CHAPTER III

REVIEW OF THE RELATED LITERATURE
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This chapter presents review of the related literature in respect of the variables included in the present study in the following order: attributional style and depression, personality and depression, social-support and depression, coping and depression, life stress and depression, and gender differences or sex role orientation and depression.

ATTRIBUTIONAL STYLE AND DEPRESSION

Golin, Sweeney and Shaeffer (1981) concluded that the attributional reformulations of the learned helplessness model of depression proposes that causal attributions about negative outcomes play a casual role in reactive depression. This research tested this hypothesis by studying the causal role of attributions in depression in 180 college students. On two occasions separated by 1 month, students were administered a battery of tests that included an Attributional Style Questionnaire and the Beck Depression Inventory. The attributional dimensions of internality stability and globality were found to be correlated with depression, when the possible causal role of attributions was tested through the use of cross-lagged panel correlational analysis, the hypothesis that stability and globality attributions for bad outcomes might be causes of depression,
was supported. There was no support, however, for the hypothesis that internal attributions for bad outcomes are a cause of depression. Evidence was also found that unstable attributions for good outcomes may function as a cause of depression. A 1979, correlational study of Pennsylvania college students by Seligman et al. supported this reformulated learned helplessness model and additional studies almost all addressed the applicability of the model to populations, other than college students, and the extent to which attributional style can be used to predict subsequent onset of depression.

Peterson, Christopher, Barbara, Seligman and Martin (1985) measured attributions and attributional style by having 66 adults (average age 21 yrs.), write essays describing the 2 worst events that the short term of the Beck Depression Inventory (BDI), causal explanation for bad events were extracted from the essays and rated by judges for internality vs (externality), stability vs (instability), globality vs (specificity). Ratings were found to be consistent across different attributions made by the same subjects. The internality, stability and globality of these unprompted attributions correlated with depressive symptoms as measured by the BDI. Taken together, the results supported the attributional reformulation of the learned helplessness model of depression, which proposes that an attributional style that explains bad events by internal, stable and global causes is likely to be associated with depressive symptoms.
Perrez, Meinhard and Reicherts (1986) compared 30 depressed patients (aged 29-62 years) and 30 normal controls on appraisal coping and attribution process in aversive or ambiguous situations, and situations characterized by loss or failure. The depressed group appraised more strain and less controllability and seemed less adaptive. Environment directed coping of this group was less active, more evasive and more passive. Self-directed coping focuses on palliation and self-punishing cognitions. Attribution after negative outcomes were more internal. Some group by phase interactions indicated process specificity (e.g. appraisal adaptivity).

Continuing the research work, Handal, Paul, Gist and Richard (1987) administered the Attributional Style Questionnaire (ASQ) by Peterson et al., and the Depression Inventory by A.T. Beck et al., to 35 male and 40 female undergraduates (aged 18-21 yrs.) enrolled at a large university in mid western 45 to determine the existence of a differential relationship for males and females between attributional style and current depression, this correlation is significant for males but not for females. There also appears to be a significant difference between concurrent depression scores for high middle and low ASQ composite negative males, but not females.

Further, in 1988, Crocker, Jennifer, Alloy and Kayne, examined the difference between depressed and non-
depressed individuals implicit perceptions of consensus which may contribute to differences in their attributional styles. Subjects rated the extent to which positive negative and neutral events happen to themselves and to the average college student and completed measures of depth, of depression, and attributional style. Perception of consensus were highly correlated with all components of attributional style for negative and positive events.

In 1988, Peterson and Christopher showed that, of 146 college students, those who believed that stable plus global factors (SPGFS) causes bad events, experienced more days of illness in the following month and visited physicians more frequently in the following year than students who explained bad events with unstable plus specific causes.

Steinsmeier & Joachim (1989) predicted that according to the reformulated learned helplessness model of depression, individuals who characteristically attributed negative events to internal-stable-global causes become depressed when confronted with negative life events. This proposition was tested in field and laboratory studies with an interpersonal, socially relevant character. In the field study, the attributional style of 86 female college students was investigated. The lab study recorded the mood of 46 female students before and after either success or failure outcomes. In both studies, changes in depressive mood were
predicted by the attribution, by outcome interaction. The direction and form of the interaction were in line with the diathesis stress model. In the field study, outcome was a significant predictor of changes in depressive mood.

Further, Marsh & Weary (1989) examined whether mildly and moderately depressed individuals were more sensitive to social information than non-depressed individuals. 564 undergraduates completed the Beck Depression Inventory and an attributional complexity scale. Mildly depressed Ss had an attributional complexity scores, non-depressed and severely depressed Ss had the lowest score. More women than men were depressed, and women also had higher attributional complexity scores. The relationship between attributional complexity and depression may reflect depressive's responses to heightened contingency uncertainty and expectations of uncontrollability.

Hunsley, John (1989) assessed the ability of the reformulated learned helplessness model (e.g. Peterson and M.E. Seligman) of depression to predict affective reactions to a stressful event, using a prospective diathesis stress model. 131 undergraduates completed the attribution style questionnaire and the depression scale of the Multiple Affect Adjective Checklist and Questions regarding performance aspirations for an upcoming examination. Ss completed the depression measure immediately following the exam. and again after receipt of their grades. The
discrepancy between Ss grade aspirations and their achieved grades was used as a measure of subjective stress. A depressive attributional style interacted with this measure of subjective stress to predict changes in Ss's depressive mood following the examination, but not after receipt of their grades. Data support the model's utility.

Endlich & Eric (1989) conducted a study in which 50 adult clients at college counseling centers completed scales measuring depression, attributions for their primary problems and its expected improvement and locus of control. Ss who were more depressed made relatively internal and stable attributions for their primary problems were less likely to believe they would improve, and expressed more belief in the importance of chance and powerful others. As a group, Ss tended to view their improvement as more internal and controllable than the cause of their problems. Results suggest that knowledge of clients' attributions for their problems could prove relevant to the treatment of depression.

Willner, Margaret & Arnold (1990) administered the Attributional Style Questionnaire (ASQ) and the Hassles and Uplifts Questionnaires (A.D. Kanner et al. 1981) (aged 23-72 yrs) who were matched for severity as well as to non-depressed controls (aged 19-68 yrs.) Melancholic Ss had higher ASQ internality and stability scores for negative attributions and reported a greater intensity of hassles and a lower frequency of uplifts. Intensity of uplifts was
reduced in both depressed groups. On all other cognitive measures reactive patients were the same as controls. Results suggest that depressive attributional style may be specific to melancholic patients and underline the importance of studying well defined diagnostic subgroups.

Kaslow, Rehm & Alexander et al. (1990) investigated patterns of cognitive functioning in three groups of 8-12 yrs. old (25 nonclinic normal ) 22 non-depressed clinic and 15 depressed clinic and their parents. Depressed clinic children self-reported more depression, had more depressive attributional style, and had more self-control problems. There were more depressed mothers in the clinic than in the non-clinic group. Depressed clinic children had more depressed-mothers than did non-depressed clinic children, there were no differences among three groups of parents in their cognitive patterns. No relationship was found between attributional style and self-control behaviour of children and their parents. Findings do not support the view that cognitive distortions of parents lead to cognitive deficits and depression in children.

Gordon & Hewitt's (1990) recent research on attributional complexity with college student samples has indicted that mild and moderate depression is associated with increased attributional complexity but more severe depression may be related to decreased attributional complexity but more severe depression may be related to decreased attributional
complexity in clinically depressed patients and normal controls. The results, confirmed that severe depression is associated with reduced attributional complexity.

Hull and Mendolia (1991), used structural techniques to assess relations of attributional style, expectancies, and depression. According to an initial theoretical model, attributions are directly related to expectancies, and expectancies related to depressions. But attributions are indirectly related to depression by means of their relation to expectancies. The results in 2 respects:

(a) Attributions for positive and negative events did not form a single latent variable, and

(b) Attributions for negative events were indirectly related to depression by means of expectancies and were directly related to depression. Attributions for positive events only were indirectly related to depression by means of expectancies.

