets things, may exhibit difficulty concentrating, and his academic performance is reduced (Del Barrio, 2013; Abello et al., 2014).

Infantile Depression

Research of Ahlen and Ghaderi (2017) showed that although the concept of depression can be considered as multi-factorial it can be evaluated objectively through the presence of two main factors: dysphoria and negative affect. In their study Weinberg et al. (1973), initially argued that infantile depression is characterized by factors of dysphoria and self-critical thinking that was later interpreted as negative self-assessment in the European versions of Del Barrio and Carrasco (2004) Infantile Depression Questionnaire. Arévalo (2008) further argued that infantile depression can be evidenced through factors of dysphoria and negative self-esteem. Historically, the causes of infantile depression have been seen as related to the interaction of environmental and personal factors (Garre et al., 2010; Del Barrio, 2013; Tochoy & Chaskel, 2014). Various factors are focused on personal aspects, whether related to biological vulnerability among first-degree relatives with depressive disorder, confirming the fact that the level of depression is higher in

children with parents who have had a history of this disorder (Garre et al., 2010). Based on genetic predisposition, psychosocial stress may increase the likelihood, both in children and adults, of suffering from depression (Tochoy & Chaskel, 2014). In relation to the environmental factors associated with depression in children and adolescents, they are found in the family as the main entity for the etiopathogenesis of depression, in the manner of manifestation of affective cold, lack of cohesion, excessive criticism and desire for control, losses, separations, Parental psychiatric illnesses, socioeconomic factors, increased stressful experiences, and experiencing natural disasters or war situations are risk factors for developing depressive disorder in childhood (Garre et al. 2010; Tochoy & Chaskel, 2014). School, where the child spends most of the time, represents another risk factor for infantile depression such as strict teaching typology, high demand for accountability and difficulties in peer relationships (Garre et al. 2010; Del Barrio, 2013 ; Tochoy & Chaskel, 2014).

The following is a summary of the main features of Infantile Depression according to age typologies:

Table 1. Characteristics of Infantile Depression according to age-groups

Areas	**Preschool age 3-5 y.o.**	**School age 6-12 y.o**	**Adolescence 13-18 y.o**
Mood	Irritation: anger and rage, destructive behavior. Alteration. Sadness.	Sadness	Sadness Alteration Irritation With bad mood, rage, rebellion
Interests	Reduce playing time with friends	Annoyance	Passivity
Eating	Bizarre behavior: state of anxiety Food problems Loss of appetite Do not gain weight Weight loss Binge eating	---	Loss of appetite Slight weight gain Weight loss Excessive eating Obesity
Sleep	Nightmares Terror nocturnal Difficulty falling asleep Insomnia	--	Insomnia Hypersomnia
Motor skills	Reducing physical activity: running, cycling, etc.	Hypomobility Agitation	--
Enerhy	--	--	Fatigue Loss of energy

Self-esteem	Decreased self-esteem Fear of punishment	Low self-esteem Self-contempt Self-aggressiveness	Concern about body image Decreased self-esteem
Feelings Emotions	Fear of failure	Self-critical Feelings of guilt	Self-contempt
Cognitive Dysfunctions	--	Concentration issues	Reduction of abstract thinking Indeterminacy
Suicidal ideation	Self-aggression: head kicking, scratching, spinning objects ... Increased risk of lesions	Ideas, plans, suicide attempts	Ideas, plans, suicide attempts Violent suicide

*Source: Synthesis processing of authors

Tolerance to Frustration

Frustration is known as an emotional state that occurs when the individual is hindered in achieving his goals (Coon & Mitterer, 2007; Jibeen, 2012). Tolerance, on the other hand, is related to the ability to withstand or resist something. Wilde (2012) described tolerance as the ability or interest to persevere in an activity despite the unpleasant feelings that may associate it. Tolerance to frustration can also be understood as an emotional state developed by the sudden suppression of positive reinforcers (Kamentzky et al., 2009; Cueny et al., 2013). Tolerance to frustration is primarily related to the individual's ability to resist adverse and stressful situations; it also means the ability to control an impulse (Oliva, et al., 2011; Wilde, 2012). Thus, frustration appears as an adaptive reaction when it is perceived that the situation is out of control and takes an unexpected direction; in order to maintain psychological well-being, the brain must exercise control over reality and in its absence, develop frustration which is a well-being rehabilitation mechanism (Ortuño, 2016). Tolerance to frustration is also related to other factors such as anxiety and the evaluation of internal resources such as inability to cope with a difficult situation by creating a change in personal goals and desires of the individual (Dos Santos & Benevides, 2014; Ortuño, 2016) . This activates the internal processes of justification and denial where a new reality is sought to be created to accommodate desires or to make others responsible for personal desires (Dos Santos & Benevides, 2014; Ortuño, 2016). Individuals with a high tolerance for frustration are perceived as able to control stressful situations because through a repertoire of behaviors that allow them to cope with contradictions and control strong emotions such as despair and anxiety (Oliva et al., 2012). Other authors have argued that tolerance and frustration create in the child sadness and resentment (Martinez & Bouquet, 2007; Ortuño, 2016), develop a process of pain where there is a part of loss, such as sadness and another part that is the perception of loss, injustice and anger (Ortuño, 2016). Coon and Mitterer (2007) have distinguished between two types of frustration: external frustration and personal frustration, where the former relies on external conditions from the individual that prevent him from achieving his goal and are normally associated with others, with failures, rejections and losses. External frustration that can be social or

