CHAPTER-2

Review of Literature
Before carrying out any research venture, it is vital to familiarize oneself with the work done by other researchers in the area. This facilitates the scholar in critical evaluation of the methodological facets of the proposed study, avoid pitfalls and conduct the research in such a manner that findings take us a step ahead in generating knowledge in the area. The total repertoire of work is extremely large therefore a brief resume of pertinent studies is being presented.

**Depression:**

The following studies are reviewed by the researcher in order to understand non-pathological or subsyndromal depression and its relation with gender, family structure, etc.

Lyness et al. (2006) found that compared with patients who were not depressed at the start of the study, patients who had minor or subsyndromal depression were 5 times more likely to have major depression after 1 year. At that time, depression scores were worst in the patients who started out with major depression, intermediate in patients who started with minor or subsyndromal depression, and best in patients who started with no depression. Patients who had had worse health and less social support were the most likely to develop worsening depression.

According to Judd, Paulus, Wells, & Rapaport (1996), in younger adults, minor and subsyndromal depression are associated with greater cumulative functional disability than major depression; they probably exist along a dimensional spectrum of symptomatic severity Lavretsky, & Kumar (2002), Judd, Schettler, & Akiskal (2002), and Kumar, Jin, Bilker, Udupa, & Gottlieb (1998), sometimes (but not always) representing a prodromal or residual phase of a major mood disorder.
In a study Lyness, Caine, King, Conwell, Duberstein, & Cox (2002) found that patients with minor depression had outcomes that were poorer than those of persons who were not depressed. Outcomes were not universally poor, however, and were better than those of patients with major depression.

According to Horwath, Johnson, Klerman, & Weissman (1992) the minor depression group had a risk for a diagnosis of major depression at 1 year that was more than 5 times greater than that of nondepressed elderly individuals, which is similar to the 1-year risk in younger adults with subsyndromal depression.

Epidemiologic studies by Pine, Cohen, Cohen, & Brook (1999) and Fombonne, Wostear, Cooper, Harrington, & Rutter (2001) indicate a clear relation between the presence of depressive symptoms that do not fulfill diagnostic criteria for major depression in adolescence and the development of depressive disorders in adulthood.

An epidemiologic study by Bijl, de Graaf, Hiripi, Kessler, Kohn, Offord, and others (2003) suggested that serious mental disorders usually start in childhood or adolescence and that school-based interventions may help reach young people with mild symptoms and prevent progression to such serious outcomes as drug problems, teen childbearing, school failure, and violent relationships.

According to Clarizio (1989), research studies indicate that so-called non-clinical or normal depression is a common and widespread phenomenon among adolescents, with as many as one in five experiencing some or all aspects of depression. The critical age period for the emergence of depression among adolescents appears to be in early adolescence at about the onset of puberty (Nolen-Hoeksema & Girgus, 1994) with girls being the gender predominantly affected (Hankin, Abramson, Moffitt, Silva, McGee & Angell, 1998). It appears that not only
is there an increase in the incidence of depression among adolescents (Van, 1990) but that there is a trend toward an earlier age onset of depression. This early onset forecasts a virulent lifetime course of the disorder, causing a chronic, recurring form of depression which has a debilitating effect on the overall functioning and quality of life of adolescents (Brage & Meredith, 1994; Hankin, et al 1998).

According to Reynolds (1984) and Wodarski & Harris (1987), current research on adolescent depression indicates that depression is particularly responsive to intervention during the early adolescent years and that early identification will prevent the development of a chronic and severe form of depression in adolescents.

Greist & Jefferson (1992), emotions such as guilt and self-blame which can affect the whole functioning of the adolescents are often the result of depression that distorts the individual's normal way of thinking.

Koplewicz & Klass (1993), anger is a common feature of depression in adolescents. They direct their anger either inwardly against themselves leading to feelings of worthlessness and subsequent depression or towards others such as family or friends (Greist & Jefferson 1992; Oster & Montgomery, 1995; Robbins, 1993).

Clarizio (1989) and Reynolds & Johnston (1994), emotions such as sadness, tearfulness, fear, guilt and sensitivity to rejection are often central features of childhood depression. Even if the adolescents are not always able to describe their persistent sad moods in words they may show it in behavior changes which include sad expressions of glumness and looking downcast, tearfulness or stooped posture, the wringing of hands and restlessness (Greist & Jefferson, 1992; Koplewicz & Klass, 1993). Moreover, continued rejection and isolation tends to perpetuate and maintain depression (The Depression and Anxiety Support Group, 1999, Lefkowitz & Tesiny, 1984; Newman & Newman, 1997; Oster & Montgomery, 1995).
Other than sad mood, withdrawal is the one feature that is most likely to distinguish depressed adolescents from non-depressed adolescents (Badal, 1988; Clarizio, 1989; Kendall, Cantwell & Kazdin, 1989). As the emotional tension of adolescents increases, they become increasingly distressed and carry out self-destructive behaviors such as suicide (Oster & Montgomery, 1995).

A survey of the literature on adolescent depression supports the finding that behavior changes associated with depression are varied and include aggressive actions such as excessive crying, fighting, shouting or throwing objects (Badal, 1988; Greist & Jefferson, 1992; Oster & Montgomery, 1995). It is also possible to identify the private and inner despair caused by depression based on behavioral and physiological cues (Greist & Jefferson, 1992) such as unusual and varied physical complaints that have no underlying medical basis but that are disabling (Badal, 1988; Greist & Jefferson, 1992; Oster & Montgomery, 1995). Such atypical pain might disguise depression in the same way as does denial (Koplewicz & Klass, 1993) and acting out behaviors such as running away from home and escapism (Clarizio, 1989; Koplewicz & Klass, 1993; Van, 1998; Wodarski & Harris, 1987).

Depression in adolescents is often characterized by somatic complaints such as changes in appetite, sleep disturbances and fatigue (Clarizio, 1989; Gotlib & Hammen, 1992; Reynolds & Johnston, 1994; Wodarski & Harris, 1987). Adolescents who are depressed are fatigued and rarely find relief by sleep or rest (Greist & Jefferson, 1992; Herbert, 1998; Koplewicz & Klass, 1993). Low energy levels tend to reduce social contact and decrease the individual's ability to find the experiences of life enjoyable (Herbert, 1998).

Depressed children tend to blame their negative experiences on external factors that are out of their control or on other people such as their parents, siblings or
teachers (Reynolds & Johnson, 1994; Robbins, 1993). They have low self-esteem and tend to feel helpless (Clarizio, 1989; Reynolds & Johnston, 1994) and hopeless about the future (Gotlib & Hammen, 1992; Reynolds & Johnston, 1994; Robbins, 1993). As the depressed feelings become prolonged, the adolescents feel increasingly inadequate and worthless and this ultimately lowers their self-esteem (Clarizio, 1989; Robbins, 1993), leading to thoughts of self-hatred and self-denigration.

The tendency of depressed adolescents to express feelings of self-hatred often begins to emerge in early adolescence (Koplewicz & Klass, 1993). When they are embroiled in the pangs of self-hatred they feel that they are not worth helping and feel increasingly worthless (Herbert, 1998; Gotlib & Hammen, 1992).

Adolescents with poor social skills are vulnerable to depression and suicide (Muzi, 2000; Oster & Montgomery, 1995) because a lack of these skills causes rejection and isolation from peer group interaction (Wodarski & Harris, 1987). Effective communication, which entails actively listening to what another has to say (Okun, 1997) is an important component in the acquisition of appropriate social skills (Oster & Montgomery, 1995). Ignoring a confidence as serious as a suicide attempt intensifies adolescent depression because survey studies reveal that when adolescents contemplate suicide they will invariably confide in a friend rather than in an adult (Emery, 1983; Wodarski & Harris, 1987).

