

## ORIGINAL ARTICLE

# Cognitive Emotion Regulation, Social Support, and Depressive Symptoms in Late Adolescence: A Mediation Analysis

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## ABSTRACT

**Introduction:** This study explored how perceived social support influences the link between cognitive emotion regulation (CER) strategies and depressive symptoms among Malaysian late adolescents and emerging adults. **Methods:** Participants were 178 individuals aged between 18 and 25 years who completed an online survey. The instruments used included the Cognitive Emotion Regulation Questionnaire (CERQ), the Multidimensional Scale of Perceived Social Support (MSPSS), and the Beck Depression Inventory-II (BDI-II). **Results:** Correlational findings revealed that maladaptive CER strategies, specifically blaming others, catastrophizing, self-blaming, and rumination, were significantly associated with higher depression scores. For adaptive strategies, both putting events into perspective and acceptance exhibited positive associations with depression, whereas positive reappraisal showed an inverse relationship. Higher perceived social support was linked to lower depressive symptoms. Mediation analyses further indicated that social support partially explained the relationships between acceptance, putting into perspective, and depression. **Conclusion:** These findings suggest that fostering effective emotion regulation strategies alongside improving perceived social support could help mitigate depressive symptoms in adolescents. Longitudinal research is recommended to clarify causal relationships and guide the development of preventive or therapeutic programs. *Malaysian Journal of Medicine and Health Sciences* (2026) 22(SUPP2):87-94. doi:10.47836/mjmhs.22.s2.12

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## INTRODUCTION

Late adolescence represents a critical developmental period in the transition to adulthood, during which individuals are required to adapt to new academic, social, and cultural demands. These shifts are often accompanied by psychological stress which may exceed available coping resources and increase emotional vulnerability. This vulnerability became particularly pronounced during the COVID-19 pandemic, as disruptions to conventional learning environments intensified experiences of isolation, uncertainty, and academic pressure worldwide. In Malaysia, the pandemic further exacerbated existing mental health concerns among adolescents, with evidence indicating a substantial increase in depressive and anxiety symptoms during and following the pandemic period (1, 2).

Depression among Malaysian adolescents is not a new phenomenon; however, its escalating prevalence

highlights a pressing public health concern. Before the pandemic, approximately one-third of Malaysian adolescents reported experiencing depressive symptoms (3, 4), with more recent estimates suggesting that over half of adolescents, particularly university students are now affected (1). Despite these alarming trends, there remains limited empirical understanding of the psychological mechanisms that may protect adolescents from depression during this vulnerable developmental stage. Specifically, it is unclear how individual-level coping processes, such as cognitive emotion regulation strategies, interact with interpersonal resources, such as perceived social support, in shaping depressive outcomes. Addressing this gap, the present study examines the relationships between cognitive emotion regulation strategies, perceived social support, and depressive symptoms among Malaysian late adolescents and emerging adults.

Cognitive emotion regulation (CER) strategies represent a crucial psychological resource for coping with emotionally charged experiences. These strategies involve deliberate cognitive processes through which individuals manage and respond to situations that evoke strong emotions (5). CER can be broadly classified as

either adaptive or maladaptive. As outlined by (6), adaptive forms include acceptance, planning-focused refocusing, positive redirection of attention, positive reappraisal, and viewing events into a wider context. In contrast, catastrophizing, self-blaming, attributing fault to others, and rumination are identified as maladaptive approaches. Empirical evidence has repeatedly associated maladaptive strategies with elevated depressive symptoms (7, 8). In the Malaysian context, evidence suggests CER strategies play a considerable role in adolescents mental health, influencing both well-being and vulnerability to stress (9, 10).

Social support is another key factor influencing mental health outcomes. Assistance and encouragement provided by family, spouses, and close acquaintances have been shown to serve as a protective buffer against the onset and continuation of psychological difficulties, including depression (11, 12). Social support provides emotional support and reassurance and enhances coping abilities by promoting adaptive responses to stress. Previous studies have shown that adolescents with higher perceived social support have been found to report better psychological well-being, greater resilience, and fewer depressive symptoms (13, 14).

