CHAPTER I

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Depressive disorders incorporate a spectrum of psychobiological functions which vary considerably in severity, frequency and duration. At one end of the spectrum is the experience of normal depression, a transient period of sadness and fatigue, generally responding to clearly identifiable stressors. At the disorder end of spectrum are a number of manifestations, including psychotic depression, in which a person not only suffers sadness and despair but also develops psychological retardations.

A critical issue in research of depression, and its correlation with other variables is the frequency and expression of depressive cognitions and behaviours. Due to the interrelatedness of all the parts a breakdown or loss in one aspect will effect other aspects and so the whole.

The true or essential nature of depression is unknown and much controversy exists. The unitary state of depression maintains that normal blends in to abnormal by gradual degrees and the difference between two states is quantitative. In contrast, the eunity state maintains that normal and abnormal are qualitatively different states. Depression exists in all types of persons to some extent but it has been observed that adolescents and older ones are prone to become more depressed as compared to children. The
common results of depression are personal unhappiness, decrease or deterioration in work and social-relations, loss of sleep and appetite etc.

Younger adolescents may show depression by boredom, restlessness, an inability to be alone, a constant search for new activities. Depression may also be manifested by feelings of alienation, isolation, and emptiness. The tendency of adolescents to group together in fraternities and communes is often an attempt to find support in each other and relief from such feelings. Such behaviour, though temporarily successful often leads only to guilt and further depression.

Difficulty in concentration is one of the most frequently encountered complaints presented by depressed students. The students will fail and get discouraged convinced that they are not able to cope with their studies. Such conclusions can diminish self-esteem and lead to further depression.

Many depressed adolescents utilize denial and acting out as a means of avoiding depressive feelings. Such acting out may lead to serious delinquent behaviour, as described by Kaufman & Heins (1988) "A crucial determinant is an unresolved depression, which is the result of the trauma which these students have experienced."

In reviewing the histories of depressed
adolescents, many exhibited behavioural difficulties prior to the onset of their depressive symptoms, difficulties known as depressive equivalents," separation from home, parents, owing to living for service & loss of love etc. So, depression is very important field to be studied to know its causal factors and symptoms. Many psychologists are paying attention to study the causes and treatment of depression.

Over the past 65 yrs, numerous issues in the depressive disorders related to etiology, symptom characteristics have coalesced into the concept of endogenous versus reactive depression.

Concurrent with theoretical debates concerning the endogenous-reactive/neurotic distinction, researchers have attempted to define the differential symptom complexes, therapeutic response patterns and outcomes associated with endogenous and neurotic depressions.

One of the most troublesome issues raised above for the learned helplessness model is that there is no strong-support or at best, vary in consistent support for the notion that neurotic depressions arise solely as a reaction to stressful life events. The prevalence of such depressions is quite high in general population surveys (Comstock & Helsing, 1976), but their relation to clinical depression is obscure. For example, one of the most common forms of situational depressions is grief, defined as an
understandable response to the death of a loved person or object. Such depressive responses are ordinarily self limited and rarely lead to seeking psychiatric help or hospitalization (Akiskal, Clayton, Desmarais & Winokur, 1968). Whatever the nature and prevalence of situational depressions, they rarely present for psychiatric treatment, and generalization of such cases to clinically depressed populations.

In the last 10 years, there has been a renewed interest in diagnosis and classification. This system defines and offers diagnostic criteria for two forms of minor depressive disorders: episodic as well as chronic and intermittent. Spitzer, Endicott & Robins (1975) argue that individuals who develop a generalized expectation of inability to control future outcomes are particularly vulnerable to the development of learned helplessness and depression. The exciting implications of this formulation are that these individuals may develop personality predispositions characterized by the expectancy of lack of control over life stressors and may exhibit more persistent feelings of helplessness and depression, in the face of numerous circumstances (which may be stressful, for either objective or subjective reasons).

The major depressions are enormously heterogeneous. Numerous researchers have suggested that in terms of research generating potential, the major depressive
disorders may be most effectively divided into bipolar and unipolar groups. This system employs a familial definition of polarity, where family history for affective disorders serve as one index of classification. Pluralistic systems of classification assume there are many types of depressive disorders.