Tracy, Bauwens, Martin, Pardoen and Mendlewicz (1992) investigated attributional style in remitted affective disorder patients (23 unipolars and 26 bipolars) and 26 non-psychiatric controls. They found a specific cognitive vulnerability in unipolars. Unipolers attributed negative events to causes that were more stable, but not more internal nor more global - than bipolars and controls, and did not attach more importance to these events.
Attributional vulnerability seemed more apparent in patients with longer histories of depression.

Summary

The review of many studies mentioned here reveals that attributional style plays a major role in the onset of depressive disorder. Mainly, the negative attributional style (RNO) of a person is responsible for depression onset, or persons who are already depressed due to onset of negative life-stress are having negative attributional style. Attributional vulnerability seems to be more apparent in patients with longer histories of depression as compared to non or never depressed outpatients.

PERSONALITY AND DEPRESSION

Callea, Rubino and Alex (1980) discussed the prevalence of personality disorders relative to that of neurosis with classical symptomatologies. It is suggested that there is an increasing incidence of symptoms halfway between neuroses and psychoses, such as vague feeling of depression, an inability to relate to others, psycho-somatic disorders and drug-dependence. The literature in this field is reviewed, citing works by authors such as W.R. Fairbank (1940) and H.Deutch (1942). The occurrence of depersonalization, passive confirmity to peer group demands and repressed aggression in personality disorders is described. In addition personality disorders are discussed in
relation to such issues as the structure of object relationships and the role of defense mechanisms such as projective identification and splitting.

Descriptions of a similar dichotomy of correlated traits associated with depression are found in the work of other theorists (e.g., Arieti & Bemporad, 1980, Back, 1983, Blatt, 1974). Although the receptive personality styles identified by these theorists appear to be similar, dependent and autonomous tendencies are postulated to be dominant modes of personality, they may nevertheless coexist within a single individual. Both personality modes are hypothesized predispose one to depression: whereas the dependent individual is particularly at risk when sources of interpersonal support are threatened, the autonomous person is sensitive to setbacks in goal attainment.

Hammen Marks, Mayol & deMayo, 1985) investigated the relationship to depression of the interaction of personality and life events using both the SAS (Robins, 1986, Robins & Block, 1986) and a schema based method for assessing personality type. The results of this research suggest that dependency, or sociotropy mediates the depressogenic effects of negative life-events, but the more specific link between sociotropy and negative social events has not been well demonstrated. Little support has been found for the role of autonomy as a mediator or either social or achievement related events.
Although extroversion-introversion covaries with depression, recovered depressives remain more introverted than never depressed people. This result is supported by the study of Hirschfeld, Klerman, Clayton and Keller (1983). They found that in addition to being more introverted, formerly depressed patients, compared to never depressed controls, were significantly less sociable, less dominant, less active, and lower in social self-confidence.

The relationship with depression of a second pair of personality dimension, introversion and extroversion has been the focus of another large body of literature. Neuroticism and extroversion-introversion are postulated by H. J. Eysenck & M. V. Eysenck (1985) to be the most universal and fundamental dimensions of human personality. The highly neurotic individual is postulated to have a low threshold for autonomic nervous system activation, to be prone to anxiety and fear responses and to be emotionally labile. In general, whereas neuroticism correlates positively with depressive symptoms, extroversion is inversely related to depression.

Davidson, Miller, Robert and Rosemary (1985) studied neuroticism and DSM-III personality disorder in 39 depressed inpatients by comparing interrelationship between these variables and their relationship to depressive typology. The relationship of neuroticism (N) DSM-III personality type and adequacy of personality to MAO inhibitor treatment was also examined. Results show that after 4 weeks treatment with
isocarboxazid, the 31 Ss who completed treatment had N scores on Eysenck Personality Inventory (EPI) that were unaffected by short term treatment. No differences in N were observed between melancholics and non-melancholics, or between endogenous and non-endogenous depressives. Higher N scores were associated with DSM-III personality disorder. Personality disorders occurred significantly more often in non-melancholics, borderline antisocial and histrionic personality disorders occurred exclusively in non-melancholia, while passive-aggressive dependent and avoidant disorders occurred in both kinds of depression. Response to MAO inhibition treatment was similar in Ss with high and low N, adequate and inadequate personality, DSM-III personality disorder and no DSM-III personality disorder. Ambiguities of the EPI N scale are discussed in relationship to depression.

Casey, Tryer (1986) assessed a random sample of 200 people (aged 18 yrs) selected from urban and rural communities using structured interview schedules to measure the prevalence of personality disorder and psychiatric illness and their relation to social functioning. Results show that explosive personality disorder was the most prevalent type of abnormal personality. Social-functioning was significantly worse in those with personality disorder, than those with normal personality. Social functioning differed between some Present State Examination diagnostic categories. An assessment is made of the variables contributing to mean social functioning score, of the
interactions between them, and of the correlation between social functioning and psychiatric symptomatology.

Joffe, Russel & Josph (1988) in their study assessed the effect of depressed mood on personality scale scores and personality disorders diagnosis on 42 Ss (aged 20-60 yrs) using the Millian Clinical Multiaxia Inventory. The Ss fulfilled criteria for unipolar non-psychotic major depression disorder on a structured interview using the schedule for Affective disorders and schizophrenia lifetime version. Results show a significant alteration in mean personality trait scores and reduction in personality disorder diagnosis between the depressed and remitted states.

Zimmerman, Bruco, William, Stangle & Dalene et al. (1988) examined the concordance between diagnosis of personality disorder (PD) in 66 consecutive inpatients with depression, that was made by independent patient interviews and by a close informant. Results indicate that suspects and informants differed in their descriptions of Ss normal personality and that informants reported more pathologic conditions than Ss did. Correlations between subjects and informants PD dimension scores were low, with informants reporting higher PD dimension scores than Ss. Results for different types of PDs are reported. Explanations for the poor agreement between these sources of information are considered.
Pilkonis and Frank's (1988) study of personality assessment of 119 treatment responsive adult patients with recurrent unipolar depression revealed that 48% showed some personality disturbance. The most common personality features were avoidant (30.4%) compulsive (18.6%) and dependent (15.7%). Factor analyses of personality data yielded results consistent with previous factor analytic studies of personality features and clinical descriptions of depressed patients. A discriminant function analysis using personality variables alone was able to distinguish (with 65% accuracy) between patients who responded normally to treatment and those who responded more slowly.

Gjerde, Block & Jeanne (1988) examined the observed and self-attributed personality characteristics associated with depressive symptoms in non-clinical adolescents. 87,18 yrs old completed the center for Epidemiological Studies Depression Scale (CES-D) scale, adjective self-description and the Multidimensional Personality Questionnaire (MPQ). Separately, California, Adult Q Sort (CAQ) ratings of the subjects were obtained. Although mean CES-D scores did not differ for the sexes, dysthymic young men were more negatively evaluated than were dysthymic young women, and nondysthymic young persons of both sexes. Extensive differences were also observed between male and female Ss in observer's, (CAQ) correlates of CES-D scores. 18 yrs-old dysthymic young men were seen as disagreeable aggressive, and antagonistic an externalizing
pattern of characteristics, 18 yrs-old dysthymic young women were seen as ego brittle, unconventional and ruminating an internalizing pattern of characteristics. In their self recognition, both male and female subjects described themselves as aggressive and alienated. Non linear relations between CES-D scores and personality were also observed.

Alanoes & Randloff (1989) interviewed 298 patients (aged 19-59yrs) with the structured clinical interview for Diagnostic and Statistical Manual of Mental Disorders (DSM-III) Axis 1 and the structured interview for DSM-III Personality Disorders. Results show that 30% of subjects with major depression also had a dysthymic-cyclothymic disorder. Ss in the mixed group of major depression dysthymic-cyclothymic disorder also had more severe depression than Ss in the pure dysthymic cyclothymic groups. Ss with chronic affective disorder had more neurotic and oral personality traits and more often personality disorders within the dramatic and anxious clusters of disorder. Borderline and avoident personality disorders were especially common among these patients.

