CHAPTER-II

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With a view to seek some guidelines* from the previous researches, which could be helpful in formulating the present investigation, the results of some of the representative studies are discussed below. The review of studies has been used for the formulation of hypotheses. The present review is, by no means, exhaustive: it is an attempt to indicate the main trends in research and theory which have a direct or indirect bearing on the present problem.

We live in the looming shadow of the Bomb. We live in war. We live against a background of poverty and deprivation, on which is imposed unprecedented wealth and the ambiguous values of advanced technology. We live in the midst of injustice and corruption, decadence and anguish, made available by modern communications for us all to see. And men race to the moon while, the techniques of chemical warfare are perfected.

But there is something more: the manifestations of clinical depression - the sense of futility, the certainty of personal inadequacy, the fear and the immobilization at the most trivial level. The significance of depression in the modern era cannot be minimised.

* What is already known, what others have attempted to find out, what problems remain to be solved, what methods of attack have been promising or disappointing, the techniques and methodology followed by earlier investigators, etc.
Depression is as old as man. It has accompanied him throughout his history and the world's literature has chronicled it with the intensity and care that so ancient and so widespread a condition warrants. Depression is a universal experience; the emotions of sadness and grief are an intrinsic facet of the human condition. However, pathological depression - that overwhelming, often apparently unprompted despair - is distinguishable from grief by its intensity, duration and evident irrationality and by its effect on the lives of those who suffer from it.

Thousands of years ago, the Book of Job recorded psychopathological depression and in a more contemporary vein, the poetry of Gerard Manley Hopkins gives an immediacy and poignant horror to the anguish of depression (cf. Mendels, 1970).

Many famous people throughout history have suffered from depression. Winston Churchill wrote about the "Black dog" that followed him throughout his life and finally immobilized him in his old age. Abraham Lincoln had bouts of depression and often dreamed of his own coffin. And the artist Vincent Van Gogh cut off his own ear in a fit of despair (cf. McNeil & Rubin, 1973, p. 488).

The central symptoms of depression are sadness, pessimism, and self-dislike, along with a loss of energy, motivation, and concentration. The extent to which these
symptoms are present and their combinations are infinitely variable; other symptoms are frequent and sometimes dominate the clinical picture.

The depressive expresses judgements of himself ranging from inadequacy and inefficiency to extreme guilt. With little or no basis in reality, and showing little or no response to reassurance, argument, or emotional appeal, he denies past achievements and abilities. He regards himself as incompetent at best and disgustingly sinful at worst.

The ideas of incompetence may be limited to one or two aspects of life or may become generalized. Then, the depressed patient believes himself to be "no good". A lifetime of efficiency and success becomes meaningless. He thinks only of failure and worthlessness. If confronted with objective evidence of past achievements, he will reject them as irrelevant or anticipate their immediate disintegration. There is no belief in the reality of past achievements.

Clinicians and researchers have debated whether the concept of depression refers to a single disease that varies from mild to severe along a continuum or whether it consists of a set of discrete subtypes that differ in phenomenology, pathophysiology, and ultimately etiology (Everitt, 1981; Kendall, 1968, 1976; Roth et al., 1972; Klerman, 1971; Eysenck, 1970; Hamilton & White, 1959; Lewis, 1938). This debate has yielded a number of
different methods for subtyping depressive disorders, such as endogenous vs. reactive, psychotic vs. neurotic, primary vs. secondary and pure depressive disease vs. depression spectrum disease (Nelson & Charney, 1980; Akiskal et al., 1978, 1979; Bhrolchain, 1979; Bhrolchain, Brown, & Harris, 1979; Winokur, Behar, Van Valkenburg, & Lowry, 1978; Lewis, 1971; Winokur, Cadoret, & Dorzab, et al., 1971; Kendell & Gourlay, 1970; Rosenthal & Klerman, 1966). Andreasen & Winokur (1979 b) emphasized that "the multiplicity leads not to an embarrassment of riches but rather to a hodgepodge of competing and overlapping systems; psychotic vs. neurotic, endogenous vs. reactive, bipolar vs. unipolar, agitated vs. retarded, manic-depressive vs. involutional" (p. 447).