Grinker and others (1961) proposed four patterns of depression based on a factor analysis of behaviours, moods, and responses to treatment. These types included: (1) empty depression, (2) angry depression (3) anxious depression and (4) hypochondriacal depression.

Further, theories of depression can be grouped into biological or psychological types. Biological theories are: genetic theories - Depue (1979) has shown, genetic factors interact with environmental factors called "endogenous" disorders. Heredity appears to influence emotional lability, cellular functioning basic arousal levels, stimulus threshold levels, and other physiological substrates of behaviour, and these may be ultimately related to depressive experience. Biological theories can be grouped into three basic types: (a) biogenic amine theories which include catecholamine, indoleamine and permissive amine hypotheses (b) electrolyte metabolism theories, which focus on sodium and potassium metabolism in the brain and (c) pituitary-adrenal axis theories argue that the primary problem in depressive disorder resides in the hypothalamic -
pituitary-adrenal axis (Sachar, 1982). There are as many psychobehavioural as biological theories of depression. Among these are the "response" theory, the learned helplessness theory, the cognitive theory, and several psychoanalytic theories related to loss of love object.

"Response" theory advanced by Peter Lewinsohn (1974) states that individuals develop depression when they receive inadequate amount of positive reinforcement. This may occur because: (a) few events are potentially reinforcing for the individual; (b) there is little positive reinforcement from the social environment and, (c) the individual lacks the skills to elicit positive reinforcement from others. Research on normal depression supports this viewpoint.

Learned helplessness theory developed by Martin Seligman (1975) is based on animal research on avoidance learning. When humans or animals are trapped in situations in which they can no longer avoid harm or threat, they develop a sense of helplessness and act "depressed." Cognitive theory - focus on the role of thought processes. Aaron Beck (1976) argues that problematic childhood experiences can lead to cognitive styles and patterns characterized by logic patterns, selective abstraction, overgeneralization, dichotomous thinking and excessive magnification. Thus depressed people tend to think in distorted ways.
In general the psychoanalytic theories argue that depression results from the loss of an ambivalently loved person. The presence of ambivalence results in self directed hostility and this constitutes the depressive experience. In some cases, traumatic experiences in childhood, especially losses, results in faulty egodevelopment and a fixation at a childhood state of helplessness and insecurity. Adults conflicts can bring about a return to this earlier state via regression mechanisms.

Depression can be cured by giving drugs like antidepressant, (ECT) electroconvulsive therapy which is safe and effective, psychotherapy is also given and many new techniques have been developed of it, like group therapy and individual therapy, reinforcement to avoid depressive behaviour. Thus new approaches to treatment have brought greatly improved outcomes.

Statement of the problem

A study of relationship of attributional style, personality, social-support, coping style, and life event stress with depression.

The identification of psychosocial factors that may cause depression has proven to be an arduous task. Many of these abnormalities such as dysfunctional cognitions, distressed relationships, anaclitic personality types and deficits in social behaviours, poor coping style and sex-
roles, have been implicated in the etiology of depression by theorists of various orientations (e.g. Abramson, Seligman, and Teasdale, 1978, Beck, 1976). However some of these problems in functioning may be symptoms or concomitants of depression that appear with the onset of a depressive episode, and disappear with remission. Although they do occur with depression, such factors can be classified as casual because they do not precede the onset of symptoms. Attempts have been made to distinguish empirically between psychosocial variables that are concomitants of depression, and variables that may serve as antecedents of this disorder. The present research investigated the relationship between depression and any of six psychosocial variables in a population of college and university male and female students. The six variables examined are attributional style personality, social-support coping style, life-stress and sex-role orientation, and as predictors of depression. Four of these variables include some further variations, for example, attribution style has two aspects: Responsibility for positive outcomes (RPO), and Responsibility for negative outcomes (RNO). Personality has two forms: Extraversion (E) and neuroticism (N). Coping style comprises problem focused coping (PF) and emotion focused coping (EF). Sex role orientation has three components: Masculanity (M) and femininity (F) and FxM interaction.