The dynamic interplay between CER and social support presents a meaningful pathway for understanding depression especially in adolescents. Perceived social support can serve as an intermediary between CER strategies and depressive symptoms. It may strengthen the benefits of adaptive strategies while potentially reducing the negative impact of maladaptive ones. In this context, mediation implies that the influence of CER strategies on depression is at least partially explained by the degree of perceived social support (15). Emerging research supports this view and provides evidence that adaptive CER techniques combined with strong social support can improve emotional regulation and reduce negative mood states (16), while poor social support may amplify the adverse effects of maladaptive strategies (17).

This study is anchored in the transactional model (stress-coping) (18) and social support theory (19). Within the transactional framework, psychological outcomes are understood as the result of individuals' cognitive appraisals of stressors and the coping strategies that they employ in response. In the present study, cognitive emotion regulation (CER) strategies are conceptualized as intrapersonal coping processes that reflect how individuals manage and regulate emotional responses to perceived stressors. Social support is positioned as an external coping resource that can influence secondary appraisal by shaping individuals' perceived ability to manage stress. Through this interaction, social support may enhance adaptive regulation strategies or buffer the impact of maladaptive strategies on mental health outcomes. Accordingly, this study examines

the associations between cognitive emotion regulation strategies, perceived social support, and depressive symptoms among Malaysian late adolescents and emerging adults, and further investigates whether social support functions as a mediating mechanism within the transactional stress-coping framework.

## MATERIALS AND METHODS

### Participants and Sampling

The participants comprised Malaysian late adolescents and emerging adults aged 18 to 25 years who were enrolled in public and private higher education institutions. Although late adolescence is commonly defined as spanning ages 18 to 21, the present study included individuals up to age 25 to reflect the extended transition to adulthood frequently observed within the Malaysian sociocultural context, where prolonged educational engagement and delayed entry into full-time employment are common. Eligibility criteria included Malaysian citizenship and sufficient proficiency in the English language to comprehend and complete the study measures. Prior to data collection, ethical clearance was obtained from the JEPeM-USM Board (Approval code: USM/JEPeM/KK/23100785).

The sample size requirement was estimated using G\*Power version 3.1.9.4. Based on a small effect size ( $f^2 = 0.02$ ), a statistical power level of 0.80, and a significance threshold of  $\alpha = 0.05$ , a minimum of 485 participants was needed. Recruitment was carried out through convenience sampling, primarily using online channels and social networking platforms. Following eligibility screening, data from 485 participants were retained for analysis.

### Research Design and Procedure

In order to analyze the interplay between cognitive emotion regulation, social support, and depression, this study applied a correlational research design among late adolescents and emerging adults in Malaysia. A correlational approach was utilized given the study's objective to explore associations without manipulating, thus allowing for the analysis of natural patterns in real-world settings (20, 21).

Data collection was conducted using a self-administered online survey distributed through a combination of university-affiliated social networking platforms and general social media platforms targeting undergraduate students. Participants provided informed consent before completing the questionnaire, which included demographic items along with three standardized measures.

A preliminary pilot test was carried out with 30 participants to evaluate the measurement reliability of the instruments. The resulting Cronbach's alpha values, which ranged between .72 and .95, reflected strong

item-to-item consistency. Data collection proceeded until the target number of participants was reached. All responses were then reviewed based on predetermined eligibility rules prior to being included in the analysis.

### Measures

This study utilized standardized self-report instruments to evaluate cognitive emotion regulation strategies, perceived social support, and depressive symptomatology.

#### ***Cognitive Emotion Regulation Questionnaire (CERQ)***

The Cognitive Emotion Regulation Questionnaire (CERQ) consists of 36 self-report items assessing nine cognitive coping strategies used in response to stressful or negative life events (6). These strategies include self-blame, acceptance, rumination, positive refocusing, refocus on planning, positive reappraisal, putting events into perspective, catastrophizing, and blaming others. Each item is rated on a 5-point Likert scale (1 = almost never to 5 = almost always). Subscale scores were calculated by summing item responses within each strategy, with higher scores indicating greater use of the respective cognitive emotion regulation strategy. In line with established classifications, acceptance, refocus on planning, positive refocusing, positive reappraisal, and putting events into perspective were categorized as adaptive strategies, whereas self-blame, rumination, catastrophizing, and blaming others were categorized as maladaptive strategies. In the present study, the CERQ subscales demonstrated acceptable to excellent internal consistency, with Cronbach's alpha values ranging from .72 to .95.