Coryell and Mark (1989) conducted a family study of 176 probands (aged 17yrs.) with non-psychotic major depression, psychotic major depression schizophrenic or no history of Diagnostic and Statistical Manual of Mental Disorders, (DSM-III) disorders and 786 relatives. Findings support familial links between Axis I and Axis II disorders,
with modest specificity. There were no clear associations between particular personality disorders and particular Axis I disorders. Instead, "Acting out" personality disorders generally characterized the families of probands with non-endogenous types of depression, and cluster 3 disorders seemed frequent among relatives of bipolar probands.

Robins & Perlon (1989) hypothesized that a number of writers have suggested that two sets of personality characteristics are associated both with vulnerabilities to depression in response to different classes of events and with different clinical presentations of depression. The present study examined the relations between levels of sociotropic and autonomous personality characteristics and specific theoretically derived clusters of symptoms associated with the concept of anxious-reactive depression and was unrelated to the autonomous personality characteristics and symptoms were not found. These results support the idea that the symptom picture in depression may be related to personality characteristics, but they also suggest that the measurement of autonomy may require revision.

Ionescu & Cristina (1989) administered the Beck Depression Inventory and the Hamilton Rating Scale for Depression to 42 male and 69 female undergraduates with depressive disorders. Half of the subjects had a concurrent personality disorder (PD), and nearly 15% exhibited traits
characteristic of a disorder but did not meet diagnostic criteria. Females revealed more disorders than males. Unstable, obsessive, Hysteric and dysthymic Pds were more frequent, and many Ss showed signs of multiple disorders. Ss with PDs had an earlier age of affective illness onset, more severe depression and a high frequency of recurrent and non-reactive depression forms. Non bipolar major depressive disorders were associated with unstable and dysthymic PDs, while minor depressive disorders were related to hysteric and multiple disorders.

Fogel & Westlake (1990) investigated the prevalence of personality disorder in elderly patients with major depression and explored issues of diagnostic practice and bias by reviewing triaxial diagnosis of 756 male and 1,566 female psychiatric hospital in patients with Axis I diagnoses of major depression. Axis II diagnoses had been made in 367 cases (15.8%). Patients older than 65 yrs. of age had a lower rate of Axis II diagnoses. The age effect was greatest for women with comorbid physical illness. In contrast with the age related decline in rate of Axis II diagnoses in general, the diagnoses of compulsive personality disorder increased with age and comprised 46% of all Axis II comorbidities in patients 65 yrs. older.

Philips & Gunderson (1990) reviewed the literature on the depressive personality and explored the issues relevant to the possible inclusion of an Axis II
personality disorder linked to Axis I depressive disorder in the upcoming Diagnostic and Statistical Manual of Mental Disorders (DSM-II). Topics discussed include German psychiatry's "depressive temperament and depression as neurosis and personality disorder in DSM - I and DSM - II".

Block & Gjerde (1991) conducted a study in which antecedents of depressive tendencies at age 18 were longitudinally evaluated using data from nursery school through high school. Depression was measured by CES-D scores from which the contribution of self-reported anxiety was partialled. At age 7, boys were aggressive, self-aggrandizing, and under control whereas girls with later depressive tendencies were intropunitive, oversocialized and overcontrolling. Similar gender-differences were observed in pre-and early adolescence. At age 14, dysthymic boys were more likely to use both marijuana and harder drugs whereas girls showed no such tendency. These girls showed tendency to experiment with hard drugs and displayed low self-esteem. The psychodynamic of gender differences in depressive affect were discussed.

Summary

From the overmentioned related research, it can be concluded that personality is also a concomitant of depression. It has been indicated that dependency or sociotropy mediates the depressogenic effects of negative life-events, and that introverted, formerly depressed
patients were significantly less sociable, less active and lower in self-confidence. It was found that, whereas neuroticism correlates positively with depression, extroversion is inversely related to depression. The literature on the depressive personality has extensively explored the issues of personality disorder linked to depression.

SOCIAL-SUPPORT AND DEPRESSION

Social-support represents an integral component of stress and psychopathology. Most research however, has been cross-sectional in design, wherein support and disorder are measured contemporaneously (Brown, 1974, Dohrenwend, 1974, Monroe, 1982, 1983). Social support is correlated with other variables as well, but the main effort is being made to find out the relationship of social-support with depression.

A number of studies indicate that it is the perception of support, particularly support satisfaction, that most consistently predicts better outcomes (Henderson et al., 1981, Hirch, 1980, Lieberman, 1982, Sandler & Barrera, 1984). Interestingly, investigations assessing the amount of support received suggest that support utilization is related to increased levels of psychological symptoms (Barrera, 1981). This apparently anomalous outcome has been interpreted as confounding availability of support with the need for support under stress (S.Cohen and Wills, 1985).
There is consistent evidence of a negative relationship between many facets of social-support and concurrent depression (Bell, Ley Roy & Stephenson, 1982, Billings & Moos, 1984). Smaller social networks, fewer close relationships are all related to depressive symptoms. The precise nature of the relationship of social-support with depression, however may depend to some extent on the nature of the support measures used.

Monroe & Wise (1983) concluded that at the broadest level, social-support has been conceptualized variously as an objective quantity of social-resources, a process by which one develops, uses, and maintains resources (Leavy, 1983), a cognitive appraisal (Turner, Frankel, & Levin, 1983) and a transaction between person & environment (Coyne & Holyroyd, 1982). Symptoms are controlled. Further, the results of this research suggest that low social integration measured with a multiterm questionnaire, by assessing subject's social participation (Phifer & Murel, 1986), or by examining the number of important relationships (Billings & Moos, 1985, Lin & Ensel, 1984) may be characteristic of people, prone to depression (Phifer & Murrel, 1986) and the cause of exciting symptoms (Cutrona, 1984, Lin & Ensel, 1984) and distinguishes remitted depressives from control subjects.

Lin & Ensel (1984) asked respondents in a community sample to indicate on a 4-point scale whether they
had a close companion and enough close friends. With initial symptoms included in the model, path analysis reveled a direct negative effect of $T_1$ social support on change in depressive symptoms at $T_2$.

In another study, Monroe et al. (1983) assessed number of best friends and social group memberships, as well as whether respondents lived with their parents. Living away from homes significantly predicted an increase in depression after the effect of concurrent symptoms were partialed out, whereas main effects for the other indicators of support were not significant. In addition, the interaction between total number of best friends and an index of perceived impact of stress was also significant, with fewer friends and more undesirable versus desirable life-events, predicting a higher level of depressive symptoms.

Cutrona (1984) concluded that there is some evidence that the relationships with depression of different aspect of extramarital social support remain significant. When the effect of concurrent depressive Cutrona (1984) obtained information on six-dimensions of social-support from women during their pregnancies. Many of these aspect of support would most probably have been provided by women's husbands but at last one concerned extramarital support, social integration. However, depressive symptoms at 8 weeks postpartum were negatively related to both social integration and social-support. Social integration accounted for 9% of
the variance in postpartum depression independent of initial symptoms and moreover, none of the interactions between support and stress was significant when alpha was controlled experiment wise.

In their study on depressives, Billings & Moos (1985) found that remitted depressives tested 12 months after admission to treatment had fewer friends and fewer close relationships, but not fewer social network contacts, than did normal controls. These results suggest that although remitted depressives maintain normal levels of superficial relationships, they may have fewer meaningful relationships than do never depressed people.

Cohen and Wills (1985) predicted that the perceived availability of functional support buffers the effect of stress by enhancing broadly applicable coping abilities. In comparison, the degree of integration in a social network, or structural support was found to have a direct positive effect on well-being, reducing negative outcomes in both high and low stress circumstances.