Feelings of rejection and social withdrawal and alienation from peer group interaction are common in depressed adolescents (Lefkowitz & Tesiny, 1984; Newman & Newman, 1997; Oster & Montgomery, 1995). Failure to interact with peers and a lack of social support from friends contributes to the development and experience of depression in adolescents (Lewinsohn, et al. 1994; Newman & Newman, 1997; Wodarski & Harris, 1987). It is important for adolescents to be
accepted by their peer groups (Gladding, 1999) because it is during early adolescence that adolescents transfer their reliance for social support from their parents to their peers (Newman & Newman, 1997; Rice, 2001). If they are rejected by their peers or are socially isolated from them they experience depression (Newman & Newman, 1997).

According to Reynolds & Johnston (1994), adolescents who are depressed readily attribute blame to others as part of their cognitive repertoire when facing interpersonal adversity. They attribute blame in a direct, aggressive way or they manipulate the perceived aggressor into an apology by storming away or by engaging in appeasing actions, hoping that the adversary will change the judgement of their worth. However, adolescents who are the recipients of blame, feel rejected, tend to withdraw and become depressed.

Zuckerbrot and Jensen (2006) have found that 3-9% of teenagers meet criteria for depression at any one time, and at the end of adolescence, as many as 20% of teenagers report a lifetime prevalence of depression.

According to Wolraich et al. (1996), Kovacs et al. (1994), and Weller et al. (1996) childhood depression, like the depression of adults, can encompass a spectrum of symptoms ranging from normal responses of sadness and disappointment in stressful life events to severe impairment caused by clinical depression that may or may not include evidence of mania.

Bienvenu et al. (2004) found that there is an established relationship between personality traits and depression, as well as between personality traits and anxiety disorders, in the general population.
According to Holmes & Rich (1990), untreated anxiety disorders and especially depressive disorders may contribute to higher suicide rates.

A study in undergraduate students by Gosling and colleagues (2003) found that the severity of depressive symptoms evaluated by the Beck Depression Inventory had a strong negative relationship with the personality dimension of Emotional Stability.

A study by Tyssen et al. (2004) found that high levels of Neuroticism (i.e. a low level of Emotional Stability) and severe depressive symptoms together with negative life events were independent predictors of suicidal behaviour in medical students.

According to Rosal et al. (1997), it is well known that perceptions of stress correlate with symptoms of depression and anxiety and also predict risk for depressive disorders in different populations, including medical students.

In a Swedish study, Dahlin, Joneborg, & Runeson (2005) found that the prevalence of depressive symptoms among students was 12.9% and a total of 2.7% of students had made suicidal attempts.

Rodrigo et al. (2010) a total of 445 students were assessed (male-54.4%, female 45.6%). Thirty six percent screened positive for depression (mild depression-17%, severe depression- 19%) and 28% screened positive for severe anxiety. Females screened positive for depression and anxiety significantly more than the males. While there were no differences between grade 9 (aged 14) and 10 (aged 15) students, grade 11 (aged 16) students had significantly high rates of depression and severe anxiety.
Numbers in grades 12 (aged 17) and 13 (aged 18) were small for a valid analysis but proportion wise, grade 13 had the second highest depression and anxiety scores.

Bansal, Goyal & Srivastav (2009) found that 15.2% of school-going adolescents were found to be having evidence of distress; 18.4% were depressed; 5.6% students were detected to have positive scores on both. Economic difficulty, physical punishment at school, teasing at school and parental fights were significantly associated with higher depression.

In a study conducted by Rao (1999), it was found that young women continue to be at high risk of depression through their early twenties, and those who have had an initial episode of depression are at very high risk of recurrent episodes. Epidemiological data suggest that the prevalence of depression sharply increases during adolescence, particularly for girls (Angold, Costello, & Worthman, 1998; Angold & Rutter, 1992).

Several large-scale epidemiological studies have shown that women have higher depression rates than men (Blazer, Kessler, McGonagle, Swartz, 1994; Bebbington, Dunn, Jenkins, et al., 1998). A meta-analysis of studies conducted in various countries has shown that women are roughly twice as likely as men to experience or report depression (Nolen-Hoeksema, 1990).

Keenan & Hipwell (2005) found that between the ages of 10 and 15, depression increases among girls at a rate that is twice as high as the rate of depression in boys. This sex difference remains throughout early and middle adulthood. Prior to early adolescence, there is essentially no sex difference in the rate of depression.
Kessler, McGonagle, Swartz, Blazer, & Nelson, (1993), & Lewinsohn, Clark, Seeley, & Rhode, (1994) found that one in five females between the ages of 15 and 50 will suffer from clinically significant levels of depression at some point in their lifetime, a rate that is more than twice the lifetime prevalence of depression in males. Beginning in adolescence, a rapid increase in the rate of depression among girls has been reported consistently (Ge, Lorenz, Conger, Elder, & Simons 1994; Hankin et al., 1998; Wichstrom, 1999).

A predominant view is that increases in rates of depression in girls during adolescence result from newly encountered risk factors that are primarily specific to adolescence including struggles between attachment and autonomy (Cyranowski, Frank, Young, & Shear, 2000) and the physical and psychological changes associated with pubertal development (Petersen, Sarigiani, & Kennedy, 1991).

Hankin and Abramson (2001) have provided a cognitively based transactional theory that is aimed at explaining sex differences in depression at adolescence and is also designed to apply across developmental levels. They propose that a causal chain begins with negative events that contribute to negative affect. Certain cognitive vulnerabilities (e.g., tendency to ruminate) increase the likelihood that the initial negative affect leads to depressive responding to other negative events. Since girls tend to report more life events, especially interpersonal, peer, and family related negative events (e.g., Little & Garber, 2000), this may explain later sex differences in depression.

Hammen (1991) has suggested that depressed women “generate” more interpersonal stress, which perpetuates or maintains the course of their depressive illness.
In a study conducted by Poongothai, Pradeepa, Ganesan, & Mohan (2009) it was found that women had higher prevalence rate of depression, which is consistent with earlier studies (Gadit, Vahidy & Shafique 1998; Husain, Creed & Thompson, 2000).

Ruchkin et al (2006) conducted a study aimed to compare cross-cultural trends of comorbid internalizing and externalizing psychopathology, prosocial beliefs and perceptions of risk in adolescents with and without clinical levels of self-reported depressive symptoms. The findings revealed that girls have higher levels of depressive symptoms than boys. The findings also demonstrated that in both genders, depressive symptoms are associated with increased levels of internalizing and externalizing problems, as well as lower levels of prosocial beliefs, and low perception of harm from risk-taking behavior. Depressed boys had relatively higher levels of externalizing problems than depressed girls. Greater levels of internalizing problems observed in depressed youth, as compared with their non-depressed counterparts, were not gender specific. It further suggests that the relationships between depression and comorbid psychopathology are not culture specific and have similar patterns in different populations.