Although occurrence of normal depression is
common in individuals, yet it may be abnormal in others, so it is important to study its causal factors and phenomenon.

Anxious depressive reactions associated with everyday life-experience are most frequently encountered and are associated with a spectrum of causes linked to situational stressors. Rates of disorder for more serious forms like unipolar and bipolar depression, vary according to many factors. Unipolar depression rates are higher in women aged 35-45 years, and are higher among individuals with histories of family disruptions and recent negative life-events. In contrast, the incidence of bipolar depressive reactions seems to increase with age and membership in higher social-economic classes (Boyd & Weissman, 1982).

People vary considerably in how they are affected by life-events. In the case of adults, some get divorced, lose their jobs, experience financial hardships, death and illness in their family, and yet appear to suffer few apparent long-term physical or psychological consequences. Others seem to develop problems even in the face of relatively small amounts of life-change. The differential response to adversity is likely to be seen in children and adolescents as well. An important issue for life event researchers concerns the nature of those social, psychological and individual difference variable that lead to increased vulnerability or that play a protective role in the face of stress.
A link between the occurrence of stressful life-events and depression has been reasonably well established for clinical depressions as well as for depressive moods in the general population (Lloyd, 1980; Billings & Moos 1982, Costello, 1982, Grant, Yager, Sweetwood, Olshen, 1982, Monroe, 1982, Imhoff et al., 1983). There have been reviews (Blaney, 1985; Thoits, 1983) and theoretical models have been proposed to characterize the contribution of stress to depression outcomes (Billings & Moos, 1982, Blaney 1985, Depue, Monroe & Paykel, 1979).

Despite this outpouring of effort however the products have been somewhat not very clear. For one thing the magnitude of the apparent relationship between depression and negative life-event appears to be small, as Rabkin & Struening (1976), Tausig (1982), Thoits (1983) and others have pointed out, much at best one major study contending that the expected antecedents and consequent pattern is quite rare (Grant et al., 1982). There seem to be a number of other factors which come between stress and depression.

Stressful life events as well as individual appraisal have been hypothesized as important antecedents of depression. To date many of the investigations have been conducted with young college student populations whose elevated depression scores may reflect considerable heterogeneity, ranging from very transient moods to clinically significant depressions (Hammen, 1980). In
addition these findings have varied depending on the population studied (mildly depressed students vs moderately depressed students), where the samples were help-seeking depressed or non-depressed out patients. Hammen and Mayol (1982) also argued that in some instances attributions are affected by actual negative events therefore groups differing in their actual life situations may reflect different attributions associated with depression.

Brown and Harris (1978) attempted to assess level of "contextual threat" surrounding stressful events and determined that more threatening events were associated with greater depression. Such efforts represent a beginning step in delineating crucial qualities of stressful events, but further work is clearly needed.

Within the past two decades, the research literature has repeatedly documented an association between stressful life-events and various forms of psychological and physical disorders like depression (Barett, 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 and Dohrenwend, 1973), the bulk of evidence from more recent work suggests that primarily undesirable events are associated with psychological symptoms (Brown & Harris, 1978).
Though the precise role that events may play in the onset of disorder is currently debated most investigators maintain that such correlations reflect important psychosocial contributions to the disorder under study (depression).

The attributional model of depression suggests that there is only weak or inconsistent support for the predicted causal ascriptions by depressed persons for negative events. Attributional model of depression (Abramson, Seligman & Teasdale, 1980) after a promising framework for predicting not only intensity but also generality and chronicity of depressive reactions to negative events. However, the great majority of the studies are correlational in form and the results therefore are compatible with the possibility that depression is the cause of the "depressive" attributions.

Studies show that depressed college students compared to non-depressed college students attributed bad outcomes to internal causes and good outcomes to external, unstable causes. Individual differences in attributional style, the tendency to make particular kinds of causal inferences across time has emerged as an important variable in attribution research on adults (cf. Peterson & Seligman, 1984).