Further in 1985, Cohen and Wills concluded that social-support has been dichotomized as either structural or functional. Structural support refers to the number and degrees of integration of relationships, whereas functional support: Comprise various content dimensions, such as esteem, informational support, social companionship and tangible support.
Billings & Moos (1985) observed that remitted depressives perceived the quality of their familial interactions to be less supportive than that reported by normal controls, however recovered patients did not differ from normal controls in the quality of a significant relationship or work support.

Coyne and DeLongis (1986) argued that the failure of previous research to recognize the qualitative difference between marital and extramarital support may have obfuscated the nature of the relationship between social-support and emotional well-being.

O'Hara (1986) was unable to differentiate women who become depressed postpartum from those who did not on the basis of respondent's perceptions of emotional and instrumental support, received from a single extramarital confident during pregnancy. O'Hara's use of rigorous diagnostic criteria to divide subjects in to depressed or non-depressed groups, which entails a loss of information about the covariance of independent and dependent variables, may account for the discrepancy in these results. It is more probable that by narrowing the source support to a single person, O'Hara failed to detect differences that may have been revealed if Cutrona's more general approach had been taken.

Monroe and Steiner (1986) concluded that social support represents an integral component of theory on
stress and psychopathology. Little attention however has been directed toward understanding social support within the context of other predictors of disorder. Although it is often acknowledged that measures of support are correlated with other variables also related to psychological functioning, a paucity of effort has been devoted to differentiating such variables from support or to studying their interrelations with support over time. Three alternative predictors are selected for discussion, pre-existing disorder, stress and personality. Research has been hindered by a lack of attention to the diverse associations between measures of social support and these related features of the individual's social environment and psychological functioning. This is due in part to, (a) measurement redundancies (b) method limitations, and (c) conceptual ambiguities involving support and other constructs.

Barnett and Gotlib (1988) attempted to distinguish empirically between psychosocial variables that are concomitants of depression, and variables that may serve as antecedents of this disorder. Six variables were compared with depression are attributional style, dysfunctional attitudes, personality, social-support, marital distress, and coping style. The review suggests that whereas there is little evidence in adults of a cognitive vulnerability to clinical depression, disturbances in interpersonal functioning may be antecedents or sequelae of this disorder. Specifically, marital distress, and low social integration
appear to be involved in the etiology of depression, and introversion and interpersonal dependency are identified as enduring abnormalities in the functioning of remitted depressives.

Fisher (1989) explores cognitive factors in depression (i.e., Learned helplessness, reactions to environmental events, and judgment of personal performance) as important determinants of the reactions of life-events and explores evidence that contradicts the view of depression as being driven by pessimistic beliefs about the world. A new methodology is discussed that incorporates a response-based definition of life-stress and that is designed to identify the epidemiology of life events, allowing the incorporation of personal meanings.

Brugha, Bebbington & Sturt, (1990) examined whether initial levels of social support would predict clinical improvement in depression (DP) even when other potential risk factors (e.g., age, sex, diagnosis, severity of DP) were controlled. 119 psychiatric hospital patients with depressive disorders were interviewed at the time of their initial contact with the hospital and reassessed 4 mo. later. Severity and duration of episode emerged as the only significant background predictors of recovery. The explained variance in recovery from DP due to social support was equal in men and women and was not diminished by the background clinical predictors. However, the aspects of personal
relationships and perceived support that predicted recovery in men and women, appeared to be different.

In another study Palinkas, Deborah & Elizabeth (1990), revealed in a survey of 1,615 elderly persons (aged 65 yrs.) that women and men differed with respect to current marital status, number of close friends and relatives, frequency of face to face contact, and participation in voluntary associations and religious institutions. Beck Depression Inventory mean scores and rates of depressive symptoms were inversely associated with social network index and participation in voluntary associations and religious institutions. Both social network index and social distance to primary source of support were independently associated with depression after controlling age, sex, and number of chronic conditions. Depressive symptoms were inversely associated with the size of social networks, the structure of which was influenced by biological factors and culturally determined rules.

Clark-Lempers & Netusil (1990) investigated the relationship among family financial stress, parents' emotional affective support for their children, academic achievement, and depressive symptoms in 105 6th, 7th, and 8th graders from farm and nonfarm families. Results of analysis of variance (ANOVA) indicate that parents from farm families reported higher levels of family financial stress and of depression than parents from nonfarm families.
Multiple regression analysis showed that family financial stress as reported by parents was strongly related to adolescents' reports of depressive symptoms.

Kessler, Heath & Eaves (1992), in a survey of 821 same sex female twin pairs from a population-based registry assessed 8 dimensions of social-support and social integration. Twin analysis documented significant common environmental influences on 5 of these 8 measures and significant genetic influences on 5 of the 8. A decomposition of the multiplicative association between support and a measure of stressful life-experiences in predicting depressed mood, an association typically interpreted as providing evidence for a stress buffering effect of social support, shows clearly that it is the environmental and genetic factors that cause support, rather than support itself, that buffer the effect of stress on mood in most cases.

Summary

A number of studies indicate that it is the perception of support that predicts better outcome. There is consistent evidence of a negative relationship between many facets of social support and concurrent depression. Various studies have predicted that social support buffers the effect of depression by enhancing the coping abilities, while those getting no-support have much more chances of becoming depressed.
COPING AND DEPRESSION

There have been some studies of the interpersonal behaviour of depressed persons and characteristic response of others in laboratory situations (Coyne 1976, Lewinsohn 1980.)

Coyne and Lazarus (1980) concluded that although coping efforts are made in response to stress appraisals, appraisal and coping are reciprocal influences. Coping efforts may change the person environment relationship by altering the situation (problem-focused coping) and by altering the person's thoughts and feeling about it (emotion-focused coping). Such changes lead to reappraisals which engender new coping efforts, and so on.

Coyne, Aldwin & Lazarus (1981) conducted a study in which 15 depressed and 72 non-depressed middle aged person were repeatedly assessed over a one year period, with respect to the thoughts and actions they used in coping in stressful episodes. Depressed persons tended to appraise situations as requiring more information in order for them to act, but they were less likely to appraise situations as requiring their acceptance. Overall, the coping of depressed persons was characterized by the seeking of emotional and informational support and by wish full thinking, but they did not differ from non-depressed persons in amount of problem-focused coping. Results were generally inconsistent with the learned helplessness model of depression and highlight the
need to examine interpersonal aspects of depression.

In 1982, factor analysis of the Depression Coping Questionnaire (DCQ: Klenike et al. 1982) identified 11 coping responses: Social Support, problem solving, self blame/escape, aggression, indulgence, activities, medication stimulation, eating, T.V. and ignoring. Multiple regression analysis indicated that the DCQ contributed significant variance in predicting Beck-Depression Inventory (BDI), scores of men ($R = .705$) and women ($R = .568$) from three population samples. Both men and women's BDI score were correlated negatively with social support, problem-solving and indulgence. Four significant functions were identified in a discriminant analysis that compared nine groups made up of schizophrenic, male veterans & male & female college students, depressed and non-depressed chronic pain patients.

Coping style of depressed and non-depressed persons also have come under scientific scrutiny. Coyne, Aldwin and Lazarus (1981) asked depressed and non-depressed participants in a community survey to report on the ways of coping checklist (Folkman & Lazarus, 1980, 1984) how they coped with a recent stressful event. Depressed people gave significantly greater endorsement to help-seeking avoidance and to seeking emotional-support.

Billings, Cronkite and Moos (1983), compared responses of depressed outpatients, and non-depressed controls on three domains of coping; Appraisal-focused,
problem focused, and emotion focused. Depressed patients reported more use of information-seeking and emotional discharge.