antisocial and involves interactions with others and objects adding to this feeling as a function of the need, intensity, or significance of motivation. Personal frustration relies on personal characteristics that hinder the achievement of the goals they have set (Coon & Mitterer, 2007; Jibeen, 2012). Frustration is a very common feeling in childhood (Ortuño, 2016; Ventura-León et al. 2018) and especially in children with social health problems because of their difficulties for self-control and self-regulation (Barkley, 2011). Studies have therefore argued the importance of the association between emotional regulation and frustration tolerance and especially the prefrontal lobe of the cerebral cortex as a potential region for the regulation of emotions in frustration (Perlman et al. 2014; Barkley, 2011; Depues et al. 2010).

Method and Procedures

Purpose

The purpose of the present study is to explore the association that exists between the presence of frustration tolerance and depressive symptomatology in childhood.

Hypothesis:

For the development of the results of this study, two hypotheses were raised:

H0 = There is no relationship between frustration tolerance and childhood depressive symptomatology.

H1 = There is a positive and significant relationship between frustration tolerance and depressive symptomatology in childhood.

Research Variables:

Based on the purpose and hypotheses , the two main variables of the present study were defined: a. Tolerance to frustration and b.Depressive Symptomatology. Because the impact of socioeconomic status on increasing the tendency of depressive symptomatology has been studied and argued by many other studies(Strulik 2019; Freeman et al.2016; Fletcher et al. 2013; Lépine & Briley , 2011; Jo et al. 2011; Muntaner et al. 2004; Cuijpers et al.2004; Kaplan et al.1987), this factor has not been considered as a variable in the recent research .

Sample

The sample of the present study is composed of a group of 100 children from vulnerable groups of families in need and with socio-economic assistance aged 9-12 years (M = 11.08; SD = 1.25) of whom 64 girls and 36 boys . The sample was selected in a non-probabilistic manner due to the access of the participants.

Research design

This study is of correlation typology because it seeks to examine the relationship between two variables through a correlation coefficient (Alarcón, 2013).

Instruments

For the purposes of this study, two types of questionnaires were used: 1) Kovacs Infantile Depression Questionnaire and 2) Frustration Tolerance Rate (Ventura - León et al., 2018) instruments aimed at researching the depressive experience and frustration tolerance in children. Both assessment instruments were adapted to the characteristics of the group of children from families in need, as the sample-target of this study. The answers received were of alternative answers; a form that allows the processing and evaluation of the dimensions in analysis.

Socio-demographic data were collected to enable further interpretation of the results. These data included the description of the sample in several demographic variables such as age, gender,

family, developmental history, socio-economic status, possible medical diagnoses.

a. Infantile Depression Inventory (CDI) Kovacs (2004) for children and adolescents aged 8-16 years to assess the presence of depressive symptomatology or a total depressive disorder. The instrument consists of 27 statistically standardized statements (items), distributed in scores from 0 to 2 (0 = low symptomatic index; 1 = medium index; 2 = high symptomatic index). The questionnaire is divided into two dimensions, dysphoria and self-assessment, where the sum of both gives the total score of depressive symptomatology (Olivero, 2017). Total scoring is further divided into levels: high level: more than 81%; moderate: from 57-75%; easy: 36-52% and without depression: from 0-25%. CDI holds instruments of stable internal consistency α = .918 in Cronbach alpha and .755 - .777 in Guttman coefficient. It also has a good correlation
(rho = .734) in the analysis between items (León, 2013). The validity of the measurement criteria has a positive correlation of .425 (p = depression in adolescents) and the validity of the construct between the functional analysis that results in 2 factors related to the items: negative self-esteem and dysphoria.
b. The Frustration Tolerance Scale (FTS) developed by Ventura et al. (2018). This instrument adapted in the child version for the purpose this study consists of eight itemas with Likert typology response alternatives from 1 to 5 (Never; Rarely; Sometimes; Often; Always). European standardization of the test originally created by Oliva et al. (2011) was conducted with 796 children aged 8-12 years, with individual or collective application. Exploratory factor analysis showed a scale unidimensionality associated with the eight items having only one tolerance and frustration factor at about 48.68% of construct variance. The reliability of the frustration tolerance variable calculated through the omega coefficient has shown a good equilibrium (ω = .80; IC = 0.77, .82).

