Chapter – 5

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Depression is listed as the chief complaint by more than half of all people coming to outpatient clinics. According to recent reports depression now rivals schizophrenia as the nation’s number one mental health problem. That fact makes depression numerically significant, as well as important from human standpoint. Thus, the possibility of suicide frequently exists, in which case treatment results as a matter of life and death. Prompt intervention emergency psychotherapy, therefore plays a crucial role in the care and treatment of the depressed people.

Depression has featured throughout history as perhaps the most pervasive of all psychopathology (cf. Boyd et al., 1982). If clinical depression was experienced as the “Epidemic of the 70s” (Weissman & Paykel, 1974), then it must be said that the epidemic appears to be growing. There is no evidence to indicate that the prevalence rates of depression are declining, and suicide appears to be on the increase especially among young adults. A disorder that will affect 5% to 10% of all adult males and 10% to 20% of all adult females demands the attention of mental health services and practitioners. Further, as society faces the continuing prospect of high unemployment and other difficulties, one may suspect that depression will continue as major mental health problem for years to come.

A number of studies have also shown that ongoing depression is associated with social support, negative cognitions and social adversity. Depressed individuals have greater difficulties in interpersonal interaction (Brugha, 1995; Upmanyu, Upmanyu, & Dhingra, 1992; Coyne, 1976; Weissman & Paykel, 1974), less gratifying social contacts (Roy, 1978) and a weak social support system (Andrews et al. 1978). They also manifest a
variety of negative cognitive patterns (Lewinsohn et al., 2000; Umanyu & Reen, 1991; Teasdale, 1988; Seligman et al., 1979; Beck, 1967). However, only prospective studies can establish whether these characteristics precede a depressive episode and whether they can be used to predict a new onset (Lewinsohn et al., 1988). Although the role of stressors in provoking depressive episodes is well documented (Billings et al., 1983; Tennant et al., 1981; Paykel, 1978), such events cannot usually be used for predictive purposes since they are usually too closely linked in time with the onset itself, usually occurring in the prior few weeks, in brief, it is imperative to note that the role of negative cognition, stressful life events and social support is well documented in the literature.

HYPOTHESES

The review of literature discussed in the proceeding pages provided the guidelines for the formulation of following hypotheses:

1. **Depression would be associated negatively with social support.**
   This hypothesis derived its rationale from the earlier researches which have revealed that either through direct protective effects or by buffering the adverse consequences of life stressors, social support is associated with a decreased likelihood of developing disorder. The presence of supportive people in one’s life enhances both physical and emotional well-being.

2. **Depression would be associated positively with neuroticism, psychoticism, introversion, and anxiety.**
   This hypothesis derived its rationale from Gotlib’s (1984) investigation which revealed positive association between depressive measures, psychopathology and anxiety as derived from self report measures.

3. **Depression would be associated positively with burnout.**
   This hypothesis derives its rationale from several studies reviewed earlier with respect to the role of burnout in the development and maintenance of depressive symptoms.
4. It is hypothesized that depression would correlate negatively with empathy.

This hypothesis derives its rationale from the following observations: The expression of emotions entails self disclosure and implies vulnerability to social censure. According to developmental interactionist theory (Buck, 1993, 1989, 1984), emotional regulation involves the ability to appropriately communicate one’s affective states to others. Therefore, personal and social characteristics that preclude emotional communication are likely to be associated with pathogenic outcomes. Ambivalence over expressing emotion, repressive defensiveness and fear of intimacy all exemplify problems in emotional communication. This breakdown of communication is likely to reduce the appropriateness of the helping effort of the conflicted individual’s social network. Thus, similar to the emotional intelligence framework, development-interactions theory also predicts that individual differences that result in inappropriate emotional expressions influence individual’s social network.

5. It is expected that internal locus of control would correlate negatively with depression.

Locus of control is defined as internal when individuals tend to attribute environment events to themselves and as external when individuals attribute such events to things outside their power (Strickland, 1978; Lefcourt, 1976; Rotter, 1966). Strickland suggested that internal locus of control as compared with external locus, improves functioning and greater resistance to psychological dysfunctions. Most of the research supports Strickland’s view: in contrast to people with external locus of control people with internal locus of control express greater motivation to take inoculations (Debbs & Kirscht, 1971), tend more to use safety belts when driving (Williams, 1972a), are more likely to have regular dental examinations (Williams 1972b) are more successful in weight reduction programs (Balach & Rose, 1975) and more often obey doctor’s orders and persist in required medical treatment (Strickland, 1978). In the area of mental health, it has been found that people with internal locus of control suffered less from severe psychiatric disorders.
(Lefcourt, 1976), especially from chronic depression (Abramson, Seligman, & Teasdale, 1978).

6. It is hypothesized that depression would correlate negatively with hardiness.

This hypothesis derives its rationale from the researches conducted by Kobasa, which clearly reveals the stress-buffering effect of hardiness. Hardiness has been theorized to affect stress and health in two ways. Greater hardiness has been conceived of as being associated with less psychological and consequently greater health because hardy individuals alter their perception of stress (e.g. to be a challenge). Secondly, both hardy and non-hardy individuals may undergo high levels of stress due to life events. However, hardy individuals are more likely to use effective coping strategies and social resources to reduce stress and prevent illness.