According to Nolen-Hoeksema, & Girdus (1994) the experience of depression can vary on the basis of age of children, adolescents, or adults. For example, after the age of 15, females are twice as likely to become depressed as compared to men. In another study of 11-year olds, only 2.5% males met the criteria for major depression while only 0.5% females met the criteria, however in a study of 14-16 year olds, 13% of the females met the criteria while 3% of the boys did. This abrupt rise of depressive disorders in females during the mid-to-late adolescence years can be attributed to the more concerns a girl has as compared to boys. These concerns and worries can range
from their achievements or lack of, body dissatisfaction, sexual abuse, and low self-esteem (Lewinsohn, Gotlib, & Seeley, 1997).

This is reinforced when another study conducted by Hankin, Abramson, Moffitt, Silva, Mcgee, & Angell (1998) who found that between the ages of 15-18, the prevalence of depression in girls will increase to twice the prevalence of boys (20.69 to 9.58) but will taper off during 18-21 years of age for both genders (15.05 and 6.58).

However, it is of interest that in another study by Parikh, Chakravorthy, Sonawalla, Mehrah, Dracass, et al., (2001) done in Bangalore among young adults attending college, men were found to be more depressed (25%) than women (18%).

A study by Upmanyu, Upmanyu, and Lester (2000) showed that, among Indian college students, more men suffer from depression than women.

Sroufe & Rutter (1984) have noted that depression in young boys often is embedded within the context of conduct disturbances – an externalizing pattern of symptom expression. In young girls, by contrast, depression is manifested in passivity and a turning inward – an internalizing pattern of symptom expression. In a similar view, Ebata & Peterson (1988, cited in Gjerdo, Block & Block, 1988) reported that depression among early adolescents was related in boys but not girls to “externalized” behavior (e.g., getting into trouble at school, to poor academic performance).

According to Hankin et al. (1998) females are not the only gender that can become depressed; a good number of males can develop a unipolar mood disorder. In the average lifetime, 49% of all males will experience a depressive episode (as compared with 63% of all females). Males will become sad and dejected for different reasons, such as intimate relationships. When an intimate relationship ends, males are more likely to become depressed at the loss than females.
While some authors found significant differences among genders, others found no such gender differences. Most recent literatures reveal significantly higher levels of depression among adolescent females (Abela & Hankin, 2008; Abada, Hou & Ram, 2008; Adlina, Suthahar, Ramli, Edariah, Soe-Soe-Aye & Ariff et al., 2007; Crowe, Ward, Dunnachie & Roberts, 2006; Maag & Irwin, 2005), while not too recent studies conducted in the 80’s suggest that males were more depressed than females (Huntley, Phelps & Rehm 1987; Smucker et al. 1986; Bartell & Reynolds 1986; Finch et al., 1985). Still other scholars found no gender differences in depression (Masten et al 2003; Nolen-Hoeksema 1994).

Hammen & Padesky (1977) failed to find differences between males and females on BDI scores, but did find statistically distinct patterns of response. Various writers, in discussing the psychological dynamics of depression, have conjectured that the basis for depression differs for men and women (e.g. Nolen-Hoeksema, 1987; Kaplan, 1986; Radloff & Rae, 1979; Weissman & Klerman, 1979).

According to Sethi & Chaturvedi (1985) and Sinha (1984) the traditional joint family that exists in India is seen as a source of social and economic support and is known for its tolerance of deviant behavior and capacity to absorb additional roles in times of crisis.

Sethi & Chaturvedi (1985) and Bharat (1991) studied the role of the family in relation to mental health and found that the nuclear family structure is more likely to be associated with psychiatric disorders than the joint family.

In a follow-up study in bipolar patients, Stefos et al. (1996) found that low level of social support and poor quality of relationships with extended family significantly predicted the occurrence of a major affective episode.

Chandrashekar, Rao & Murthy (1991) reported that fewer patients from rural
families sought hospitalization when compared to urban families because of the existing joint family structure.

Gotlib and Hammen (1992) discussed the social functioning of people with depressive disorders and found that people with the symptoms of depression are found to test low in social activities, close relationships, quality close relationships, family activities, and network contact, yet they test high in family arguments.

In a study performed by Joiner, Alfano, and Metalsky (1992), it was tested whether a depressed individual would have an effect on other people in one-on-one interactions and they found that affected people did have such an influence on other people. This influence could be described as responding negatively to their constant searching of reassurance and rejecting them, which in turn will "confirm" the affected person’s belief that he or she is unworthy as a person.

Lewinsohn, Gotlib, & Seeley (1997) found that a depressed individual can impact his social settings by exhibiting a lack of self-esteem, becoming more sensitive to the opinions of others, and more importantly (and interestingly), become less physically active.

Kenney-Benson and Pomerantz (2005) found that parents’ heightened use of control especially that of the mother, caused perfectionistic traits in children, which led to heightened depressive symptoms when the child was not able to achieve highly. The parent’s high expectations for their children, seen often in families of foreign students, or in this case the families of Asian-American students, has been shown to lead to depressogenic thoughts and early symptoms of depression.

Martire, Lustig, Schulz, Miller, & Helgeson (2004) found that families also have a positive influence on their relatives when it comes to depression. When the
family is there for the person, they can help to reduce the person's stress and anxiety by showing their love.

Ramachandran, Menon & Ramamurthy (1981) studied the relationship between family structure and mental illness in old age. Functional disorder was found to be high in subjects living in nuclear families and living in alone as compared to those living in 'joint' or 'loosely joint' families. The results highlight the importance of family support as a protection from mental illness.

Rammurti & Jamuna (1984) reported on the basis of their study in India that individuals, both men and women, living in joint families were found to have better adjustment than individuals living in nuclear families.

Mirza and Jenkins (2004) reported that the major factors associated with depressive disorders were female sex, middle age, low level of education, financial constraints and relationship problems.

Mason (1992) and Bongaarts (2001) have both suggested that urbanization would lead to nucleation of family systems in developing countries and a decrease in the support of the elderly.

Weich, Twigg, Lewis (2005) found that rural residents had slightly better mental health than non-rural counterparts. The effects of geographical location on the mental health of participants were neither significantly confounded nor modified by socio-economic status, employment status or household income.

Wang (2004) found that Canadian National Population Health Survey participants in rural areas had a lower prevalence of Major Depressive Episode(s) than those in urban areas, controlling for the effects of race, immigration status, working status and marital status.
Van, Hanssen, Bijl, & Vollebergh (2001), Paykel, Abbott, Jenkins, Brugha & Meltzer (2000) and Blazer, George, Landerman et al. (1985) have shown that urban areas have a higher prevalence of psychiatric disorders than rural areas.

According to Probst, Laditka, Moore, Harun, Powell, & Baxley (2006), the prevalence of depression is slightly but significantly higher in residents of rural areas compared to urban areas, possibly due to differing population characteristics.

One particular study indicated higher rates of minor depression among young rural women in Taiwan, highlighting an association between adverse rural environments and related psychosocial stress (Cheng, 1989). It may well be that frequent social activities and contact provide supportive resources for residents in more urbanized areas. Whereas stress from work, marriage, child rearing, security, and the effort to sustain shelter may pose more complex challenges in urban areas, the pernicious or salutary consequences on mental health arising from urbanicity remain controversial and could be even more complex than previously thought (Marsella, 1998).

It is evident from the above studies that non-pathological or subsyndromal depression may worsen overtime and may result in a diagnosis of major depressive disorder, which can impair the overall functioning and quality of life of the individual and further severity of these symptoms may become a predictor of suicidal behavior. There was a conflict in studies related to gender differences in depression, in majority of the studies females were found to have higher depression than males, in some studies it was found that males have higher depression rate, but in some studies no gender differences were found. However, it was observed that the basis for depression differs in men and women. It was also found that
individuals living in a nuclear family are more prone to psychiatric disorders than individuals living in a joint family and as urbanization leads to nucleation of the family system, this may raise the possibility of mental illness.