Data administration

For the collection of information in the present study, a formal letter of introduction was sent to the Directorate of Social Services in Albania from where we obtained the authorization to contact the families resulting in the economic-social assistance fund from whom 100 children aged 9-12 were selected. The families were informed about the Informed Approval process in cooperation with the social worker and the psychologist of the Social Service Directorate who also helped in the administration of the questionnaires. The time of administration of the questionnaires for the children varied between 15-20 minutes.

Data analysis

The statistical program JASP and R. were used to analyze the data of the present study. First, the distribution of data through the Shapiro-Wilk coefficient was examined, which showed an abnormal distribution, so a more complete measurement like Pearson Winzor was used (Tuğran et al. 2015) that has some advantages in small samples (Ventura-León, 2020) where, $r_w \geq$ .10 low $r_w \geq$ .30 average; $r_w \geq$ .50 high (Cohen, 1988). The Man-Whitney U test with probability of superiority (PSest) was used for comparisons as an instrument influencing effects (Ventura-León, 2016): Low (PSest $\geq$ .56); Medium (PSest $\geq$ .64) and High (PSest $\geq$ .71).

Ethical Issues

Based on the approval of the Ethics Commission at the Order of the Psychologist of Albania, we started collecting data on the juvenile subjects in the study. A Detailed Informed Approval was presented to parents regarding the purpose, research design, general questionnaire guidelines, and expected treatment outcomes. At the end, a complete copy of the treatment results report was handed to each parent participating in the study.

The protection of the confidentiality and anonymity of the subjects was carried out according to the ethical criteria of the protection of privacy where subjects were informed about the treatment of personal data of children and minors. The parents were informed that the collected data would be used only for research purposes respecting the principle of anonymity and confidentiality according to the European Act on Protection of Privacy and Personal Data.

Results

The following table presents descriptive statistics of the study variables: tolerance to frustration and infantile depression. The indices show a total arithmetic mean equal to M = 5.60 in M = 16.90 in both variables. In variability it is seen that Depression scores maintain a high dispersion (SD = 8.00), while, Dysphoria has the lowest levels of variability. It is also seen that both variables maintain a positive asymmetry in the distribution which means that there is a low tendency towards scoring. Kurtosis indices show a higher amount of mean grouping in the negative self-esteem variable.

Table 2 Descriptive statistics of both Dimensions

Variable	Trimmed	SD	g1	g2	%
Tolerance	16.90	5.84	.44	.21	50
Dysphoria	4.60	4.01	1.25	1.54	20
Negative self-esteem	4.63	5.26	1.45	2.82	23
Depression	10.33	8.00	1.28	3.24	25

Note:Trimmed=summed mean ;SD=standard deviation ;g1=asymetrics ;g2=curtosis;%= accumulative percent

The following table introduces the Pearson correlations between study variables. As it can be deduce, a relationship between tolerance and depression is seen that is strong and positive (r_w = .91).

In terms of depression dimensions, dysphoria reveals the highest correlation (r_w = .67) compared to negative self-esteem (r_w = .47) and both have a moderate correlation with each other.

Table.3 Correlations between Tolerance to Frustration, Depression and the dimensions between them (n=100)

	Tolerance to Frustration
Depression	.91
Dysphoria	.67

Negative self-esteem	.47

The following table summarizes the comparison between the variables in the study in relation to gender. The indices showed that girls exhibit higher scores on all group variables compared to boys; although the magnitude of differences between groups does not have a high specific weight it shows an effect of frustration tolerance on depressive symptomatology (PSest> .56).