#### ***Multidimensional Scale of Perceived Social Support (MSPSS)***

Perceived social support was measured using the Multidimensional Scale of Perceived Social Support (MSPSS), a 12-item instrument assessing support from family, friends, and significant others (22). Items are rated on a 7-point Likert scale, with higher scores reflecting greater perceived social support. Subscale scores were calculated by averaging responses for each support source, and an overall perceived social support score was derived by averaging all 12 items. Higher scores indicate stronger perceived social support. The MSPSS demonstrated high internal consistency in this study, with Cronbach's alpha coefficients ranging from .92 to .95 across subscales.

#### ***Beck Depression Inventory-II (BDI-II)***

Depressive symptoms were assessed using the Beck Depression Inventory-II (BDI-II), a 21-item self-report measure evaluating the severity of depressive symptoms over the past two weeks (23). Each item is rated on a 4-point scale ranging from 0 to 3, yielding a total score between 0 and 63, with higher scores indicating greater depressive symptom severity. In the present study, BDI-

II total scores were treated as a continuous variable for statistical analyses. Severity categories (minimal, mild, moderate, and severe) were used for descriptive purposes only. The BDI-II demonstrated high internal reliability in this sample (Cronbach's  $\alpha = .93$ ).

### Data Analysis

All statistical analyses were performed using IBM SPSS Statistics (Version 27.0). Reliability testing for each measurement scale and subscale was undertaken using Cronbach's alpha, applying a threshold of .70 as the criterion for acceptable consistency. Table 1 presents the reliability coefficients for each scale and subscale. Descriptive statistics were produced to outline participants' demographic profiles.

**Table 1: Internal reliability of Cognitive Emotion Regulation Strategies, Social Support, and BDI-II**

Scale	Cronbach's Alpha ( $\alpha$ )
CERQ Self-Blame	.89
CERQ Acceptance	.76
CERQ Rumination	.85
CERQ Positive Refocusing	.72
CERQ Refocus on Planning	.86
CERQ Positive Reappraisal	.94
CERQ Putting into Perspective	.80
CERQ Catastrophizing	.85
CERQ Blaming Others	.95
MSPSS Social Support Score	.95
MSPSS Significant Others	.94
MSPSS Family	.92
MSPSS Friends	.93
BDI Score	.93

To explore variable associations, Pearson's correlation analysis was applied to cognitive emotion regulation strategies, perceived social support, and depression scores. The potential mediating function of social support was subsequently examined through multiple linear regression, complemented by mediation testing with the PROCESS macro (24).

### Assumption Testing

Before performing the regression analysis, diagnostic tests were run to confirm that the assumptions of linearity, homoscedasticity, and normality were met. Visual inspection of scatterplots and normal probability plots indicated that the assumptions were fulfilled. The presence of multicollinearity was evaluated through Variance Inflation Factor (VIF) and tolerance calculations. All values were found to be within acceptable boundaries (VIF < 10; Tolerance > .20). Two cases were identified as outliers based on standardized residuals greater than  $\pm 3$ , but did not significantly affect the overall model fit.

The multiple regression model demonstrated a

statistically significant overall fit ( $F(12,472) = 9.85, p < .001$ ), explaining 41.7% of the variance in scores on the depression scale (adjusted  $R^2 = .38$ ). The Durbin-Watson statistic (1.45) suggested no autocorrelation in the residuals.

**RESULTS**

**Correlation between Cognitive Emotion Regulation Strategies and Depression**

Correlational analysis using Pearson’s  $r$  was applied to examine the relationships between cognitive emotion regulation (CER) strategies and depression. As anticipated, maladaptive CER strategies exhibited positive associations with depressive symptoms. In particular, self-blame was moderately correlated with depression,  $r = .483, p < .01$ , as was catastrophizing,  $r = .482, p < .01$ . Rumination also showed a moderate positive correlation,  $r = .398, p < .01$ , while blaming others demonstrated a weaker but significant positive relationship,  $r = .295, p < .01$ . The full set of correlation coefficients for each CER strategy is presented in Table II.

**Correlation between Social Support and Depression**

Pearson’s correlation analysis indicated a significant inverse relationship between overall perceived social support and depressive symptoms,  $r = -.259, p < .01$ , indicating that respondents who perceived higher levels of support have a higher tendency to report fewer depressive symptoms.