The complexity of depressive phenomena, the difficulty of making causal inferences based on the results of naturalistic research, and the plethora of factors hypothesized to cause depression all militate against drawing firm conclusions concerning the etiological status of these variables. The number of competing viewpoints and nosological symptoms clearly mirror the incomplete knowledge of etiological and contributory factors in the depressive disorder. Nevertheless, as Akiskal & McKinney's (1973) "pluralistic" view of depression suggests, most explanatory models, including psychological and biological models
provide a unique perspective that can contribute to a fuller understanding of these clinical syndromes.

The present study is not concerned with the problem of classification or subtypes of depression, but intends to investigate the correlates of depressive tendencies in adolescence.

**Correlates of Depression**

The related studies have been reviewed under the following main headings:

(A) Negative Cognition and Depression;
(B) Social Support and Depression;
(C) Body Image, Physical Attractiveness and Depression;
(D) Self-report measures of Depression, Anxiety and other forms of Psychopathology; and
(E) Gender Differences and Depression.

It can be noted from the review of the related literature that over the last 25 years, considerable progress has been achieved in the delineation of the psychological, psychosocial, and biogenetic characteristics associated with affective disorders. The results of this body of research have been summarized in increasingly voluminous reviews by Carson & Carson (1984), Whybrow, Akiskal, & McKinney (1984), Mendels (1975), and Becker (1974). In particular, previous research has identified a number of variables associated with unipolar depression. Thus, depressed individuals have been shown to have difficulties in interpersonal interaction (e.g.
Coyne, 1976; Weissman & Paykel, 1974; Lewinsohn & Libet, 1972; Lewinsohn, Weinstein, & Apler, 1970), to manifest a variety of negative cognitive patterns (e.g., Seligman, Abramson, Semmel, & Von Baeyer, 1979; Rosensky, Rhm, Fry, & Roth, 1977; Beck, 1967), to show a reduced rate of engagement in the enjoyment of pleasant activities (Lewinsohn, 1974) and to report having experienced a greater number of stressors, in the months preceding the depression (e.g., Lewinsohn & Talkington, 1979; Brown & Harris, 1978; Paykel et al., 1969).

Freud emphasized the importance of early life events in accounting for later psychological disorder, and his theory of depression (1917) was no exception. He suggested that some people become excessively dependent on others for the maintenance of their self-esteem, as a result of either too much or too little gratification of their needs during the oral period of psychosexual development. When these people experience a loss during adulthood, such as the death of a loved one, they tend to feel unconscious anger toward this person for leaving them. This anger, however, is not directly expressed, but is instead turned inward against the self, leading to the self-blame and self-hatred characteristic of depression. The loss that triggers such reactions is not necessarily someone’s death. It may also be symbolic loss, such as rejection which the person experiences as a result of a total
withdrawl of love. Following Freud (1917/1957), Abraham (1924/1949) postulated that parental rejection in early life produces severe injuries to infantile narcissism, which in turn leads to a sadistic introjection of the parental figures, hostility toward one's own ego in the form of self abusive cognitions and guilt feelings (Fenichel, 1945).

In recent years, the psychoanalytic theory has been losing ground in favor of the cognitive theories of depression. Beck (1967) has advanced a cognitive theory of depression that attaches central importance to negative cognitive schemata that dominate depressed persons' evaluations of themselves, their environment, and their future. Beck (1967) was explicit in stating that these schemata develop as a consequence of parental behavior. That is, depressed persons are assumed to have had parents who were critical and nonapproving of their self-worth. These evaluations are internalized and form the building stones for a negative schema.

**Negative Cognition and Depression**

There has been a virtual explosion of research demonstrating various cognitive differences between depressed and non-depressed people (general review by Coyne & Gotlib, 1983). In this context, much of the impetus has come from the theoretical and empirical work of Peter Lewinsohn (1976), Aaron Beck (1967, 1974) and Martin Seligman (1974, 1975). Indeed, the recent empirical
literature on the psychology of depression is dominated by studies addressing Beck's cognitive theory, Seligman's learned helplessness model, or Lewinsohn's theory, which attributes depressive states to a low rate of response - contingent positive reinforcement.