**Emotional Intelligence:**

The following studies provide a review about the relationship between Emotional Intelligence and its components and Depression.

A study conducted by Downey et al (2008) indicated that in a clinical sample, the ability to manage and control emotions was related to severity of depression, and further reflected in significant deficits in the EI abilities to recognize and express emotions, manage positive and negative emotions adaptively and control strong emotions. This result further supports the notion that the lack of emotional control and the inability to regulate emotions are important factors associated with depression (Bar-On, 1997).

Ciarrochi and colleagues (2002) also observed a relationship between Emotional management skills (in particular, emotional management and emotional control) and depression, and there is also some evidence concerning the existence of deficits in emotional recognition in depressed patients (Mikhailova et. al, 1996).

A large number of studies have shown a relationship between low self-reported EI levels with poor mental health, measured through depression, anxiety and emotional adjustment scales (Fernández-Berrocal, Alcaide, Extremera & Pizzaro, 2006; Fernández-Berrocal, Salovey, Vera, Extremera, & Ramos, 2005; Latorre & Montañés, 2004; Liau et al., 2003; Salovey et al., 2002; Sánchez, Montañés, Lattore & Fernández-Berrocal, 2006; Williams, Fernández-Berrocal, Extremera, Ramos-Diaz & Joiner, 2004). Also, poorer mental health indices women tend to have as compared
to men for these disorders have been reported (Caro Gabalda, 2001; Montero et al., 2004; World Health Organization, 2008).

According to Salovey (2001) and Brown, Harris & Hepworth (1998) the inability to control negative emotions can leave individuals vulnerable to stress and depression.

Evidence have accumulated that trait EI is associated with better mental/physical resistance to stress (Salovey, Stroud, Woolery & Epel, 2002).

Initial secure or insecure attachment will subsequently influence several dimensions of emotional regulation that will come into play in stressful or threatening situations (Carlson & Sroufe, 1995; Sroufe, Carlson, Levy & Egeland, 1999). Attachment theory postulates that the experience of vulnerability and the intensity of the emotional distress caused by a stressful attachment-related situation or traumatic event may reactivate early attachment experiences as well as the emotion regulation strategies linked to them. The use of these strategies in turn influences emotional adjustment and psychopathology development in adulthood. Recent advances in both research and theory suggest that attachment insecurity may constitute a risk factor for the development of psychopathology (Fonagy et al., 1996; Van Ijzendoorn & Bakermans-Kranenburg, 1996; West & George, 2002).

Khosla & Dokania (2010) found that happy participants as compared to unhappy participants reported significantly greater positive affect and emotional intelligence. Happy as compared to unhappy men had significantly greater emotional intelligence while happy women were found to be more emotionally intelligent than unhappy women. There were significant group and gender differences in the use of reappraisal strategies but not suppression strategies. The findings reveal the significance of happiness in promoting emotional intelligence.
Zahn-Waxler (2000) stated that higher order emotions, such as empathy and guilt, are necessary components of emotional health and well-being. Deviations in either direction are reflected in different forms of psychopathology: the absence of these moral emotions is associated with disruptive behavior problems and the excess with anxiety and depression.

Cox, Taylor, and Enns (1999) tested the hypothesis that a desire for emotional control would be associated with DSM-IV based depressive symptoms.

Campbell-Sills & Barlow's (2007) emotion dysregulation theory of emotional disorders posits that individuals with depression and anxiety tend to avoid their emotions, and this avoidance may limit emotional self disclosures.

Barr, Kahn, & Schneider (2008) found that individual differences in emotional disclosure were negatively related to a discrimination function comprising measures of depression and anxiety symptoms.

Hertel, Schütz, & Lammers (2009) conducted a study to measure emotional intelligence in patients diagnosed with major depressive disorder, substance abuse disorder, or borderline personality disorder (BPD). Findings showed that all clinical groups differed from controls with respect to their overall emotional intelligence score. Specifically, we found that the ability to understand emotional information and the ability to regulate emotions best distinguished the groups.

Prati, Liu, Perrewé, & Ferris (2009) examined the moderating role of emotional intelligence in the surface acting-strain (i.e., depressed mood at work, somatic complaints) relationship. The findings revealed that higher emotional intelligence attenuated the positive relationship between surface acting and depressed mood at work and somatic complaints.
Austin, Saklofske & Egan (2005) have found high emotional intelligence to be associated with greater happiness and better psychological function.

Schutte et al. (1998) have found that higher emotional intelligence is associated with lower depression, greater optimism and increased ability to repair moods.

Muris (2002) found a significant relationship between self-efficacy and depression and anxiety in adolescents. It was found that low level of emotional self-efficacy was strongly linked with high levels of anxiety and depressive symptoms.

Gupta & Kumar (2010) found that emotional intelligence and self-efficacy are positively correlated with mental health. It also revealed that male students were better than female students in terms of mental health, emotional intelligence and self-efficacy.

The study conducted by Depape et al. (2006) examined self-talk, year of study and gender as predictors of emotional intelligence in a diverse sample of 126 undergraduate participants. The results indicated that year of study and self-talk were significant predictors of emotional intelligence and were associated with emotional intelligence in a positive direction. Gender was not found to be a significant predictor.

Extremera & Fernandez-Berrocal (2006) investigated the association between perceived emotional intelligence and life satisfaction in Spanish undergraduate university students. Results showed significant association between clarity & repair and higher life satisfaction. Hierarchical multiple regression analysis confirmed these findings and indicated that clarity accounted further variance in life satisfaction not accounted for by mood states and personality traits.

Katyal & Awasthi (2004) studied gender differences in emotional intelligence and its correlates and found that girls have higher Emotional Intelligence and self-
esteem than that of boys. On the other hand, boys were found to have higher emotional maturity than that of girls. However, these differences touched only 0.10 level, hence, are just suggestive of the trend.

The findings of studies reported by Bhosle (1999), King (1999), Sutarso (1999), Wing and Love (2001) and Singh (2002) revealed that females have higher Emotional Intelligence than that of males.

According to Duckett & Raffalli (1989) and Sandhu & Mehrotra (1999) higher Emotional Intelligence among girls can be explained in terms of the society which socializes the two genders differently.

Tapia (1999) and Dunn (2002) found that girls’ higher Emotional Intelligence can be explained by some of their personality characteristics. They observed that girls score higher with regard to empathy, social responsibilities and interpersonal relationships than boys. They are more sensitive towards their relationships with parents, friends and siblings. All these traits help them to acquire more emotional intelligence as compared to boys.

According to the studies conducted by Feldman Barret, Lane, Sechrest & Schwartz (2000), Garaigordobil & Galdeano (2006) and Sunew (2004) the relationship between the female sex and emotional competencies are closely linked since childhood due to a socialization that is in closer touch with feelings and their nuances (Candela, Barberá, Ramos, & Sarrió, 2001).

It has been affirmed that women tend to be more emotionally expressive than men, that they understand emotions better and that they have a greater ability as regards certain interpersonal skills. It is evident from the studies conducted by Aquino (2003), Argyle (1990), Hargie, Saunders, & Dickson (1995), Lafferty (2004) Tapia & Marsh II (2006) and Trobst, Collins & Embree (1994) women recognize other
people’s emotions better, are more perceptive and have greater empathy. In addition, some evidence exists that certain areas of the brain dedicated to processing emotions could be larger in women than in men (Baron-Cohen, 2003, 2005; Gur, Gunning-Dixon, Bilker & Gur, 2002) and that there is a difference in cerebral activity based on sex (Jaušovec & Jaušovec, 2005).