When the subscales were examined separately, family support showed the strongest negative correlation with depression,  $r = -.309, p < .01$ , followed by support from friends,  $r = -.197, p < .01$ , and support from significant others,  $r = -.181, p < .01$ . The findings imply that having strong social support, with family support being especially influential, could play a role in safeguarding individuals from depressive symptoms. The complete correlation coefficients for the overall scale and each subscale are presented in Table III.

**Table II: Pearson’s Correlation between CERQ Subscales and BDI-II Total Scores**

Variables	1	2	3	4	5	6	7	8	9	10
1. BDI-II Scores										
<i>Maladaptive CER Strategies</i>										
2. CERQ Self-Blame	.483**									
3. CERQ Rumination	.398**	.592**								
4. CERQ Catastrophizing	.482**	.523**	.446**							
5. CERQ Blaming Others	.295**	.428**	.325**	.599**						
<i>Adaptive CER Strategies</i>										
6. CERQ Acceptance	.229**	.586**	.688**	.298**	.390**					
7. CERQ Positive Reappraisal	-.124*	.130*	.337**	.050	.159*	.526**				
8. CERQ Putting into Perspective	.237**	.434**	.587**	.372**	.253**	.533**	.585**			
9. CERQ Positive Refocusing	.029	.233**	.479**	.307**	.293**	.493**	.638**	.543**		
10. CERQ Refocus on Planning	.059	.349**	.483**	.227**	.154*	.592**	.735**	.537**	.654**	

\*\* Correlation is significant at the 0.01 level (1-tailed).  
\* Correlation is significant at the 0.05 level (1-tailed).

**Table III: Pearson’s Correlation between MSPSS and BDI-II Scores**

Variables	1	2	3	4	5
1. BDI-II Score					
2. MSPSS Score	-.259**				
3. MSPSS Significant Others	-.181**	.908**			
4. MSPSS Family	-.309**	.869**	.677**		
5. MSPSS Friends	-.197**	.876**	.718**	.626**	

\*\* Correlation is significant at the 0.01 level (1-tailed).  
\* Correlation is significant at the 0.05 level (1-tailed).

**Regression Analysis of Cognitive Strategies and Social Support**

Multiple linear regression was used to assess the influence of cognitive emotion regulation strategies and perceived social support on depression severity. The model explained 42% of the variance in depression scores ( $R^2 = .42$ ), indicating moderate explanatory power.

Significant positive predictors of depression severity included self-blaming ( $\beta = .224, p = .014$ ), rumination ( $\beta = .193, p = .049$ ), and catastrophizing ( $\beta = .223, p = .014$ ). In contrast, positive reappraisal ( $\beta = -.224, p = .047$ ) and family support ( $\beta = -.180, p = .047$ ) were significantly linked to lower depression scores. These findings suggest that maladaptive coping strategies increase vulnerability to depression, whereas positive reappraisal and family support serve as protective factors. The regression findings are shown in Table IV.

**Mediation Analysis of Cognitive Coping and Depression**

Mediation analyses were conducted using bootstrapping procedures with 5,000 resamples to examine whether perceived social support mediated the relationship between cognitive emotion regulation strategies and depressive symptoms. The results indicated that perceived social support did not significantly mediate the relationships between acceptance and depressive symptoms, as the bootstrapped confidence interval for the indirect effect included zero (95% CI [-.430, .003]). Similarly, no significant indirect effect was observed for putting events into perspective, with the confidence

**Table IV: Multiple Linear Regression Predicting Depression from CER Strategies and Social Support**

Predictor	Unstandardized Coefficient (b)	Standard Error (SE)	Standard Coefficient (β)	t-value	p-value
Constant	6.413	4.795		1.337	.183
Self-Blame	.758	.307	.224	2.471	.014*
Acceptance	-.095	.363	-.027	-.261	.794
Rumination	.713	.359	.193	1.985	.049*
Positive Refocusing	-.337	.306	-.100	-1.100	.273
Refocusing on Planning	.261	.406	.069	.643	.521
Positive Reappraisal	-.807	.403	-.224	-2.002	.047*
Putting into Perspective	.419	.329	.116	1.274	.204
Catastrophizing	.700	.281	.223	2.488	.014*
Blaming Others	.107	.258	.034	.414	.680
Significant Others	.132	.190	.068	.696	.487
Family	-.370	.185	-.180	-1.997	.047*
Friends	-.238	.203	-.108	-1.169	.244

\* Indicates significance at  $p < .05$ ,  $R^2 = .42$

interval also crossing zero (95% CI [-.555, .088]). These findings indicate that perceived social support does not function as a mediating mechanism for these strategies in the present sample.