An important body of evidence accumulated
over the post 2 decades has demonstrated a link between stressful life events and both psychological and physical morbidity (B.S. Dohrenwend & B.P. Dohrenwend, 1981). Johnson & Sarason (1978) reported that although life-stress was associated with anxiety and depression for college students, characterized by an external locus of control/social support, no relation between stress and pathology for depression was found.

Attributional style is viewed as a trait that is individuals are believed to exhibit cross-situational and temporal consistency in their causal explanations for positive and negative events (Peterson and Seligman, 1984). A stable attributional style is often inferred from respondents causal explanations for hypothetical events such as those present in the ASQ (Attributional Style Questionnaire, Peterson et.al, 1982). A hypothesized depressive attributional style, consisting of internal, stable, and global attributions for undesired outcomes is posited to lead to an expectation of future non-contingency and thus to symptoms of helplessness. Individuals with this type of attributional style are more likely to become depressed when faced with important life-events.

The relationship with depression of introversion and extroversion has been the focus of another large body of literature. Neuroticism, and extroversion-introversions are postulated by H.J. Eysenck &M.W. Eysenck
(1985) to be the most universal and fundamental dimensions of human personality. Extroverts have been found to engage in more social interaction, to initiate conversation and verbalize more often, and to be less avoident of stressful situations than are introverts (Furnham 1981).

In general, whereas neuroticism correlates positively with depressive symptoms extroversion is inversely related to depression (Garside, Ray, Beemish, 1970). Symptomatic depressives have been found to be more neurotic and less extraverted than non-depressed people (Hirshfeld and Klerman, 1979, Kendell and Discipio, 1968). Finally neuroticism but not extroversion significantly predicted treatment outcome in one study (M.M. Weissman, Prusoff & Klerman, 1978).

The evidence linking the extroversion-introversion personality dimensions with previous depression is more consistent. It has been found that extroversion scores are not significantly effected by recovery from depression (Garside et al., 1979). Three additional studies, however, found evidence of instability in extroversion scores, in one case for both males and females (Coppen and Metcalfe, 1965) and, in another, for females, but not for males (McDonald-Scott and Larkin, 1983).

In the third study, there was an interaction of gender and measurement instrument (Bailey & Metcalfe,
1969). Four of the five studies that included comparisons with published norms found that depressed patients had higher than normal introversion scores following recovery (Benjamisen, 1981, Hirshfeld and Klerman, 1983). The results of these studies are consistent with those studies employing never depressed controls, in which remitted depressives found to be more introverted than the control subjects (Hirschfeld, Herman, Clayton, & Keller, 1983).

Overall these results suggest that although extroversion introversion covaries with depression, recovered depressives remain more introverted than never depressed people. It has been found that in addition to being more introverted depressed patients, compared to never depressed controls were significantly less sociable, less dominant, less active, and lower in social self-confidence (Keller, 1983).

H.J. Eysenck (1985) hypothesized that introverts are chronically more aroused than are extroverts, and that the increased arousal associated with social interaction becomes aversive to them. It is concluded that, remitted depressives tend to engage in less social activity, to be more restrained in their social interactions, and to avoid stressful situations, to a greater extent than do never depressed people. Depressive symptom is associated with several different personality types. Cycloid personality traits consist of alternating states of euphoria and
dysphoria to external situations. These individuals appear unstable, labile and constantly fluctuate in mood, obsessive compulsive personalities are stubborn, over conscientious, over serious, sober, studious, narrow in their interests, have difficulty in adjusting to change, bound by high moral codes, and to forth. A variation of this personality type may manifest itself by over compliance, politeness, and subservience. Although these may be the most common personality types, associated with depression, other traits such as hostility and over suspiciousness to the extreme of being paranoid are also observed.

Children can become profoundly depressed by trivialities but they are almost immune to prolonged changes of mood. From adolescence to the late twenties the incidence of depression rises sharply and women are more vulnerable than men by a three or four to one ratio.