Table. 4 Comparison between depression and gender tolerance

Dimensions	Female (n=64)	Male (n=36)	U	PSet
Dysphoria	39	26.76	241.56	.29
Negative self-esteem	41.63	25.93	198.45	.25
Depression	40.35	26.01	217.65	.26
Tolerance to Frustration	33.56	32.01	370.23	.46

Discussion

The aim of this study was to determine the relationship between tolerance to frustration and depressive symptomatology of children of the lower socio-economic status. The results showed that there is a positive, strong and stable relationship between the two variables (r_w = .. 91) of tolerance to frustration and depression and a moderate relationship in dysphoria (r_w = .67) and in negative self-esteem (r_w = .47). These findings are in line with the hypothesis of the study on the inter-relationship between frustration tolerance and depressive symptomatology. Thus, sadness, dissatisfaction with life, feelings of inadequacy, and negative self-esteem are clinically and statistically related to the ability to cope with or resist a problematic event in school-age children (Del Barrio, 2013; Wilde, 2012). This relationship has been proven theoretically by several studies which have replicated that low tolerance to frustration, develops sadness and anger in the child (Seymour & Miller, 2017; Garaigordobil et al. 2017; Ortuño, 2016; Meinzer et al. 2014; Hames et al. 2013; Martinez & Bouquet, 2007). The results of this study are in line with the argument of the Spanish authors Ortuño (2016) and Ventura-León et al. (2018) claiming that children of marginalized socio-economic contexts have a lower tolerance to frustration and increased depressive symptomatology as they have difficulty balancing self-regulation and self-control (Depues et al., 2010). These findings are in line with previous studies that noted the fact that volume reduction in areas of prefrontal regions affects self-control and self-regulation and thus tolerance to frustration and depressive symptoms (Perlman et al., 2014; Barkley, 2011). The impact of socioeconomic conditions on the reduction of frustration tolerance and the onset of depressive symptomatology has been replicated by various studies and understanding the impact of this specific variable was not an aims of the present research (Yang et al. 2021; Jannat-Khan et et al. 2020; Krsteska & Pejoska, 2013; Grace & O'Brien, 2003; Lorant et al. 2003; Lorant et al. 2007; Dohrenwend et al. 1992). Emotional aspects such as imbalance and negative self-esteem are the first symptoms seen in a child's academic performance when reflecting frustration and depressive symptoms (Barkley, 2011; Franco, 2012; Orjales, 2012; Mrug et al., 2012; López & Romero, 2013; Cuellar, 2015) . Therefore, it can be referred that there is an

emotional disposition that after being activated by changing the level of tolerance to frustration is associated with feelings of inadequacy and dysphoria, socio-emotional difficulty and school environment (Barkley, 2011; López et al., 2013; Seymour et al., 2016). To understand the relationship between gender and tolerance to frustration and depressive symptomatology in children we used Pearson rho correlation coefficients. The indices showed that in addition to girls having higher scores in all variables, in relation to boys, the difference is not sufficient to show a certain effect on the increase of depressive symptomatology in this population group (PSest> .56). These results are partly in line with the research hypothesis in the sense that gender does not significantly affect the presence of feelings of sadness, inadequacy, and the ability to cope with an adverse event (Del Barrio, 2013; Wilde, 2012). Such data are in line with various studies conducted on the association of depressive symptomatology in vulnerable and marginalized groups (Heberstick et al. 2016; Otte et al. 2016; Cao et al. 2013; Spinelli et al. 2012; Yanku, 2010; Van de Velde, 2010; Kessler, 2003) that have argued that the scores of depressive symptomatology, tolerance frustration and gender are low, with occurrence in about 24%, where the majority of individuals do not report mood problems.

Conclusions

In the current research we focused on whether tolerance to frustration has a clinically and statistically significant impact on the occurrence of depressive symptomatology in children of marginalized contexts and with low socio-economic level. Numerous researchers have highlighted the role of coping with frustration in increasing the tendency for depressive symptomatology (Seymour, 2017; Mahon et al.2007).

The indices showed us a relationship between tolerance and depression that is strong and positive (r_w = .91) while in the dimensions of depression, dysphoria carries the highest correlation (r_w = .67) compared to negative self-esteem (r_w = .47). The Pearson indices also showed that girls exhibited higher scores on all group variables compared to boys. The differences in depressive symptomatology and gender-related frustration tolerance are not significant enough to influence their specific weight scale (PSest> .56). This means that frustration tolerance and the onset of depressive symptoms are not "exclusive" to a particular gender, although studies have shown that women have a higher prevalence of depression than men (Zhao et al.2020; Harkness et al. 2010; Young et al. 1990).

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