Significant indirect effects were observed for several adaptive strategies, including positive refocusing, refocus on planning, and positive reappraisal, particularly when mediated through overall perceived social support and family support. For instance, positive reappraisal demonstrated a significant indirect effect through overall social support ( $b = -.296$ , 95% CI [-.545, -.083]) and through family support ( $b = -.279$ , 95% CI [-.578, -.063]), as the confidence intervals did not include zero. These results suggest that the association between certain adaptive cognitive emotion regulation strategies and depressive symptoms may operate indirectly through perceived social support.

In contrast, no significant indirect effects were found for maladaptive strategies such as self-blame, rumination, and catastrophizing, as the bootstrapped confidence intervals for these indirect effects included zero. This indicates that the associations between these maladaptive strategies and depressive symptoms were not mediated by perceived social support. Overall, the mediation analyses provide partial support for the proposed model, indicating that perceived social support serves as a mediating factor for some, but not all, cognitive emotion regulation strategies. A summary of the indirect effects is presented in Table V.

## DISCUSSION

This study adds to the understanding of how depression, cognitive emotion regulation (CER) strategies, and perceived social support interact among late adolescents and emerging adults in Malaysia.

**Table V: Mediation of the Relationship between CER Strategies and Depression through Social Support**

Variables	Mediator	Indirect Effect (b)	95% Bootstrap of Confidence Interval (CI)	
			Lower CI	Upper CI
Self-Blame	Social Support	.012	-.134	.172
	Significant Others	-.003	-.079	.069
	Family	.067	-.073	.252
Acceptance	Friends	-.027	-.141	.066
	Social Support	-.181	-.430	.003
	Significant Others	.027	-.109	.177
Rumination	Family	-.084	-.280	.105
	Friends	-.065	-.249	.078
	Social Support	-.091	-.288	.098
Positive Refocusing	Significant Others	-.013	-.137	.096
	Family	.015	-.133	.202
	Friends	-.024	-.145	.065
Refocus on Planning	Social Support*	-.308	-.563	-.113
	Significant Others	.051	-.170	.303
	Family*	-.252	-.512	-.052
Positive Reappraisal	Friends	-.044	-.290	.157
	Social Support*	-.347	-.635	-.125
	Significant Others	.054	-.161	.315
Putting into Perspective	Family*	-.345	-.625	-.108
	Friends	-.048	-.293	.164
	Social Support*	-.296	-.545	-.083
Catastrophizing	Significant Others	.118	-.130	.418
	Family*	-.279	-.558	-.063
	Friends	-.037	-.296	.237
Blaming Others	Social Support*	-.296	-.555	-.088
	Significant Others	.009	-.172	.197
	Family	-.043	-.202	.135
Self-Blame	Friends	-.101	-.325	.083
	Social Support	.051	-.055	.191
	Significant Others	-.004	-.072	.045
Acceptance	Family	.100	-.012	.271
	Friends	.003	-.070	.074
	Social Support	.003	-.146	.143
Rumination	Significant Others	.001	-.073	.070
	Family	.024	-.156	.188
	Friends	-.001	-.092	.051

\*Significant indirect effect with bootstrap confidence interval based on 5000 samples at  $p < .10$

## Relationship between Cognitive Emotion Regulation Strategies and Depression

The present study reinforces the evidence that maladaptive cognitive emotion regulation strategies, most notably self-blaming, rumination, and blaming others, are positively linked to depression. This finding aligns with prior research demonstrating that individuals who habitually engage in self-critical or catastrophizing thought patterns are more likely to exhibit elevated levels of depressive symptoms (25, 26, 27).

The findings from this study also reaffirm that among the various adaptive strategies, only positive reappraisal demonstrated a significant negative correlation with depression, suggesting that reframing negative

experiences in a constructive way may buffer against depressive symptoms. This notion is parallel with findings by (26) who reported lower depression levels among individuals who used positive reinterpretation techniques.

However, certain adaptive strategies, namely acceptance and putting into perspective, were unexpectedly found to have positive correlations with depression. In contrast, strategies such as positive refocusing and refocusing on planning did not demonstrate significant associations. These mixed findings deviate from previous research (e.g., 28, 29) and may reflect the contextual or cultural differences. Although it is unanticipated, these findings suggest that adaptive strategies may not be universally effective across situations.