Beck (1967, 1976) has provided the most comprehensive exposition of the cognitive view of depression. From his perspective, there are three causes of depressed effect: (a) the negative cognitive triad, in which the person has a negative conception of the self, the world, and the future; (b) dysfunctional schemas developed in early life experience; and (c) systematic errors in thinking.

Beck (1967, 1976) proposed that self-deprecating and negatively biased thinking styles are not only core features of adult depression, but also may play a key-role in the development and maintenance of this disorder. In addition to the overriding negative triad-negative view of self, current circumstances, and future and stereotypic schemas, premises, or dysfunctional attitude (should and musts), a central theme of Beck's cognitive model is that depressed individuals characteristically make specific dysphoria - provoking cognitive errors, collectively referred to as distortions, in response to ambiguous or negative life experiences. Beck, Rush, Shaw, & Emery (1979) described seven of these typical negative errors: overgeneralization (believing that if a negative outcome
occurred in one case it will occur in any case that is even slightly similar); selective abstraction (attending exclusively to negative features of a situation in the belief that only the negative features matter); assuming excessive responsibility or personal causality (seeing oneself as responsible for all bad things, failure, and so on); presuming temporal causality or predicting without sufficient evidence (believing that if something bad happened in the past then it is always going to be true); making self-references (believing oneself, especially one's bad performances, to be the center of everyone's attention); catastrophing (always thinking of the worst on the premise that it is most likely to happen to one); and thinking dichotomously (seeing everything as one extreme or another, black or white, good or bad). These cognitive errors or distortions are interpretations and predictions that are not usually justified by the information provided (Hammen, 1981). Even if there is a partially realistic foundation for such interpretations, and predictions in the lives of some depressed patients (Coyne & Gotlib, 1983; Krantz, 1983), their repetitive, self-deprecating quality, and extremely negative character, can be still considered dysfunctional or maladaptive (Kovacs & Beck, 1978).

The cognitive distortions are seen to develop from early life experiences and to be triggered by present environmental conditions or events, thus, leading the
person to view the self, the world, and the future in a negative way. Beck believes that the activation of these maladaptive thought patterns leads to the affective, motivational, and physical symptoms of depression.

Furthermore, it can be stated that the major cognitive theories of depression, the reformulated learned helplessness theory (Abramson, Seligman, & Teasdale, 1978) and Beck’s (1967, 1976) cognitive model, emphasize the importance of hopelessness about the future in the etiology, maintenance and treatment of depression. In the reformulated helplessness theory, the expectation of hopelessness — the belief that desirable outcomes not forthcoming are hypothesized to be a sufficient cause of depression (Alloy, Clements, & Kolden, 1985). In Beck’s model, a permissive view of the future along with negative perceptions of the self and the world (the negative cognitive triad) are seen as sufficient causes of depressive symptoms. Empirical research has demonstrated that depressed individuals endorse hopeless statements about the future more than do non-depressed individuals (e.g., Greenberg & Alloy, 1986; Beck, Weissman, Lester, & Trexler, 1974; Minkoff, Bergman, & Beck, 1973), although, the causal role of hopelessness in depression is as yet untested.

Several lines of research have supported the relationship between cognitive distortions and mood
assumed by Beck (e.g., Hamilton & Abramson, 1983; Krantz & Hammen, 1979; Weintraub, Segal, & Beck, 1974). Similarly, mood induction studies that induce depression through self-statements support the notion that negative thoughts can cause depression (e.g., Teasdale & Bancroft, 1977). Beck’s cognitive theory of depression led to the development of a relatively affective treatment approach for adult unipolar depression (Rush, Beck, Kovacs, & Hollon, 1977). Several investigators (Nolen-Hoeksema, Seligman, & Girgus, 1986; Kaslow, Rehm, & Siegel, 1984; Seligman et al., 1984; Craighead, Smucker, & Duchnowski, 1981) who have tested children and adolescents in a school setting, have also reported data to verify hypotheses derived from the reformulated learned helplessness theory of depression (Abramson, Seligman, & Teasdale, 1978). They have consistently found substantial and significant positive correlations between self-reported depression and the composite of internal, stable, and global attributions for negative events and have occasionally found significant negative correlations between self-reported depression and the composite of internal, stable, and global attributions for positive events.