Brody & Hall (1993) and Fivush et al. (2000) found that girls have more information about the emotional world and therefore speak more about emotional aspects and use more emotional terms than boys. For their part, boys do not receive any kind of education to help them verbalize their feelings can show a lack of awareness about their own emotional states and those of other people. Nonetheless, it has been verified that boys tend to be able to speak clearly about emotional states and have an interest in them when they come from families in which the mother and boy hold conversations about emotional states (Dunn, 1990).

In the recent field of research on Emotional Intelligence (EI) gender differences have been detected in childhood, adolescence and adulthood (Harrod & Scheer, 2005; Houtmeyers, 2002; Santesso, Reker, Schmidt & Segalowitz, 2006: Young, 2006).

In some cases, no clear significant differences in self-reported emotional intelligence have been found among men and women (Aquino, 2003; Bar-On, 1997; Bar-On, Brown, Kirkcaldy & Thome, 2000; Brackett & Mayer, 2003; Brackett, Rivers et al., 2006; Brown & Schutte, 2006; Dawda & Hart, 2000; Depape et al., 2006; Devi & Rayulu, 2005; Jinfu & Xicoyan, 2004; Lumley et al., 2005; Palomera, 2005; Schutte et al., 1998; Tiwari & Srivastav, 2004), while in others women turn out to be more skillful at directing and handling their own and other people’s emotions. At times, women turn out to be better at Emotional Attention and Empathy, while
men are better at Regulating Emotions (Austin, Evans, Goldwater & Potter, 2005; Bindu & Thomas, 2006; Brackett, Warner & Bosco, 2005; Fernández-Berrocal, Extremera, & Ramos, 2004; Goldenberg, Matheson, & Mantler, 2006; Harrod & Scheer, 2005; Pandey & Tripathi, 2004; Silveri, Tzilo, Pimentel & Yurgelun-Todd, 2004; Van Rooy, Alonso, & Viswesvaran, 2005).

Trinidad, Unger, Chou & Johnson (2004) found that emotional Intelligence was a protective factor for smoking risk factors in adolescents.

In another study, Trinidad and Johnson (2002) reported that emotional intelligence was negatively significantly correlated with tobacco use and alcohol use. Riley & Schutte (2003) found that self-reported low emotional intelligence was a significant predictor of both drug-related problems and alcohol-related problems.

Lopes, Salovey & Straus (2003) explored links between EI, measured as a set of abilities and personality traits, as well as the contribution of both to the perceived quality of one’s interpersonal relationships.

Devi & Rayulu (2005) conducted a study to understand the Emotional Intelligence levels of adolescents. They found that majority of the boys and girls fell into an average and above on EI levels. Significant difference was noticed in interpersonal skills component of boys and girls favouring surpass of boys on self-awareness, empathy, social responsibility and problem solving. Adolescent boys and girls showed similar scores on levels of EI. It was also found that younger adolescents were high on interpersonal skills than older adolescents.

Bindu & Thomas (2006) studied the nature and extent of the relationships that exist among two cognitive variables viz., intelligence and creativity, and two non-cognitive variables viz., Emotional Intelligence and maladjustment among young adults. They found that the two gender groups differed significantly in the mean
scores on the variables and also in their inter-correlations. Maladjustment was identified as the most important predictor of all the other variables, in the case of the male sample. EI played a significant role in determining overall creativity and maladjustment in the female sample.

Aleem (2005) found that male students are more emotionally stable than female students.

Shah & Thingujam (2006) found that appraisal of emotions in the self was positively correlated with plan-full problem solving and positive reappraisal coping styles. Appraisal of emotions in others was positively correlated with plan-full problem solving and positive reappraisal. Emotional regulation of the self was positively correlated with plan-full problem solving, confronting coping, self-controlling, positive reappraisal and with distancing, but negatively correlated with escape avoidance. No gender differences were found in perceived emotional intelligence and ways of coping except for self-control, where males reported higher than females.

Zahn-Waxler et al. (1991) argue that the sex differences, in the context of a society that teaches girls to minimize self-expression and maximize their efforts at caring for others sets the foundation for later increases in depression in girls. Girls who are taught to be more sensitive to others’ emotional distress but who lack the skills for effectively coping with that distress are placed in a psychologically vulnerable position. Girls who fall at the extreme (high) end of the empathy continuum in the absence of other deficits are likely to be vulnerable to depression.

Olah (1995) in a cross-cultural study of adolescent responses to anxiety provoking situations, girls were more likely to express their negative emotions and
seek support than boys. This sex difference was found across all five cultures included in the study: Indian, Italian, Hungarian, Swedish and Yeminite.

Yilmaz (2009) investigated the effect of an emotional intelligence skill training program on the levels of consistent anger of university students. Results indicated that the level of consistent anger of those who attended the 12-session emotional intelligence skill training program was lower than for those who did not attend this program. In the follow-up study conducted 3 months later with the study group, there was no significant difference between consistent anger posttest scores and follow-up test scores. The data gathered indicate that an emotional intelligence skill training program may lower the levels of consistent anger for university students.

Belanger (2005) studied the emotional intelligence of undergraduate’s students in United States. The researchers found that although student’s emotional intelligence was not directly linked to academic success, students with higher levels of emotional intelligence had more self-efficacy and that in turn enhanced their academic performance.

Singh & Udainiya (2009) found that the male participants of joint family showed higher initiative than female participants.

It may be seen from the above review of studies that higher Emotional Intelligence is associated with lower depression. Deficits in factors like management, recognition, expression, control and regulation of emotions was found to be associated with higher depression. Gender differences were also found, in most studies females were found to have better Emotional intelligence, in some studies males were found to have better Emotional Intelligence. It was also indicated that men and women differ on the dimensions of Emotional
Intelligence. Therefore, it is important to study whether different aspects of Emotional Intelligence are responsible for depression among males and females.

**Anger Expression:**

The following studies point toward the role of anger in depression.

The study conducted by Bridewell & Chang (1997) examined the role of internalized anger, externalized anger, and anger control (Spielberger, 1991) as predictors of depressive, anxious, and hostile symptoms. Based on regression analyses, internalized anger, followed by lack of anger control, was found to play an important role in predicting both depressive and anxious symptoms. However, for depressive symptoms, sex and externalized anger were also found to play a significant role in predicting this outcome.

Gilbert, Chang, Irons & Mc Ewan (2005) set out a study to explore depression-focused rumination and anger-focused rumination in relation to shame and entrapment, and depression. Both depression-focused and anger-focused rumination were related to depression, and to the frequency of shame and entrapment thoughts. In a meditational model, the link between depression-focused rumination and depression was partially mediated by feeling trapped by, and wanting to escape from, one’s thoughts and feelings. Thus the link between rumination and depression is complex. Although rumination may contribute to depression by generating a spiral of negative thinking and negative feeling, feeling trapped and unable to control one’s rumination, and being flight motivated, may add a further dimension to the depressogenic qualities of rumination.

Von, Maria & Vogelgesang (2005) conducted a longitudinal study to explore strategies of anger regulation among friends. Results suggest that participants tended to use negotiation more frequently as adolescents than as children. Aggressing and
distancing strategies decline in adolescence. Results are discussed under the perspective that learning to manage conflicts of interest and anger without resorting to hostility (or avoidance) is a social task in friendship.