Mitchell, Cronkite and Moos (1983) conducted a study in which community couples (N = 157) and couples in which one of the partners was clinically depressed (N = 157) were studied within the framework of an expanded stress-illness paradigm that encompassed life-events, ongoing-strains, coping-responses, family-support and depression. Depressed patients were found to be at a disadvantage relative to control subjects at each point in the stress-process, they experienced more stress and possessed fewer of the personal and social resources. The overall pattern of effects involved in the stress process was similar across patients and non-patient populations. Negative life-events, coping, and family support were primarily directly related to depression whereas strains exhibited some indirect effects through their relationship with lack of family-support.

Billings & Moos (1984) reported that problem solving and affective regulation styles of coping were correlated negatively with depressive symptoms and that emotional discharge and avoidance styles of coping were correlated positively with depressive symptoms.

A study by Mc Crae (1984) supports the argument for specific coping measures by showing that people choose different coping responses for different kinds of stressors.
In another study, Eisen (1986) discussed adolescent coping and vulnerability within a developmental framework that considers biological, psychological, social growth and maturation. Types of coping strategies are identified and factors that may increase vulnerability to psychological disorders like depression are delineated, including developmental disabilities, abuse and socioeconomic deprivation.

Cupplier & Blanchet (1986) investigated the strategies that 52 elderly persons used to cope with depressive feelings, measuring the intensity of depressive symptomatology, and the other dealing with coping strategies and their usefulness. Results suggest that coping strategies used by the elderly did not fundamentally differed from the ones advocated by younger individuals, in that they favoured strategies involving goal oriented action. The subjects who reported the most depressed feelings differed from the other on 2 points: (1) they less frequently relied on the strategy of problem solving and (2) they considered general activity as less useful in their struggle against depressive feelings.

In 1986, Koeing contended the belief, that mental illness increases with age is a myth and that the increase in the admission of elderly to mental hospitals is mostly due to organic brain syndromes. It is concluded that current data from recent epidemiologic studies indicate a decrease in frequency of mental disorders among the elderly.
and an increased ability to cope with the major life changes in comparison with younger age people.

Perrez & Reicherts (1986) compared 30 depressed patients (aged 20-26 years) and 30 normal controls on appraisal, coping and attribution process in aversive situations and situations characterized by loss or failure. The depressed group appraised more strain and were less adaptive. Environmental directed coping of this group was less active, more evasive, and more passive, self-directed coping focused on palliation and self-punishing cognitions. Attributions were more internal for negative outcomes. Some group-by-phase interactions indicated process specificity.

Nezu & Nezu (1987) replicated research that demonstrated that psychological well being and distress are strongly associated with masculinity, but unrelated to femininity. 211 under graduate and graduate students were administered the Beck Depression Inventory and the State-Trait Anxiety Inventory. Results from multiple analysis of variance (MANONA) reveal that high masculine subjects reported significantly lower scores on self-report measure of depression-state anxiety, and trait anxiety. No differences in distress, problem solving were found as a function of sex or the femininity dimension. High masculine subjects were found to rate their problem solving ability as more effective, to engage in more active behavioural and less avoidance methods of coping, and less emotional-focused
coping style regarding stressful situations.

Burns, Shaw & Croker (1987) assessed thinking styles and coping behaviour in 13 unipolar depressed female inpatients (mean age 41.2 yrs.) and 12 non-depressed female controls Ss (mean age 32.1yrs). Measures of cognitive distortion and the willingness to cope were significantly correlated with the diagnosis and severity of depression. Depressed subjects showed more negatively distorted thoughts, and reported less coping behaviour when they were upset. They were less willing to try potentially helpful coping activities and had lower expectations than non-depressed subjects, that coping effort would be helpful. The additive contribution of cognitive and motivational factors suggest that both should be considered in the etiology and treatment of depression.

Brown, Barbara & Patricia (1989) investigated the coping responses used by adolescents in high risk situations. 66 adolescents (aged 12-19 yrs) described situations in which it was difficult to resist drinking alcohol. Cognitive and behavioural responses in the perceived high risk situations, but differed significantly in the cognitive and behavioural strategies used to cope with drinking pressures. Cognitive strategies associated with abstaining from alcohol use included defining oneself as a non-drinker and viewing other drinkers, negatively. Behavioural responses associated with not drinking, included
engaging in an alternative activity and avoiding or limiting direct exposure to the high risk situations.

Dews & Williams (1989) examined the emotional and psychological issues facing musicians and their various ways of coping with problems. Results of a questionnaire revealed issues of concern for 201 undergraduate and graduate music students. These included stress, performance, nervousness, depression stage fright, and friends or teachers and (less frequently) from counseling, when experiencing problems with their music. Internal sensitivity/motivation and perfectionism seemed to be the 2 major dynamics characterizing these subjects.

Wierzbicki & Michael (1989) extended research on adults' perception of counter-depressive activities (V. Rippere, (1977) to children's perceptions as a function of their sex, age, and depression level. In study 1, 166 boys and 156 girls (aged 8-12 yrs) were asked to identify as many counter-depressive activities (CDAₕ) possible. Girls provided more CDAₕ than did boys and more often reported help-seeking responses. In study 2, 49 boys and 49 girls girls (aged 8-14 yrs) completed the Children's Depression Inventory and generated CDAₕ. Girls provided more CDAₕ than boys, and older children provided more CDAs than younger ones.

Wood, Sattzberg, Neale, John and Arthur A. et al., (1990) examined several questions concerning the relation between self-focused attention and depressed mood :
(a) Does the association involve global negative effect rather than sadness per se? (b) Is self-focus associated with specific negative affects other than sadness? (c) Does the association occur at the between subjects or within subject level? Also hypothesized was the self-focus is associated with coping responses that may perpetuate negative mood. In an idiographic/nomothetic design, 40 male community residents completed daily reports for 30 days. Results suggest that self-focus is linked with global negative mood as well as specific negative affects other than sadness and that the association occurs on a between persons, basis. In addition, highly self-focused men reported using passive and ruminative coping styles, which in turn were associated with distressed affect.

Kirsch, Mearns, & Salvatore (1990) in their study examined the predictors of coping styles, depression and somatic symptoms in college students. In previous research, the use of active and avoidant coping strategies was predicted by stress, family-support, self-confidence, and easy-going disposition. This study found that the expectancy to be able to alter one's mood state added significantly to the prediction of coping. Mood regulation expectancies also predicted dysphoria and somatic symptoms, even with the effect of coping behaviour and other variables partialled out. Consistent with response expectancy theory of I. Kirsch, these data indicate that beside affecting mood indirectly through their impact on coping behaviour, expectancies can
directly alter dysphoric moods. However, when the effects of expectancy were statistically controlled, active coping was positively associated with dysphoria, which suggests that coping strategies may not be effective unless they are believed.

In another study by Rohde, Lewinsohn, Tilson & Seeley (1990), the dimensionality of coping as measured by 65 items from 3 commonly used instruments, and the relation of coping and stress to concurrent and future depression were studied in a community sample of 742 older (50 years old) adults. Measures of coping, stress and depression were obtained at 2 time points over a 2 year period. Depression was assessed by symptom checklist and by diagnostic interview. Three coping factors - cognitive self-control, Ineffective Escapism, and Solace seeking - that had adequate psychometric properties and accounted for 25% of total item variance were identified. Ineffective escapism was associated with current depression and had a direct and interactive effect on future depression, exacerbating the negative impact of stress rather than active as a buffer. Although cognitive self-control was unrelated to either concurrent or future depression, solace-seeking significantly buffered the effect of stress in predicting a future diagnosis of depression. Stress and initial depression level predicted both measures of future depression. Gender (being female) predicted the future diagnosis of depression but not the increase of depressive symptoms.
Kirsch et al. (1990), found that expectancies for negative mood regulation were significantly positively associated with the use of active, problem-focused coping strategies and negatively associated with avoidance strategies.