### **Relationship between Social Support and Depression**

In line with earlier studies, the present findings found a clear negative correlation between perceived social support and depression, with greater support linked to fewer depressive symptoms (1, 30). Social support not only reduces emotional distress but also enhances resilience, academic performance, and quality of life for adolescents (31, 32).

Among the various sources of support, family was identified as the most significant and impactful protective factor. This notion supports earlier findings that family involvement plays a pivotal role in reducing depressive symptoms and even suicidal ideation (33, 34). These findings point to the fundamental role and critical function of familial relationships in mental health interventions.

### **Mediating Effect of Social Support**

The present findings provide partial support for the proposed role of perceived social support in the relationship between cognitive emotion regulation strategies and depressive symptoms. Specifically, mediation analyses indicated that perceived social support, particularly family support served as a significant statistical mediator for several adaptive cognitive emotion regulation strategies, including positive reappraisal, refocus on planning, and positive refocusing. These results suggest that the potential benefits of certain adaptive strategies may be more evident when they are embedded within a supportive interpersonal context. In other words, adaptive cognitive efforts may be more effective in mitigating depressive symptoms when individuals perceive adequate emotional and instrumental support from their social environment.

Importantly, not all strategies traditionally classified as adaptive demonstrated significant mediated effects. Acceptance and putting events into perspective did not show significant indirect effects through social support, despite their associations with depressive symptoms.

This finding highlights the contextual and culturally contingent nature of cognitive emotion regulation processes. In high-demand or uncontrollable stress contexts, such as academic pressure or prolonged uncertainty, acceptance may reflect resignation or passive coping rather than active emotional regulation (35, 36). Similarly, attempts to “put things into perspective” may overlap with cognitive overprocessing or rumination, thereby diminishing their protective value (37, 38). These interpretations align with emerging evidence suggesting that the adaptiveness of certain cognitive strategies may vary depending on situational demands and cultural meaning systems.

Consistent with prior literature, family support emerged as the most salient interpersonal resource in the present study. Within collectivistic cultures such as Malaysia, family relationships often play a central role in emotional validation, decision-making, and stress management during late adolescence and emerging adulthood. The observed indirect effects through family support suggest that adaptive cognitive strategies may be reinforced when they are socially validated or supported within the family system. This finding is consistent with previous studies demonstrating the importance of family-based support in buffering psychological distress among tertiary-level students (39, 40), particularly during periods of heightened stress such as the COVID-19 pandemic (10).

In contrast, no significant mediation effects were observed for maladaptive strategies such as self-blame, rumination, and catastrophizing. This suggests that these strategies may exert their associations with depressive symptoms through more internally driven mechanisms that are less responsive to external social resources. Such strategies may reflect entrenched cognitive patterns that persist regardless of perceived support, underscoring the need for interventions that directly target maladaptive cognitive processes rather than relying solely on the enhancement of social support.

Taken together, these findings highlight the complexity of interactions between cognitive emotion regulation and social support. While perceived social support appears to play a meaningful mediating role for some adaptive strategies, its influence is neither universal nor uniformly protective. Given the cross-sectional nature of the study, these mediation effects should be interpreted as statistical associations rather than causal mechanisms. Future longitudinal research is needed to clarify the temporal sequencing and contextual conditions under which social support may amplify or constrain the effectiveness of cognitive emotion regulation strategies in reducing depressive symptoms.

### **CONCLUSION**

This study contributes to a clearer understanding of the

intricate links between cognitive emotion regulation (CER) strategies, social support, and depression in Malaysian late adolescents and emerging adults. The results indicate that maladaptive approaches, namely self-blaming, rumination, and catastrophizing, are strongly linked to higher levels of depressive symptoms, whereas positive reappraisal and family support emerge as protective factors. Mediation analysis further demonstrates that social support, particularly from family, partially explains the beneficial impact of adaptive coping strategies on depression. Nonetheless, the use of a cross-sectional design and the relatively modest sample size limit causal interpretations and generalizability. Future research should adopt a longitudinal design and culturally sensitive tools of measurement to better understand the temporal dynamics of these relationships. It could also facilitate opportunities to explore intervention models that integrate both cognitive and social support components to promote mental health among adolescents.

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