7. It is expected that depression would correlate positively with perceived stress.

Recent years have witnessed a burgeoning interest in stress and its potential to affect health. However, as with the concept of health itself stress is prone to woolly definitions and imprecise meaning. As much as health has been described as a discourse still in the process of fabrication (Beattie et al., 1993). Stress is still subject to multiple explanations from a diverse set of academic viewpoints. Stress needs clear definition, it is familiar to professionals and layman alike, it is understood by all, but defined satisfactorily by none. A plethora of disciplines – psychology, psychiatry, nursing, medicine, sociology, anthropology, and pharmacology have studied stress, each with their own objectives and particular methodologies. Indeed, between 1987 and 1992 the psychological literature alone, cites 10,385 articles related to this subject (Mulhall, 1996). The concept of stress is, however, not confined to the professional discourse, it is also widely invoked by people on an explanation for certain forms of illness. A relationship with excessive work, modern living, type ‘A’ personality, executive lifestyle and potentially stressful life events and so on are suggested, and this view is reinforced through television-programmes, magazines, articles and numerous books written by professionals, health care workers, and lay people (Mulhall, 1996).
SAMPLE

Three hundred nurses (150 head nurses and 150 staff nurses) participated in the study. The sample of 300 nurses was selected from various hospitals in Chandigarh. Further, the participants to be included in study were also required to be showing:

1. No evidence of drug addiction or alcoholism, and
2. Not currently in treatment for a diagnosed psychiatric disorder.

The sample was limited to participants, who were available and willing to participate in this study, thus limiting the assumption of randomization.

MEASURES / TOOLS

The following tests were used:

1. Zung’s Self Rating Depression Scale (Zung, 1965).
2. Eysenck Personality Questionnaire (Eysenck & Eysenck, 1975).
3. Hardiness Scale (Kobasa et al., 1982).
4. Social Support Questionnaire (Sarason et al., 1983).
7. IPAT Anxiety Scale Questionnaire (Cattell & Scheier, 1963).

DATA COLLECTION

The tests were administered in a uniform sequence as follows:

1. Zung’s Self Rating Depression Scale.
2. Eysenck Personality Questionnaire.
3. Hardiness Scale.
4. Social Support Questionnaire.
5. Mehrabian Epstein Emotional Empathy Scale.
6. Internal External Scale.
7. IPAT Anxiety Scale Questionnaire.
8. Maslach Burnout Inventory.

The tests were administered to subjects individually. The general testing conditions were satisfactory. Sincere efforts were made to establish rapport with the participants in order to elicit reliable and authentic information. All of them were assured that the information given by them would be kept confidential and would be used for research purpose only. Despite the task being tedious, participants showed keen interest in filling out different questionnaires.

SCORING OF TESTS

The tests were scored strictly in accordance with the procedure(s) suggested by the authors of different tests. Hand scoring was done by using separate keys for respective tests used in the current study. Zung’s Self-Rating Depression Scale was used to measure depression. The IPAT Anxiety Scale Questionnaire was used to measure anxiety as revealed by five distinct factors, namely Factors Q3, C, L, O and Q4.

The Eysenck Personality Questionnaire was scored for measures pertaining to psychoticism, neuroticism, extraversion, and social desirability and Hardiness Scale was scored for three measures, namely control, commitment and challenge. Social support questionnaire was scored for two indices of social support: quantitative and qualitative social support. Internal-external Scale, Perceived Stress Scale and Burnout Inventory were scored for independent measures of internality/externality, perceived stress, and burnout.

As a result of scoring different tests 19 measures as mentioned below were obtained:

1) One measure of depression.
2) Four dimensions of personality concerning extraversion, psychoticism, neuroticism, and social desirability.
3) Three measures of hardiness referring to control, commitment and challenge.
4) Two measures of social support: quantitative and qualitative social support.
5) One measure each of empathy, burnout, locus of control and perceived stress.
6) Five measures concerning second-order factor of anxiety.

ANALYSIS
The data were analysed to obtain the following information:
1. Frequency distributions of scores on 19 measures.
2. Mean, standard deviation, skewness and kurtosis for different measures.
3. Intercorrelations among different variables.
4. Factor Analysis.

RESULTS AND DISCUSSION
The results have been presented and discussed under the following headings:
A) Frequency distributions of scores on tested variables.
B) Reliability coefficients of different measures.
C) Bivariate correlations between tested variables.
D) Structural relationship among the tested variables.

Conclusions

Overall it can be concluded that the present study has shown some interesting results in the sense that depression as derived from Zung’s Self Rating Depression Scale is associated negatively with empathy and positively with perceived stress. Among nurses empathy and perceived stress are important variables relating to depression. Empathy has been found to play a positive role while perceived stress has been found to play a negative role so far as depression in nurses is concerned.
The current study has revealed the importance of empathy and perceived stress in depression among nurses. Since empathy is negatively correlated and perceived stress is positively correlated to depression among nurses. The high empathy persons may be at particular risk and need greater support as they enter in professional practice. The role of empathy and perceived stress has been discussed at appropriate places in the light of relevant constructs involving empathy, perceived stress, and depression among nurses.