Saylor, Finch, and colleagues (Saylor, Finch, Baskin, Purey, & Kelly, 1984; Saylor, Finch, Spirito, & Bennett, 1984) reported data on the relation between attributional style and self-reported depression with two small clinical inpatient samples of children and adolescents. They
obtained correlation in each samples between the total score on the Children’s Depression Inventory and the difference score on the Children’s Attributional Style Questionnaire, $r = .46, p < .01$ was similar in magnitude to correlations obtained with nonclinical samples. The authors interpreted their findings to be consistent with reformulated helplessness theory. The direction of the correlation was opposite to that of correlations reported in other studies, probably because of the unspecified method of calculating the attributional difference score. Finally, Kaslow, Rehm, Pollack, & Siegel (1988) reported that depressive attributional style significantly differed between 8 to 12-year old outpatient children with and without diagnoses of major depression.

Curry & Craighead (1990) evaluated the relation of self-reported depression, anxiety, and social maladjustment to attributional style. Subjects who reported more severe depression had a significantly lower composite score for internal, stable, and global attributions for positive events. The composite of internal, stable, and global attributions for negative events was not significantly related to either diagnosed or self-reported depression.

In summary, it can be stated that both the reformulated learned helplessness model (Abramson, Seligman, & Teasdale, 1978) and the cognitive theory of
depression (Beck, 1967, 1976) hypothesize that specific maladaptive thinking patterns play important roles in the onset or in the maintenance of clinical depression. Each theory hypothesizes that certain maladaptive thinking patterns are latent in depression - prone individuals during asymptomatic periods - these patterns are activated by stressful events, and the result is clinical depression.

Presently, empirical support for the etiological role of cognitions in depression remains equivocal. Prior investigations (Hollon, Kendall, & Lumry, 1986; Eaves & Rush, 1984; Hamilton & Abramson, 1983; Dobson & Breiter, 1981) clearly indicate that symptomatically depressed individuals reported greater pessimism, more negative thoughts, more dysfunctional attitudes, and greater attributional biases than do non-depressed normal control subjects.

However, studies that have investigated the stability of these putatively deeper cognitive processes (dysfunctional attitudes and attributional biases) by assessing patients, both during and often a clinical episode of depression, have yielded mixed results. Eaves & Rush (1984) and Dobson & Shaw (1986) found that endorsement of dysfunctional attitudes on Dysfunctional Attitude Scale (DAS) either was not significantly reduced or remained elevated in comparison with normal control
levels, during a remission of depressive symptoms, which implied that the dysfunction is traitlike.

Conversely, four other studies have found, in patients with longer lengths of clinical remission, that scores on the DAS normalized with remission and are, therefore, statelike (Hollon et al., 1986; Silverman, Silverman, & Eardley, 1984; Simons, Garfield, & Murphy, 1984; Hamilton & Abramson, 1983).

Social Support and Depression

Over the past 10-15 years, there has been a virtual explosion of research demonstrating the role of social support in psychology. The breadth and consistency of the research on the beneficial effects of social support are impressive. Ranging from animal laboratory studies to large scale epidemiologic investigations of psychopathology, disease and mortality, the majority of the work documents that social support concepts, involving ties and transactions between individuals over time, represent a fundamental component of stress and disorder theory. Either through direct protective effects or by buffering the adverse consequences of life stresses, social support is associated with a decreased likelihood of developing disorder. The presence of supportive people in one’s life enhances both physical and emotional well-being.

Traditional models on the formation of self-esteem (Sullivan, 1953; Mead, 1934; Adler, 1927; James, 1890)
have underlined the importance of social forces, but tended to portray the individual as a passive target of their influence. Early reference to the "social mirror" neatly encapsulates a view in which self-esteem arises to a large degree, as the simple, somewhat mechanical reflection of evaluations expressed by significant others.