Kitamura & Hasui (2006) found that the depression was predicted by state anger and anger-in positively, and by anger-out and anger-control negatively.

Broota, Dey & Kaur (2007) conducted a study to explore adolescent depression in the light of parental depression and to examine the morbidity of depression with anxiety and anger. The results indicated a significant positive relationship between severity of depression in female adolescents and parental depression. The subjects high on depression had parents with depression, in comparison to the subjects who were low on depression. The study found non-significant difference between maternal and paternal depression. A comorbid relationship was found to exist between depression and anxiety, and between depression and anger.

It is evident from the studies conducted by Axelson & Birmaher (2001), Essau (2003) & Levintan et al. (2003) that the comorbidity of depression with anxiety and/or anger often results in increased impairment and disabilities, as a result, these people experience significantly longer time to recover, a higher rate of multiple drug treatments, a higher incidence of suicide, and more frequent episodes of depression.

Withers & Kaplan (1987) found that depression, anger, and impulsivity were the most predominant characteristics reported among adolescent suicides. It has been noted in the studies conducted by Boergers et al. (1998) and Gjerde & Westenberg (1998) that anger is often seen along with depression in adolescents who experience suicidal ideation.
According to Hurd, Wooding and Noller (1999) anger and depression are sufficiently associated with suicidal and violent behaviour to serve as warning signs.

Anger can play an important role in depression and suicide risk among adolescents. The study conducted by Cautin, Overholser & Goetz (2001) evaluated internalized and externalized anger in 92 adolescent psychiatric inpatients. Results indicated that adolescents who internalized their anger were more likely to be depressed and to experience feelings of hopelessness. In addition, adolescents who internalized their anger made more serious suicide attempts than did those who externalized their anger. In contrast, adolescents who externalized their anger were more likely to have alcohol-related problems. Thus, different modes of anger expression appear to be related to different manifestations of psychopathology. It was concluded that assessment of mode of anger expression in adolescents may enhance our understanding of suicide and its risk factors. Anger is an associated feature of numerous externalizing disorders in adolescents including oppositional defiant disorder, conduct disorder, and depressive and anxiety-based disorders.

According to Riley, Treiber, & Woods (1989) the severity of depression has been found to be positively associated with levels of hostility and anger. In a retrospective chart review, depression, anger, and impulsivity were the most predominant characteristics reported among adolescent suicide attempters (Withers & Kaplan, 1987).

In a 3-year longitudinal study Myers, McCauley, Calderon, & Treder (1991) found that the experience of anger was a major variable in the prediction of later suicidality.

Many investigators have quantified levels of anger based on either subjective means of assessment (e.g., Gispert, Wheeler, Marsh, & Davis, 1985) or retrospective
chart reviews (e.g., Withers & Kaplan, 1987). Only a few studies have used psychometrically reliable measures of anger (e.g., Johnston, Rogers & Searight, 1991; Maiuro, O'Sullivan, Micheal, & Vitaliano, 1989). Another confounding factor is difficulties in differentiating internalized anger from behavioral signs of depression. In fact, in a study designed to assess hostility and depression in relation to violent behavior in three groups of males (assaultive, suicide attempting, and nonviolent), a positive correlation was found between covert anger expression and depression severity (Maiuro et al., 1989). However, other research has supported the distinction between covert anger and depression (Johnston et al., 1991).

High levels of externalized anger have been reported to be associated with lower levels of depression. In a study by Apter and colleagues (1991), two groups were matched on demographic variables as well as risk for suicide, differing only in terms of violence levels. In the nonviolent group, there was a high correlation between sadness and risk for suicide. There was no such correlation for the violent suicidal group. There was also a low prevalence of affective disorders in the violent group. These findings suggest that either severe depression or high levels of aggression signal risk for suicidal behavior.

In a study conducted by Lehnert, Overholser, & Spirito (1994) depression and hopelessness were found to be related to internalized anger but not to externalized anger in a sample of adolescent suicide attempters.

A study conducted by Koh, Kim, Kim & Park (2005) showed that in depressive disorder patients, anger expression had a stronger effect on somatic symptoms through depression than did anger suppression, although both anger expression and anger suppression had a significant indirect effect on somatic symptoms. The depressive disorder group also showed a significant but negative
direct effect of anger suppression on anger expression in the path from anger suppression to anger expression to depression to somatic symptoms. However, only anger suppression had an indirect effect on somatic symptoms through depression in somatoform disorder patients.

In the studies conducted by Diong, & Bishop (1999) & Diong et al. (2005), it was found that the feeling of anger experienced by the individual and the expression of anger is related with feeling high level of stress.

Cheng, Mallinckrodt & Wu (2005) studied Taiwanese undergraduates regarding anger expression toward parents and depressive symptoms. All modes of expression were either neutral or positively associated with depressive symptoms. This result is contrary to studies of western culture suggesting that some modes of anger expression may be beneficial. However, a significant buffering interaction effect was detected for women. Higher relative preference for outward verbal expression of anger (verbal-out) was associated with fewer depressive symptoms at increasing levels of anger antecedents. For men, in contrast, greater preference for physical demonstrations of anger (Action-out) was associated with more depressive symptoms at increasing levels of anger antecedents.

Singh and Mishra (1997) examined the structure of anger experience in everyday life as people grow in the course of their lives and explored gender differences on measures of anger and aggression, life goal and life satisfaction and depression. The narrative accounts of anger revealed many similarities and some differences across males and females. The analysis also highlighted the role of appraisal and interpretation in emotional regulation of anger in experienced depression and/or life satisfaction.
A study conducted by Mathew & Ram (1999) explored the role of some demographic variables like sex, religion and marital status in the experience and expression of anger. Results showed that males scored significantly higher on state-anger and anger-out than females, and muslims scored significantly higher on state-anger, trait-anger and trait-anger/R than hindus. Significant differences were found with married persons scoring higher than unmarried ones on trait-anger/R and the latter scored higher on anger-in.

Konwar & Ram (2005) investigated the influence of cultural context on anger among young adults who differed on state-anger and anger expression. They found that anger as a stable emotional disposition is not affected so much by cultural context as the experience (state) and expression of the emotion, which may be influenced by the cultural display rules.

Linden et al., (2003) found that males relied less on social-support seeking as anger coping style than females. However, they relied more on direct anger expression.

Externalized anger may also be related to other forms of psychopathology, such as substance abuse (Milgram, 1993). Further, alcohol abuse has been found to be a very strong predictor of suicidal behavior (Pfeffer et al., 1988). In addition, substance abuse has been found to be more closely associated with suicide attempts than with suicidal ideation in children and adolescents (Kosky, Silburn, & Zubrik, 1990; Hoberman & Garfinkel, 1988).

Goodwin (2006), in her analysis of data from a health behavior survey of US school-aged children, noted that outward anger expression was associated with an almost 3-fold increased risk of feelings of depression among boys. Similar positive associations between anger expression with symptoms of depression have been
reported by others including those who studied male Japanese students, as well as
Turkish and American female students (Thomas & Atkan, 1993).

Although an association exists between negative life events and depressive
symptomology, we cannot necessarily support the intuitive notion that the onset of
depression spurs from negative experiences; perhaps depressed youth adopt a
cognitive style in which they interpret all life events in a more negative light
(Mezulis, Hyde & Abramson, 2006).