The extroversion introversion and Neuroticism are postulated by Eysenck & 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.
Coping refers to efforts, both cognitive and behavioural, to manage environmental and internal demands and conflicts affecting an individual. Coping serves two main functions, emotion focused coping refers to coping efforts made at reducing emotional distress. Problem focused coping refers to efforts to deal with the sources of depression and stress. Research shows that symptomatic depressives do exhibit coping styles that are different from those of non-depressed persons. With respect to behaviour the results of a number of studies suggest that depressives engage in more emotion-focused coping than do non-depressed students (Coyne, Aldwin, & Lazarus, 1981).

If students are having healthy (effective) coping style the onset of depression is less likely. It has been observed that individuals/students cope with depression through emotional release, either their coping style is poor or they lack the capacity of problem-solving to deal with its causal factors. So instead of engaging in some sort of creative activity like writing, reading, or working to cope with depressogenic situation, he may choose negative coping style such as, may take stimulating drugs, smoke cigarettes, drink more tea or coffee. These are signs of negative coping or emotion-focused coping style, but if a person is having positive-style with problem focused coping then chances of depression are far less.

The idea that coping style may be involved in
the etiology of depression, has also been the focus of empirical research. The available evidence suggests that symptomatic depressives do exhibit coping styles that are different from those of non-depressed person. Depressed person compared to non-depressed have been found to perceive themselves as having more 'at stake' when appraising stressful situations (Folkman & Lazarus, 1986), and as needing more information before being ready to act (Coyne, Aldwin & Lazarus, 1981). With respect to behaviour, it is suggested that depressives engage in more emotion-focused coping than do non-depressed individuals. Mitchell and Hadson (1983) obtained a relationship between depression and a high level of avoidance coping combined with a low level of active, cognitive, and behavioural coping strategies. By definition, coping behaviours mitigate the pathogenic effects of major life-events as well as of "micro-stressors" (Coyne etal., 1981). If a coping style is effective the onset of depression is less likely.

The present study was intended to provide preliminary data describing how depressed people cope with the stresses of every day life. It has been observed that the assessment of coping in naturalistically occurring depressed or stressful situations shows difference between depressed and non-depressed persons.

Coping efforts may change the person environment relationship by altering the situation. Billings
and 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. Nezu & Nezu (1987) replicated research that demonstrated, that psychological well-being and distress are strongly associated with masculinity but unrelated to femininity.

Although epidemiological data have documented sex-differences in depression the nature and origins of the differences are unclear. Depression in a large sample of young unmarried college students was measured and described by the Beck Depression Inventory. No sex-differences were found in the degree of depression experienced by these students, and yet discriminant function analysis of the responses of the most depressed scores yielded a significant and interpretable sex-differences in the patterns of symptom expression.

Researchers have suggested that differences in rates of male and female depression are "artifactual" consequences of various sex-role socialization experiences and stereotypes. Sex-differences in depression are viewed as sex-differences in the experience and expression of depression, that make women more likely to identify it in themselves, seek help for it, overtly express affective complaints, or become psychiatrically labeled and treated as
depressed. Men may be equally depressed but do not admit depression, do not seek help for it, or fail to be labeled by professionals as depressed (Weissman & Klerman, 1977).

The interaction between masculinity and femininity (Hall & Taylor, 1985) are not expected to be associated with depression when life stress is taken in to account. Attitudes and patterns of sexual behaviour are fundamentally significant in the development of maladjustments and abnormal behaviour patterns. Sex plays a dual role, namely as a primary cause of behaviour disorder and as a major symptom of abnormal behaviour.

It was Freud who gave special emphasis to the role of sex in the etiology of neurotic behaviour. Although sexual drives were not considered the only forces in human behavior, yet they were placed in a position of central importance. The role of sex as a primary motivating force in human behaviour has been almost universally accepted by psychiatrists and psychologists.