Mearn (1991) predicted that three studies assessed the impact of generalized expectancies for negative mood regulation experience following the end of a relationship. The Negative Mood Regulation Scale (NMR) measured these expectancies. In study 1, the NMR predicted college students reports of initial depression in the first week after the relationship ended. Study 2 (n=114) demonstrated that subjects with higher expectancies used active coping strategies than those with lower expectancies. Study 3 (n=78) provided data that showed subjects' NMR scores to predict initial depression in the first week after a relationship ended. Results support the importance of expectancies for negative mood regulation as determinants of emotional reactions to distressing events, and support the validity of NMR.

Epstein (1992) found that responses of 3 groups of Ss differing in coping ability, as measured by the Constructive Thinking Inventory, were compared on matched sets of items that differed according to whether the outcomes were positive or negative and directed at the self or at others. All groups reported widespread overgeneralization to
items with unfavorable and favorable outcomes. It was concluded that poor constructive thinkers have a selective bias toward making negative inferences about the self, which has widespread implications for general coping ability. A theoretical framework is presented to find out the implications for depression and self-esteem as well as for general coping ability.

SUMMARY

Coping efforts may change the person environment relationship by altering the situation, and altering the person's thoughts about it. Depressed patients reported more use of information seeking and emotional discharge when compared to non-depressed patients on coping domains. Similarly depressed subjects showed more negatively distorted thoughts and reported less coping behavior when they were upset, as compared to non-depressed subjects.

LIFE STRESS AND DEPRESSION

Probably the largest number of studies focusing on life events and a specific class of psychiatric disorder has been for the depressive disorder (Rabkin, 1982). Recent reviews provided evidence for the importance of events for depression (Blaney, 1985, Lloyd, 1980, Paykel, 1982, Rabkin, 1982). With respect to the issue of onset, several investigators have demonstrated that individuals who become depressed have experienced a higher incidence of life-
stressors prior to the episode.

In particular, the work of Brown and Harris (1978) and Paykel (1982) suggests that events involving high threat or actual loss are particularly important for the onset of depression.

Within the past two decades, research literature has repeatedly documented depression, and various other forms of psychological and physical disorders (CF. Barrett, 1979; Depue, 1979). There is an emerging consensus that increased exposure to life-changes may be particularly related to many forms of psychological disturbance. Although early formulations suggested that desirable and undesirable events were of equal importance (Dohrenwend, 1973; Holmes, and Masuda, 1974).

Finley, Robert (1981), presents condition that shows that some quality of life events are causes of depression. Recent advances in methodology that need to fulfill these conditions are reviewed in the field of life-events, depression and survey design that may have been regarded as refuting a causal link between life-events and depression are analysed and their conclusions challenged. Studies that have claimed a causal link, have used methods that in general fulfill the conditions for showing a cause. It is concluded that the hypothesis, that severely unpleasant life-events particularly events involving loss, are a cause of depression has not been refuted. Further more a number of
studies have accumulated evidence for such a causal link.

Hamman and Mayol (1982) interpreted that stressful life-events as well as individual appraisals have been hypothesised as important antecedents of depression. However, the examination of characteristic of life-events has been relatively a neglected topic. The present study investigated depression and life-event characteristics by applying an event classification scheme, proposed by Fairbank and Hough (1979). Cognitive appraisal properties of event types were also examined to shed light on event inventory, and on Attribution Questionnaire. The results indicated that event classification scheme was successful in separating types of events by their degree of association with depression.

A recent study by Rothwell and Williams (1983) found that depression and internality were correlated after the life-events of job-redundancy, but not if no life-events had occurred. They found no evidence of a correlation between depression and other attributional variables, however, and the study was retrospective with respect to the occurrence of the event in question.

In another study William's (1985) results of the reformulated learned helplessness model of depression (Abramson, Seligman and Teasdale, 1978) have demonstrated correlations between attributional style and affective disturbance but have left open the question of whether an
uncontrollable aversive event is a necessary part of the casual sequence in depression onset. Metalsky, Abrason, Seligman, Semmel and Paterson (1982) claimed to have related this aspect of the model in a prospective study of examination success or failure. Their finding of a significant attribution mood correlation following failure but not following success is ambiguous, however because they did not test the difference in correlation between the success and failure groups, which leaves the main hypothesis unresolved.

Wood (1987) discussed the social model of depression that associates onset of depression with stressful life-events.

Slack and Vaux (1988) investigated the relationship between undesirable life-events, social-support, attributions and perception of those events, and depression was tested in a retrospective study of 51 male and 63 female college students. Undesirable life-events were significantly related to depression for females, but not for males. Social support moderated this relationship for females but associated directly with depression for males. Depressive mood was associated with appraisals of undesirable events as upsetting involving uncertainty, and likely to recur for males, and with appraisals of events as involving uncertainty and leaving stable and global causes for females. Factor analysis of event appraisal revealed 3 factors; impact,
control, and preparedness. For males, and females, depressed mood was associated with impact, but not control or preparedness; nor was depressed mood associated with the interaction of events and event appraisals.

Daniels and Rudloff (1990) described the Life Stressors and Social Resources Inventory-Youth form which provides an integrated assessment of life-stressors and social resources in eight domains: physical health, home/money, parent, sibling, extended family, school, friend and boy/girlfriend. The indices were developed on data obtained from 4 groups of youth: 49 depressed Ss, 58 Ss with conduct disorder, 45 Ss with rheumatic disease, and 38 healthy Ss. Depressed Ss reported more acute and chronic stressors and fewer social resources than did healthy Ss. Negative life-events, ongoing stressors in different domains, and stable social resources, all contributed unique variance to the functioning criteria.

Oei and Zawrt (1990) in another study discussed the significance of a context dependent approach to researching life-events, social support and depression, the significance of events does not stand isolated from their context nor from the individuals perception of them. In this regard, a combination of one provoking agent and one vulnerability factor presents a greater risk for depression than do 1 or 2 provoking agents without a vulnerability factor. Effective social support depends on the person
helped, being able to interpret the aid appropriately so as to feel secure within his or her self-esteem.

In 1990 Stephenson, Schwab and Roger interviewed 34 families in a prospective epidemiologic study of risk for depression. Ss were interviewed at base line, 6 month later, and 9 month after the 2nd interview (Times 9, 2, and 3). At the Time 1 and 3, a stressful life-events (SLE) inventory was given to each adult and child over the age of 11, and at Time 2, the family as a whole. Risk for depression was evaluated by screening instruments and the Diagnostic Interview Schedule. Almost 2 more SLEs per family were reported at Time 3 then at Time 1. Methodologic factors and being in risk status at some time, during the study, were responsible for the greater number of events reported at Time 3 then at Time 1.

In another study, Robins, Block and Peselow (1990) made a comparison between endogenous and non-endogenous depressed patients on several characteristics on which they traditionally have been asserted to differ, and which play important role in cognitive approaches to depression. The non-endogenous patients reported more dysfunctional attitudes and a greater number of recent life events then did endogenous patients. These results support the distinction between endogenous and non-endogenous depressions, and suggest that cognitive theories of aetiology may be more relevant for the latter group. However both
groups perceived their recent upsetting events in relatively maladaptive ways, consistent with the idea that biased perceptions are more related to the depressive state, whereas dysfunctional attitudes may represent a trait vulnerability.

Barrnet and Gotlib (1990) tested hypotheses generated by the diathesis stress model of depression (A.T. Beck et al., 1979) by examining separately for 199 female and 69 male undergraduates the moderating effect of dysfunctional attitudes (DATs) on the relations of depression with social support and stressful life-events. Ss completed the Beck Depression Inventory twice, 3 month apart as well as the Dysfunctional Attitude Scale, Form A (A.N. Weissman, and A.T. Beck, 1978) and measures of social support and stressful life-events. Among women the interaction of DATs with social support, but not with stressful life-events, significantly predicted the severity of depressive symptoms. DATs did not have a main or a moderating effect among men. Findings are discussed with reference to sex differences in the development and maintenance of depressive symptoms.