Arslan (2010) investigated anger and anger expression styles with respect to
coping with stress and interpersonal problem-solving and found a negative
relationship of trait anger with problem-focused coping and anger in with problem-
focused coping and seeking for social-support and anger-out with avoiding and
problem-focused coping and a positive relationship of anger control with problem-
focused coping and avoidance. However, a positive relationship was found among
approaching problems in a negative way, lack of self-confidence, unwillingness to
take responsibility with trait anger, anger in and anger out while a negative
relationship was found with anger control. A negative relationship was seen among
constructive problem-solving, trait anger and anger-in, and a positive relationship was
found between constructive problem-solving and anger control. And, a negative
relationship was found between insisting-preserving approach and anger-in, while a
positive relationship was found with anger-out and anger control. Besides, it was also
found that coping with stress and interpersonal problem-solving significantly explain
the trait anger and the anger expressing styles.

Bromberger and Matthews (1996) found that women who hold their anger in
had higher scores on depression 3 years later.
Zeman et al. (2002) assessed the association between strategies used to regulate anger and sadness and internalizing and externalizing scores in a primarily Caucasian sample of girls and boys in 4th and 5th grade. Three types of emotion regulation were assessed separately for sadness and anger: inhibition (e.g., getting mad inside but not showing it), dysregulated expression (e.g., whining), and emotion regulation coping (e.g., staying calm). Inhibition of anger, not sadness, was associated with internalizing but not externalizing problems.

Toti (2007) found that those with higher levels of anger tended to have lower total emotional intelligence and a lessened ability for emotional management, the most sophisticated aspect of emotional intelligence that includes emotional self-knowledge, social awareness, and refraining appraisals. These individuals also tended to see hostile intent in social situations where the intent was ambiguous; however, these individuals also saw hostility in the social situations in which there was no hostility present. Results indicated significant gender differences in scores. Men scored significantly higher on Trait Anger, Angry Temperament, and Angry Reaction Scales. Men scored significantly higher on the Angry Hostile Scenario types of the Hostile Question. Women score significantly higher on all major scales of the MSCEIT except the Understanding Emotions Branch. Results also indicated that emotional intelligence was a predictor of anger level and hostile attributional bias in ambiguous situations. Anger level and level of hostile attributional bias also predict overall emotional intelligence.

It was ascertained from the above studies that anger-in, anger-out as well as anger-control plays a significant role in predicting depression, however the role of anger-out was bidirectional i.e. in some studies it was found to have a positive relationship with depression and in some studies a negative relationship
was found. Not much information was found in relation to anger-control. Therefore, it is very important to study the aspects of anger in relation to depression in a comprehensive manner.

Peer Relationships:

The role of peer relations in depression is brought out by studies discussed in the forthcoming paragraphs.

In a study conducted by Laible & Thompson (2000), adolescents who scored high on measures of both peer and parent attachment were found to be the best adjusted (defined as least aggressive and depressed and most sympathetic), and those low on both were the least well-adjusted. Those high on peer but low on parent attachment were better adjusted than those high on parent but low on peer attachment, suggesting that peer attachment might be relatively more influential on adolescent adjustment than parent attachment.

The study conducted by Prinstein, Cheah and Guyer (2005) discovered that ambiguous peer experiences was most closely associated with depressive symptoms particularly if it was accompanied by high levels of peer victimization.

Roth, Coles and Heimberg (2002) and Olweus (1993) assert that verbal victimization in childhood is related to depressive symptoms in adulthood. A number of studies have equally found depression caused by victimization to be associated with suicidal ideation (Kim, Koh, & Leventhal, 2005; Storch, Brassard, & Masia-Warner, 2003; Juvonen, Graham, & Schuster, 2003; Storch, & Esposito, 2003; Wilkins-Shurmer, O’Callaghan, Najman, Bor, Williams, & Anderson, 2003; Rigby & Slee, 1999).
According to Coie (1990), problematic peer relations could be a marker for, a correlate of, or a causal pathway to psychopathology in youth.

Adolescents affiliating with high status peer crowds report higher self-esteem, less loneliness (Brown & Lohr, 1987; Prinstein & La Greca, 2002), and lower levels of depressive symptoms (La Greca & Harrison, 2005) than other adolescents.

Close friendships may also represent significant stressors. La Greca and Harrison (2005) found that negative interactions with a best friend (e.g., conflict, exclusion) predicted adolescents’ depressive symptoms, even after controlling for other aspects of social functioning (e.g., rejection, peer victimization).

Lopez and Dubois (2005) found that both peer victimization and perceived peer rejection contribute to depressive symptoms among adolescents, but only for girls whose self-esteem was influenced by the negative peer experiences.

In a study Prinstein et al (2005) found that depressive symptoms and negative peer relations predicted increasing levels of girls’ reassurance-seeking; initial levels of reassurance-seeking and depressive symptoms predicted deteriorating friendship quality among girls and low friendship stability, respectively; and reassurance-seeking combined with poor peer experiences predicted increases in girls’ depressive symptoms.

Greenberger, Cheu, Tally & Dong (2000) examined the correlates of symptoms of depressed mood among U.S. and Chinese adolescents. The findings revealed that the quality of family relationships and grades in school had significantly stronger associations with depressive symptoms among Chinese youths than among U.S. youths, whereas gender differences in depressive symptoms were greater among
U.S. youths. Peer warmth moderated the effects of particular risk factors for depressive symptoms in each cultural setting.

According to Parker, Rubin, Price, & de Rosier (1995), the act of developing premium peer relationships and friendships are important because young people who have difficulties in developing or maintaining such friendships are more likely to exhibit higher degrees of depression.

Research has also shown that victimization may result in negative self evaluation which can lead to depression, disassociation or suicide (Cleary, 2000).

Stice, Ragan & Randall (2004) found that support decreases the risk for depression but suggests that this effect may be specific to parental support during adolescence. They also found that depression promotes support erosion but imply that this effect may only occur with peer support during this period.

A study conducted by Wade & Kendler (2000) to determine the relation between social support and depression found that individuals who are mildly depressed often end up creating situations where friends can no longer take the constant assurance-seeking and cut off the relationship with the individual, leading to more serious depression.

Scholars have found significant relationship between bullying and depression (Li, 2006; Ivarsson, Broberg, Arvidsson & Gillberg, 2005; Van der, Wal, Wit & Hirasing 2003; Kowalski, 2003), victimization and depression (Abada, Hou, & Ram, 2008; Benas & Gibb 2007; Sweeting, Young, West, & Der 2006; Gibb, Alloy, Abramson, & Marx, 2003; Gibb, Butler, & Beck, 2003; Brockenbrough et al., 2002; Kaltiala-Heino et al., 2000) and between pro social behaviour and depression (Perren,
Evidence from these studies also revealed that bullying and peer victimization were associated with severe emotional and behavioral problems among adolescents (Juvonen, Graham, & Schuster, 2003; Willkins-Shurmer, O'Callaghan, Najman, Bor, Williams, & Anderson, 2003).

In the view of Turner, Finkelbor and Ormrod (2006), victimization among peers represents a substantial source for mental risk.

Abada, Hou and Ram (2008) and Sweeting, Young, West and Der (2006), discovered gender differences in peer victimization with females reported as more victimized than their male colleagues. Other studies found no such gender differences (Dill, Vernberg, Fonagy, Twemlow & Gamm, 2004; Fekkes, Pijpers, & Verloove-Vanhorick, 2004).

Vernberg (1990) found that aversive peer experiences evaluated in the context of less contact with friends and less closeness with a best friend, predicted increases in depressive affect over time.