While some studies on social support and psychological distress have used representative community samples (e.g., Holahan & Moos, 1986; Henderson et al., 1981), others have employed particular subgroups such as working-class women (e.g., Brown et al., 1986), the elderly (e.g., Kraus et al., 1989), or students (e.g., Cramer, 1985, 1988, 1990, b,c; McLennan & Omodei, 1988; Cohen et al., 1986). Social support has long been recognized as a significant factor in the formation of adolescent self-esteem (Rosenberg, 1981). Correlational and Longitudinal studies over the last three decades have demonstrated the pervasive influence of affirmation, aid, and affection proffered by parents and peers (Hoffman, Ushpiz, & Levy-Shiff, 1988; Greenberg, Siegel, & Leitch, 1983; Burke & Weir, 1978, 1979; O’Donnell, 1974; Rosenberg, 1965). Eaton (1978) reported that the occurrence of stressful life events is associated with more psychiatric disorder among those living alone or unmarried than those living with others or married. Andrew, Tennant, Hewson, & Schonell (1978) found that the
combination of recent stressful life events, low level of social support and adverse childhood experiences, successfully predicted the occurrence of maladjustment in adults. There is an evidence that the depressive individual tend to report the lack of availability of supportive others (Winefield, 1979). Henderson (1980) concluded that a deficiency in social bonds may, independent of other factors, be a cause of some forms of behavioural dysfunction. The literature on the nature and role of social support in relation to life events is literally burgeoning. There are now a plethora of findings based on a variety of measures that social support sometimes interacts with life events, and sometimes is directly related to a vast array of mental and physical health outcomes (Thoits, 1982; Gore, 1981; House, 1981; Cobb, 1976).

Central to contemporary health psychology is the assumption that social support from significant others, is of major importance in coping with important life-events, and that social support can reduce or eliminate the adverse consequences of these events upon health or well-being (critical reviews by Buunks & Hooren, 1992; Coyne & Downey, 1991; Sarason, Sarason, & Pierce, 1990; Cohen, & Wills, 1985).

There is accumulating evidence that supportive personal relationships are associated with greater psychological adjustment (e.g. Cramer, 1991; Henderson &
There is substantive evidence for a small negative association between psychological distress and variously defined indices of social support (e.g. Henderson & Brown, 1988; Cohen & Syme, 1985; Biegel, McCardle, & Mendelson, 1985). Although, most of this research has been cross-sectional in design, an increasing number of prospective studies suggests that prior social support is also negatively related to subsequent psychological distress (e.g. Krause, Liang, & Yotomi, 1989; Brown, Andrews, Harris, Adler, & Bridge, 1986; Monroe, Imhoff, Wise, & Harris, 1983). Since intervention experiments are difficult to conduct in this area, casual interpretation of the observed association is problematic (e.g. Monroe & Steiner, 1986). Although this relationship is usually taken to indicate that social support reduces psychological distress, it is equally compatible with the view that psychological distress decreases social support, or that the relationship between these two variables is either reciprocal or spurious. Because of the problems of realistically manipulating social support, most of the research in this area is of a non-experimental nature. Consequently, the causal nature of the observed association is difficult to ascertain. However, a few prospective studies which have compared the size and direction of the cross-lagged coefficients between support and adjustment, have found that the association between
earlier support and later adjustment is more positive than that between earlier adjustment and later support (Cramer, 1988, 1990a; Krause, Liang, & Yamoti, 1989). These findings suggest that support is a stronger determinant of adjustment than adjustment is of support. Likewise, Cramer (1988, 1990a) using both cross-lagged panel correlation and linear structural relationships analysis, found that the association between the initial overall quality of a close relationship and subsequent self-esteem was more positive than between initial self-esteem and subsequent quality of a close relationship. This finding implies that the quality of this relationship predominantly determines self-esteem rather than the other way round. Further evidence for the casual influence of support comes from intervention studies which have found that the provision of non-professional contact is of greater therapeutic benefit than no contact (e.g., Vachon, Lyall, Rogers, Freedman-Letofsky, & Freeman, 1980; Strupp & Hadleg, 1979).