Rideout and Littlefield (1990), in their study investigated the level and frequency of depressive symptoms in spouses of 40 dialysis patients (aged 24–77 years) as a function of (1) severity of patient's disease (2) level of stress experienced by the spouse, and (3) perception of support from the ill partner. Measures of depression, impact on family, perceived social support, and disease-
severity were applied. Significant depressive symptoms were reported by 20% of spouses. The amount of social support received from their ill partner accounted for 37% of the variance in spouse depression, while social and financial stressors reported by the spouse explained 30% of the variance in spouse symptoms. Depressive symptoms in spouses of dialysis patients are associated with the social and economic consequences of the illness for the family but even more so with the amount of perceived support from the patient.

Kessler, Heath & Eaves (1992) in a survey of 821 same sex females twin pairs, assessed 8 dimensions of social-support and social integration. A decomposition of the multiplicative association between support and a measure of stressful life-experiences in predicting depressed mood—an association typically interpreted as providing evidence for a stress buffering effect of social-support.

Summary

The review of life-stress and depression provides the importance of life-event for depression. Individuals who become depressed, have experienced a higher incidence of life-stressors prior to the episode. Although some studies show a correlation between internality and depression in the presence of a life-event, others do not. Reviews of many studies conclude that individuals, who perceive many negative life-events in their lives are likely to become depressed as compared to those perceiving lesser negative-events.
The commonly reported preponderance of female over male-depression in incidence and prevalence studies requires further analysis. One explanation is that the social consequences of expression of depressive symptomatology are different for males and females. A comparison of participant's reactions to male and female case histories of common reactions to stress confirmed the hypothesis. Depression elicited more rejection of males than females and the sex-differences in rejection of depression was more pronounced than for anxiety or flat-effect-detached-responses. A discriminant analysis further suggested that depressed males are especially likely to be perceived as impaired in role functioning as compared with depressed females. Results suggest that depressed males are not rejected for expression of emotionality as such. Speculations about the causes and consequences of differential rejection of depression are noted.

Eaten & Kessler (1981) used a self-report inventory of depressive symptoms called the CES-D scale was completed by a nationwide sample of 2,867 adults. They reported that 11% of the men and 21% of the women in their study scored in the severe range of the CES-D (ie. 15 or above). This is a female to male ratio of 1.9 (P<.01). Thus, even though the rates of severe depressive symptoms in this study are five times those of diagnosis depressive disorders.
in men and women in Myer's et al., study, the female to male ratio in the two studies are nearly identified.

The claim that women are more willingly to seek psychotherapy for depression has also not been consistently supported in the literature. In addition, Amenson and Lewinson (1981) found that men and women with equal level of self reported symptoms were equally likely to be diagnosed as depressed in clinical interview.

In a critical review of the literature on depression and alcoholism, especially in men, than for alcoholism, to follow the onset of depressive symptoms, Petty & Nasrullah (1981) found that, then in evidence that depression is as likely a consequence of alcoholism in men Winokur (1971) and his colleagues argued that depression and alcoholism are genetically linked to each other and alcoholic features linked to female chromosomes, and alcoholic features linked to male chromosomes.

Bower (1981) describes a vicious cycle between mood and memory that would maintain and deepen a depressed mood. The depressed mood activates a storehouse of negative memories, which amplify the current depressed mood and lead one to interpret current events in light of memories of past failures and losses. The depressed mood is thereby exacerbated and extended.

Winokur, Tsuang, and Crowe (1982), found no
significant differences between men and women in the median age of onset of unipolar depression in a sample of 255 hospitalized depressives. In addition Spicer, Hare, & Staler (1973) found the first admissions for depression in England and Wales peaked at an earlier age for women than for men. Thus, it does not appear that the absence of sex differences in depression among college students can be explained by a tendency toward earlier onset of depression in men.

Radloff and Ensel (1982) stated that the differences observed in rates of depression in men and women are the result of differences in socioeconomic status instead of gender differences. They tested this possibility by comparing men's and women's mean scores on the CES-D controlling for income level, education level, and occupation. In both of these studies, women still had more depressed CES-D scores than men, after all these socioeconomic indicators were taken into account.

King and Buchwald (1982) predicted that men should be less willing than women to disclose symptoms in a public-disclosure condition. Instead they found men no less willing to disclose in the public than women, and neither sex was less willing to disclose symptoms in a public disclosure system than in private. Bryson and Pilon (1984) have replicated these results. Both of these studies however, used college students for subjects. Recall that there is no tendency toward sex-differences in depressive phenomena in
this population.

Quite similar sex-differences in response to depressed mood have been found in other studies (Chino & Funbiki, Staveski, & Mason (1982) and Kleinke et al. (1982) found that male college students more likely than female college students to say they, coped with depression by thinking about other things, ignoring their problems, or engaging in physical activity. Female students were more likely to say they would cut down on responsibilities and activities when depressed. Again, the men's response to their mood tended to be active and designed to relieve the mood by distraction, whereas the women's response tended to be less active and more likely to focus attention on their mood.

Williams and Spitzer (1983) report the only large study to date of the rates of treated depressive disorders according to the DSM-III clinicians in many different treatment settings across the United States used DSM-III criteria to diagnose their parents. The female to male ratios of 2.1 and 9.1 for MDD and DD, respectively, indicate a clear and significant preponderance of women among depressives.

Diener and Dweck (1981), Kuhl (1981), Zullow (1984) explained that ruminative response sets during depressive episodes may increase the likelihood that an individual will consider depressogenic explanations, for current negative effects, thereby increasing expectations of
helplessness and hopelessness. That is ruminating about one's current state generates depressing explanations that increase depression (e.g., "I am depressed because I really blew it at the meeting today"). Such explanations, according to the reformulated helplessness theory (Abramson et al. 1978), increase the individual's expectations that he or she will continue to have problem in the future. Another type of vicious circle is set up, in which the individual's expectations of uncontrollability lead to decrease in positive, goal oriented behaviour, and the resulting failures enhance the individual's sense of helplessness & depression.

Beck, Emery and Greenberg (1985) and others have recommended setting aside a half-hour at the end of the day to do one's worrying. The ruminator often finds her worries diminished in size and number by the time the "worry hour" arrives. In addition, the depressive should be encouraged never to make a decision or try to solve a problem when she is depressed, because she has particular access to negative memories and depressing attributions for events. Instead, she should do something to distract herself to relieve the mood state, then go back to the decision or problem to think about it.

Several studies have been conducted on sex-differences, such as Roberts (1981), Weissman (1977) Mc Dermott (1987) has shown that depression was commonly experienced in college students (195 women, 166 men). Women
showed greater intensity and frequency in depression. It has been suggested that while symptoms of depression decline after adolescence, they are commonly expressed by both high school and college students.

Sherr (1985) reported the prevalence of depression among 149 students surveyed at a southern university to be 11.4. Similarly Hawkins (1989), Newman (1984), O'Neal (1985), and Padesky & Hammen (1981) also found sex differences in depressive symptoms, expression and also help seeking among college students. They concluded women were significantly more prone to become depressed, and they too found high rates of depressive symptoms among university students.

Nolen-Hocksema (1986) presented college students with a "list of things people do when depressed" and asked them to rate how likely they would be to engage in the behaviours or thoughts described when depressed. The subjects were instructed to be sure to "rate these items according to what you think you would do, not what you should do." The men in the same had significantly higher scores than women on 4 of 37 items. "I avoid thinking of reasons why I am depressed, I do something physical". Each of these responses would tend to distract the individual from his depressed mood. The women in the sample scored significantly higher than the men on "I try to determine why I am depressed." These responses tend to focus and maintain the individual's attention on her mood.
Further, Nolen, Hocksema, Gigrus, and Seligman (1986) found that the depressed girls from non-depressed girls were different from those, distinguishing depressed boys from non-depressed boys. These sex differences in most prominent depressive symptoms do not translate directly into sex differences in response to depressed effect. They do indicate that even in childhood, depressed boys tended to be active, whereas depressed girls tended to be more contemplative or self-focused.