For each individual, however variations occur in cognitions about these state of societal expectations, in beliefs about the appropriateness of sex-role expectations, in personal preference for various activities, and in the desire to avoid the negative consequences of role confirmity of violation (Spence, Deaux & Helmreich, 1985). Masculinity and femininity can be seen not as two distinct biological categories but as spectrum stretching from one extreme to the
other the individual in place on this spectrum by the knowledge of his/her values. Studies show that there was a negative relationship between masculinity and depression and essentially no relationship between depression and femininity. The relationship between femininity and depression is highly unstable, however a significant positive relationship was found in some studies. Rates of depression are found to be consistently higher in women than in men. Whether assessed in terms of self reported symptom or diagnostic criteria (Weissman, Tischler, 1984). It has been argued that as a consequence of sex-role socialization, women are less well prepared than men to deal with life-stress events (Cox & Radloff, 1983). According to Radloff and Rae (1979) gender typed patterns of sex-role socialization render women more susceptible than men to the negative impact of life-stress and consequently more vulnerable to depression.

Specifically, the finding of a negative relationship between masculinity and depression, while femininity is generally correlated to depression (Whitley, 1985), is consistent with the notion that having a traditional female sex-role style, one characterized by low masculinity, may predispose women to depression.

The well documented sex differences in depression may be due to a sex difference in susceptibility, in precipitating factors, or in both. Data from survey, were used to study precipitating factors. It was found that women
were exposed more often to more of the factors that related to depression similarly for men and women. Matching on these factors did not eliminate the sex difference in depression. This suggests that there may be a sex-difference in susceptibility.

However, there are studies which predict that not only the sex role but coping style is also a causal factor for depression occurrence. An important emphasis of the study is to fluid out the sex-differences and correlates or predictors of depression which effect the lives of students. Sex-biases have also been hypothesized for self-labeling and self presentation regarding depression (Hammen & Padesky, 1977). The biological hypothesis postulates that women have a unique vulnerability to depression, associated with events in the reproductive cycle or in the sex-linked genes.

Social - support is also one aspect of depression, three levels of conceptual analysis are evident in different uses of the term social support. First, social-support has been regarded as a process by which one develops, uses, and maintains resources (Levin, 1983) a cognitive appraisal and a transaction between person and environment (Coyne & Holyroyel, 1982). Second, Social-Support has been dichotomized as either structural or functional (Cohen &Wills, 1985). Structural support refers to the number and degree of integration of relationships, whereas functional
support comprises various content dimensions, such as esteem, informational support, social-companionship, and tangible support. Finally, the most fine-grained analysis reveals from whom support it received.

There is consistent evidence of a negative relationship between many facets of social support and concurrent depression (e.g. Bell, Le Roy, and Stephenson, 1982). Smaller social networks fewer social relationships, and less perceived adequacy of relationships are all related to depressive symptoms. The precise nature the relationship of depression, with social support, however, may depend to some extent on the nature of the support measure used. Cohen and Wills (1988) concluded that the perceived availability of functional support buffers the affects of stress by enhancing broadly applicable coping abilities. In comparison the degree of integration in a social network has a direct positive effect on well-being, reducing negative outcomes in both high and low stress circumstances.

Billings, and Moos (1985) found that remitted depressives tested 12 months after admissions to treatment had fewer friends and fewer close fewer relationships but not fewer social network contacts, than did normal controls. So it can be presumed that although remitted depressives maintain normal level of superficial relationships, they may have fewer meaningful relationships than the never depressed people.
Similarly, decreased perceived adequacy of social-support has also been found in some studies to predict the future level of depressive symptoms and to differentiate remitted symptoms in normal controls. Social-support also plays a major role to get reliance, from depression to some extent. Although depression can not be reduced completely, yet we can conclude that if a person is getting social-support from his family, friends, and teachers, or other ones, than onset chances of becoming depressed are lesser as comparison to the person getting no-support.

Objectives

The main objective of the present research is to determine the combined and relative predictive efficacies of attributional style, personality, social support, coping style, and life-stress to depression among a population of students. It is also desired to examine the sex-differences in the relationship of the prediction variables of interest and depression.

The study also proposes to find out how sex-role orientation of the subjects contributes towards prediction of depressive symptomatology among them.

Another important objective is to study the effect of initial level of depression among the subjects measured at Time one ($T_1$) along with other predictors on the level of depression measured at Time two ($T_2$).