The assumed beneficial effects of social support have often been divided into two types; direct and buffer effects. Evidence for both main and buffering effects has been obtained (e.g. Cohen & Wills, 1985). Direct effects encompass the general positive influence of social support, regardless of whether someone experiences social stress or not. A buffer effect refers to the fact that a high level of social support protects the individual
against the negative consequences of stressors once these have arisen (Cohen & Wills, 1985). One of the puzzling finding in the domain of social support concerns the existence of negative direct as well as a buffer effect (Barrera, 1986). For example, in a study of nurses, Kaufman & Beehr (1986) found that all the significant buffer effects turned out to be the opposite of their expectations: the relationship between sources of stress and stress reactions appeared to be higher among individuals who had access to strong social support systems than among individuals who lacked these systems. Winnubst, Marcelissen, & Kleber (1982) found that people who had a high responsibility for others at work became more depressed when their colleagues and superiors were more supportive. In a study carried out by Hobfoll & London (1986) among Israeli women whose loved ones were mobilized in the 1982 Israel-Lebanon War, social support appeared to be related to greater psychological distress. In a study on occupational stress among nearly 2000 employees, Buunk, Janssen, & Van Yperen (1989) noted so-called boomerang effects. For example, in some cases social support aggravated the stress reactions or did not affect them at all in work units characterized by a high degree of role conflict, while, at the same time, social support reduced stress reactions in units with a low
degree of role conflict. In other words, social support seemed to aggravate instead of alleviate stress.

While, positive relations between stress and support may indicate that those under stress seek out help more often (Buunk & Verhoeven, 1991), in some cases social support does appear to increase the impact that stress has on well-being instead of reducing that effect. For various reasons, this seems quite understandable from a social comparison point of view.

In these studies, social support has been defined as the existence, or availability of people on whom we can rely, people who let us know that they care about, value and love us (Sarason, Levine, Basham, & Sarason, 1983). Thus, social support is an interwoven network of personal relationships that provides companionship, assistance, attachment, and emotional nourishment to the individual. Bowlby’s theory of attachment (1969, 1973, 1980) relies heavily on this interpretation of social support. When social support, in the form of an attachment figure, is available early in life, Bowlby believes children become self-reliant, learn to function as supports for others, and have a decreased likelihood of psychopathology in later life. Bowlby has also concluded that the availability of social support bolsters the capacity to withstand and overcome frustrations and problem solving challenges.
In a review of the occupational stress literature, Buunk (1990) made a distinction between four different conceptualizations of social support. First, from a sociological perspective, social support has primarily been viewed in terms of the number and strength of the connections of the individual to others in his or her social environment. In other words, the degree of one's social integration or the size and structure of one's social network. According to Rook (1984), social integration may promote health, among other things, by behaviour providing stable and rewarding roles, by promoting healthy behaviour, by deterring the person from ill-advised behavior, and by maintaining stable functioning during a period of rapid change. A second perspective on social support has been provided by authors who equate social support with the availability of satisfying relationships characterized by love, intimacy, trust or esteem. For instance, Cutrona & Russell (1990) have shown that certain provisions of relationships, including attachment and reassurance of worth, can act as buffers against stress. In the third perspective, the perceived helpfulness view, social support constitutes the appraisal that under stressful circumstances, others can be relied upon for advice, information and empathic understanding, guidance and support. In this context, there is some evidence for the assumption that the mere
perception that one can turn to someone for help already reduces stress (Sarason & Sarason, 1986). Finally, for some authors the concept of social support refers primarily to the actual receiving of supportive acts from others, once a stressful situation has come into existence. While the foregoing perspectives assume a certain preventive function of support against stress, this perspective focuses upon the curative function of actual help when a person is under stress (cf. Barrera, 1986). Although, all these conceptualizations may be important for understanding the role of interpersonal relationships in reducing stress, the four levels may bear different relationships to health and well-being.

Regardless of how it is conceptualized, social support would seem to have two basic elements: (a) the perception that there is a sufficient number of available others to whom one can turn to in times of need, and (b) a degree of satisfaction with the available support. These two factors in social support may vary in their relation to one another, depending on the individual’s personality. Some people may think that only a large number of available helpers provide sufficient possibilities of social support. Others may consider that even one person is adequate. How gregarious people are and how comfortable they feel with others may determine the number of supports they believe necessary. In the same way, satisfaction with
the support perceived to be available may be influenced by
personality factors such as self-esteem and a feeling of
control over the environment. Recent experiences may also,
influence a person to regard the support available as
satisfactory or not satisfactory.

In the light of the above discussion and the
diversity of available measures of social support, this
study made use of the extensively used Sarason's Social
Support Questionnaire (Sarason, Levine, Basham, & Sarason,
1983) which yields scores for a perceived (A) number of
social support, and (B) satisfaction with social support
that is available.