With older adolescents, Harrison (2006) found that peer victimization predicted increases in depressive symptoms over a 2-month period and this relationship was stronger for adolescents who were high in rejection sensitivity (the tendency to expect, perceive, and overreact to rejection; Ayduk, Downey, & Kim, 2001).

Bishop and Inderbitzen (1995) found that adolescents with at least one reciprocal close friend had higher self-esteem (an indicator of low depression) than those who had no close friends.
According to Hussong (2000) adolescents who are involved in controlling friendships, which are characterized by peer pressure and social dominance, report low self-esteem and feelings of depression.

Biggs, Nelson, & Sampilo (2010) employed a five-month longitudinal study to test a model in which the association between anxiety and depression symptoms is mediated by peer relations difficulties among a sample of 91 adolescents ages 14-17 ($M=15.5$, $SD=.61$) years. Anxiety symptoms predicted depression symptoms, and this association was mediated by low perceived peer acceptance and victimization from peers, both of which emerged as unique mediators when they were considered simultaneously in the model. In addition to it, qualities of adolescents' best friendships did not emerge as mediators and were largely unrelated to symptoms of anxiety and depression.

In a study by Helsen et al. (1999), parent support remained the best indicator of emotional problems during adolescence. In fact, a friend's support appeared to depend slightly on the level of perceived parent support, with the high parent support group showing a slightly positive effect of friend support and the low parent support group showing a negative effect of friend support.

Uba, Yaacob & Juhari (2009) conducted a study to examine the predictors of depression in peer relationship (bullying, victimization and pro-social behaviour). The study indicated that depression has a significant and positive correlation with both bullying and victimization and a negative and non-significant correlation with pro-social behaviour. Significant difference was only found between male and female teenagers in bullying. The survey further discovered victimization as the unique predictor of depression among peers.
According to Marini, Dane, Bosacki, & Ylc-cura (2006), direct bully victims exhibit a wide range of maladjustment which includes internalizing problems, peer rejection, lack of close friendships, acceptance of deviance, less supportive and uninvolved parents, less optimal temperament, negative emotionality and reactive aggression.

Kupersmidt & Patterson (1991) have found a stronger relationship between peer rejection and depression for girls than for boys.

Prinstein and Aikins (2004) found that peer rejection predicted symptoms of depression, but only in adolescent girls who placed high importance on their social status or who exhibited a depressogenic attributional style.

According to Kowalski (2003), consequences of bullying and malicious teasing on victims include feelings of shame, humiliation, depression, anxiety, and low self-esteem.

In an earlier study conducted by Eisert and Jensen (2003) which examined bullying on teenage psycho-social health, bullying among teenagers was found to cause depression.

On the incidences of bullying among teenagers, scholars appear to have reached a consensus with males are more involved in bullying compared to their female counterparts (Abada, Hou & Ram, 2008; Ivarsson, Broberg, Arvidsson, & Gillberg, 2005; Baldry, 2004; Van der, Wal, Wit & Hirasing, 2003).

According to findings from a study conducted by Bearman & Moody (2004), relationships with friends play a significant role in whether teenage girls think about
attempting suicide but have little impact on suicidal thoughts among boys. Investigators found that girls were nearly twice as likely to think about suicide if they had only a few friends or were isolated from their peers. Girls were also more likely to consider suicide if their friends were not friends with each other. These relationship factors had no significant effect on whether boys considered suicide.

Studies of neglected adolescents (low in acceptance but not rejection) have been mixed; Hecht et al., (1998) have found levels of depressive symptoms comparable to that of rejected adolescents, while others have not (East et al., 1987).

According to Graham & Juvonen (1998) adolescents’ reports of peer victimization have been associated with internal distress, including feelings of loneliness, social anxiety, and low self worth.

According to Prinstein et al. (2001) both overt and relational victimization have been related to adolescents’ reports of depression, loneliness, and low self-esteem. Moreover, relational victimization has been strongly associated with adolescents’ reports of social anxiety and depression, even when other aspects of adolescents’ social status are controlled (La Greca & Harrison, 2005).

Field and colleagues (2001) found that depressed adolescents reported fewer friends than non-depressed peers.

Franzoi & Davis (1985) and Moran & Eckenrode (1991) found a stronger relationship between positive friendship qualities and fewer symptoms of depression in girls than in boys, but others have not (Townsend, McCracken & Wilton, 1988).

Cyranowski et al. (2000) focused on sex differences in affiliative style as a risk factor for depression. The authors argued that these differences are present
relatively early in life and are thought to be the result of biological and social factors. Problems arise in adolescence when, the authors posit, there is a transition of attachments from parents to peers, and eventually to romantic partners. Adolescent girls who are most challenged by this transition and, as a result, are more likely to become depressed, are characterized by an insecure attachment to their parents, an anxious or inhibited temperament, and low instrumental coping.

Dodge’s (1993) research indicated that poor peer relationships were closely associated with social cognitive skill deficits. He found that adolescents who had developed positive peer relationships generated more alternative solutions to problems, proposed more mature solutions, and were less aggressive than youth who had developed negative peer relationships. Along those same lines, Bansal (1996) found that adolescents who compared themselves negatively in reference to their peers experienced a reduction in attention to problem-solving tasks.

It was evident from the review of the above studies that peer attachment plays a very important role in depression. Problems in peer relations, e.g. peer rejection, peer victimization, bullying etc. may predict depression among adolescents as well as among young adults. The type of attachment style in peer relationships plays a vital role. It is therefore important to study attachment styles in peer relationships in relation to depression.

On the basis of previous investigations and theoretical outlines, the following hypotheses were formulated by the researcher.

HYPOTHESES:

The first set of hypotheses are concerned with Emotional Intelligence and its components viz. perceiving and understanding emotions, expressing and labeling emotions and managing and regulating emotions as predictors of depression among
1. a) Perceiving and understanding emotions has negative predictive relationship with depression.

   b) Expressing and labeling emotions has negative predictive relationship with depression.

   c) Managing and regulating emotions has negative predictive relationship with depression.

   d) Total Emotional Intelligence has negative predictive relationship with depression.

The second set of hypotheses is concerned with Anger Expression viz. anger-in, anger-out, anger-control and anger-total as predictors of depression among students.

2. a) Anger-In has positive predictive relationship with depression.

   b) Anger-Out has positive predictive relationship with depression.

   c) Anger-Control has negative predictive relationship with depression.

   d) Anger-Total has positive predictive relationship with depression.

The third set of hypotheses are concerned with Peer Relationships viz. peer attachment related anxiety and peer attachment related avoidance as predictors of depression among students.

3. a) Peer attachment related anxiety has positive predictive relationship with depression.
b) Peer attachment related avoidance has positive predictive relationship with depression.

4. Different factors predict depression among male and female students.

5. Different factors predict depression among students living in joint and nuclear families.

6. Different factors predict depression among students belonging to urban and rural areas.

7. Interactional effect of Emotional Intelligence, components of Emotional Intelligence, Anger expression and Peer Relationships explain variance in depression among students.

8. Male and female students differ in terms of –

   a) Depression
   b) Emotional intelligence
   c) Components of Emotional Intelligence
   d) Anger expression and
   e) Peer Relationships

9. Students from joint family and nuclear family differ in terms of -

   a) Depression
   b) Emotional Intelligence
   c) Components of Emotional Intelligence
   d) Anger expression
e) Peer Relationships

10. Students from rural region and urban region differ in terms of -

a) Depression

b) Emotional Intelligence

c) components of Emotional Intelligence

d) Anger expression

e) Peer Relationships