Neal (1986) examined whether elderly women experience more symptoms associated with depression than elderly men. Results from a random community survey of 35% older adults (65-95 yrs. old) indicate that women were more depressed than men, analyses suggest that greater vulnerability among women to the effects of chronic life-strains explained the observed sex-differences in distress. Stressful life-events were a less-important factor in this process.

Kathleen & Gill (1986) investigated the relationship of gender and sex-types to the accuracy of self-perceptions of social-competence in 40 depressed and 42 non-depressed college students. In small discussion groups, Ss rated themselves, and were rated by group peers and trained observers on social-competence. Analyses revealed that the poor and self-ratings of the non-depressed subjects were significantly higher than those ratings of the depressed Ss.
Observers failed to differentiate between the depressed and non-depressed Ss on the measure of social-competence. Post hoc analysis indicated no significant gender difference or differences due to the Ss' Sex-types on the Bem-Sex role inventory.

Nezu & Nezu (1986) evaluated the moderating function of sex roles on stress-related depressive symptomatology. Using self-report data on life-experiences, life-stress, depression and sex-role stereotyping from 168 undergraduates. A measure of family-social-support was also included. Analysis indicated that the masculinity dimension served as a moderator of both negative life-stress and family social-support. Ss high on the masculine dimension reported lower dimension scores under high levels of stress. Ss with high masculinity scores and low level of family-support also reported lower depression scores, as compared to people low in masculinity. The femininity dimension was found to contribute little to the prediction of depressive symptoms. No differences as a function of sex were noted.

Frances, Pierre & Harper (1987) explored sex-role conflict, sex role ideology and sex-role satisfaction in 46 clinically depressed hospitalized women & men (mean age 36-39) at a time when they were depressed and 6 mo later to see whether improvement in their depression were associated with changes in the various sources. Data was compared with those for 51 controls (40.3 yrs.). Results indicate that sex-
role conflict as measured by the Bem-Sex Role Inventory, experienced by all subjects. Women scored as less traditional than men on the sex-role ideology scale. Depression seemed related to a decrease in sex-role satisfaction and resolution of depression was not correlated with changes in sex role conflict.

McDermott (1987) examined symptoms of depression in a sample of college students (193 women and 156 men), using the Centre for Epidemiologic Studies Depression Scale. Depression was commonly experienced in this setting by men and women, but with greater frequency & intensity by women. It is suggested that depression of a transient nature may be more common among university students than has been widely believed.

Stoppard & Paisely (1987) conducted a study in which 266 female and 136 male undergraduates completed the Bem-Sex Role Inventory, the Life Experience Survey, and the Beck Depression Inventory. Regression I analysis indicated significant effects of life-stress, masculinity (M) and femininity (F) on depression. Although M and F were significant predictors of depression, life-stress accounted for a greater proportion of the variance. It is concluded that excluding environmental influence in favour of M and F may lead to an over emphasis on individual sex-role orientation differences in studies of gender factors in depression.
Krames & Flett (1988) in their study administered a battery of questionnaires including the Personal Attributes Questionnaire, a geriatric depression scale, the hopelessness scale, and 3 subscales from a self-evaluation of life-function scale to 30 women. Consistent with previous meta-analytic results, correlational analysis revealed significant negative relations between masculinity and the cognitive measures of depression and no correlation between femininity and these same cognitive measures. Femininity however, was correlated with social satisfaction and symptoms of aging, proportion of the variance masculinity was unrelated to these social and physical indices of depression. The implications of these findings for the androgyny and masculinity models of mental health are discussed with particular reference to the role that femininity may play in potentiating or exacerbating depression.

Craighead, & Barbara (1989) examined the relationship between depressed mood, self-esteem, and endorsement of sextype personality characteristics (STPCs) in 327 boys and 297 girls (aged 12-15 yrs.). For positively valanced STPCs, masculinity was inversely related to depression. For negatively valanced STPCs, the masculine and feminine scales were all positively correlated with depression. Result support previous findings with younger children (J.A. Hall and A.G. Halberstadt) and high school students. Presence of negative feminine-typed characteristic
was as highly correlated with depression as absence of positive masculine characteristics, and both relationships were stronger for females than males.

Merton and Lewinson (1990) investigated the role of certain psychological variables. Sex, age, body image self-esteem, stressful life events, and the degree to which an individual identifies with the cultural stereotype of masculinity as correlates and antecedents to depression in adolescents and explored possible intraindividual mediators of the stress-depression relationship in adolescents. A battery of self-report measures was administered to public high school students in grades 9-12 in their classrooms at two different time/month apart. Female adolescents reported more depressive symptoms, self-consciousness, stressful recent-events, feminine attributes and negative body image and self-esteem, no age effects were obtained. Results suggest a model of adolescent depression in which body/self-esteem and stressful recent events are significant contributors.

Fujita, Diener & Sandvik (1991) concluded that affect intensity (AI) may reconcile 2 seemingly paradoxical findings. Women report more negative effect than men but equal happiness as men. AI describes people's varying response intensity to identical emotional stimuli. A college sample of 66 women an 34 men was assessed on both positive and negative affect using 4 measurement methods, self-report,
peer-report, daily-report, and memory performance. A principal component analysis revealed an affect balance component and an AI component. Multimeasure affect balance and AI scores were created, and the t tests were computed, that showed women to be as happy as and more intense than men. Gender accounted for less than 1% of the variance in happiness but over 13% in AI. Thus depression findings of more negative affect in women do not conflict with well-being findings of equal happiness across gender. Generally women's more intense positive emotions balance their higher negative affect.

SUMMARY

Various studies try to predict that antecedents and consequences of expression of depressive symptomatology are different for males and females. Rates of occurrence of unipolar depression when compared in males and females show that males are less likely to become depressed as compared to females with a similar history of previous depression. But some studies reveal that true prevalence of depression is equal for men and women. As it is there, is a case for further investigation of the incidence of depression and the psychological factors associated with its occurrence in male and female subjects.

Conclusion

The overall review of the related research
shows that there are psychosocial factors which play a key role in the onset of depression, such as attributional style (RPO, RNO) personality (E,N) social support, coping style (EF and PF coping), life events and sex roles (F,M,and FxM). Negative life-events, negative-attributional style, introverted or neurotic personality, poor coping or emotion-focused coping style, feminine sex roles, and gender difference. Females are likely to be more depressed as compared to males, however there is evidence that it is the particular set of psychosocial factors which play a major role in the onset of depression in both males and females.

Hypotheses

Based on the review of related research, the following hypotheses were framed:

(1) Negative attributional style (RNO-Responsibility for negative outcomes) will significantly and positively predict depression,

(b) and RPO-Responsibility for positive outcomes will be significant and negative predictor of depression in both male and female subjects.

(2) Neuroticism, the personality dimension as measured by Eysenck's EPI will be significantly and positively related to depression in males as well as in females.

(b) Extroversion, the personality dimension as measured by Eysenck's EPI will be significantly and negatively related to depression in both cases of males and females.
(3) Social-support will be significantly and negatively related to depression in both females and males.

(4) Emotion focused coping style will be significantly and positively related to depression in both genders.  
    (b) Problem focused coping will have significant negative relationship with depression in males as well as in females.

(5) Negative lifestress will significantly contribute to the prediction of depression in male as well as in female subjects.

(6) There will be significant negative association in both males and females, between masculinity and depression, and significant positive relationship between femininity and depression.  
    (b) Interaction of masculinity and femininity will not contribute significantly to the prediction of depression in both males and females.

(7) Time one (Dep.\textsubscript{T\textsubscript{1}}) or initial level of depression will significantly contribute to Time two (Dep.\textsubscript{T\textsubscript{2}}) depression in both males and females.