Further, Monroe & Steiner (1986) concluded that
although it is conceivable that personality plays a
dominant and immutable role in the prediction of disorder,
it is equally likely that personality will provide useful
information on the components of specific support
mechanisms that predict differential outcomes. Hence, the
inclusion of personality variables in social support
research may be useful strategy for delineating the basic
processes involved. In this study, personality variables
and social support measures have been included to examine
the correlates of depression among adolescents.
Figure: Interrelations between social support, preexisting disorders, stress, and personality (cf. Monroe & Steiner, 1986).
Research has documented the importance of an individual's physical attractiveness within the culture. Attractive people are perceived to be happier, more successful, popular (Berscheid & Walster, 1974), more sensitive, kind, interesting, strong, poised, modest, sociable and outgoing than less attractive people (Dion, Berscheid, & Walster, 1972). In addition, physical attractiveness has consistently been reported as the most important factor in a person's desirability as a dating partner (Tesser & Brodie, 1971; Brislin & Lewis, 1968; Walster, Aronson, Abrahams, & Rottman, 1966).

Women have become increasingly preoccupied in maintaining a thin body type in recent years (Mori & Morey, 1991). Some believe that this has been due, in part, to the unrealistic weight standards that society has set to define attractiveness (e.g., Mitchell & Eckert, 1987; Schwartz, Thompson, & Johnson, 1982). The dissatisfied females experience with their body and their desire to be at a lesser "ideal" weight is highlighted by the finding that 69.7% of the 227 college women studied by Fallon & Rozin (1985) felt that they were heavier than their ideal weight. Women in American society often link their self-worth with their attractiveness and body weight and this leads them to have a high degree of concern with their appearance and a greater desire to conform to the society's "ideal" thin body type (Polivy & Herman, 1987;
Orbach, 1979; Wooley & Wooley, 1979; Lerner, Orlos, Knapp, 1976; Lerner & Karabenick, 1974). Furthermore, it appears that females may have legitimate reason to associate their self-worth with their attractiveness since it has been found that being attractive and thin helps women achieve certain goals such as status, popularity, male companionship, and ultimately a marriage partner (Safilios-Rothschild, 1977; Dwyer, 1973).

Dissatisfaction with one’s body frequently becomes manifest in a negatively distorted body image. In its most general sense, the term body image refers to the mental image one has of one’s physical appearance (Crisp, 1977; Kay & Leigh, 1954). The term also includes the attitudes or feelings one has toward one’s own body (Crisp, Fenton, & Scotton, 1968). A body image disturbance (BID) is a diagnostic criteria of anorexia nervosa (American Psychiatric Association, 1987) and, as such, is defined as an inability to recognize how thin one really is, and is exhibited by a sense of feeling overweight in spite of severe emaciation. Although a number of psychological variables have been discussed in the context of body image disturbance, one variable that appears to have received considerable attention is depression (Mori & Morey, 1991; Garner, 1981; Strober, 1981; Emery, 1981; Beck, 1978; Peto, 1972).
Beck (1973, 1976) described a negative appraisal of personal appearance as one of the cognitive symptoms of depression. He further suggests that depressed people do not feel positive about themselves and tend to interpret and distort incoming information about their appearance and personality so that it reinforces their pervasive negative beliefs about themselves (Beck, 1967). Thus, in Beck’s (1973, 1976) cognitive theory of depression, "distortion of body image" (Beck, 1973, p. 24) is included among the cognitive symptoms of depression. Beck (1973, 1976) described a negative appraisal of personal appearance as one of the cognitive symptoms of depression. Beck (1973) classified 975 individuals as non-depressed or as mildly, moderately, or severely depressed based on their Beck Depression Inventory scores. He reported that in each group, 12%, 33%, 50% and 66% respectively, suffered from a "distortion of body image". His use of the word 'distortion' here may be inappropriate, however, because Beck did not compare subject's own ratings of body image with ratings by objective and reliable raters.

In a classic study, Secord & Jourard (1953) found a high positive correlation between body cathexis (ratings of body parts) and self-cathexis (ratings of aspects of the self). Berscheid, Walster, & Bohnstedt (1973) surveyed 2,000 Psychology Today readers and found body satisfaction was related to personal happiness. Teenagers who reported being unattractive were by far the most
unhappy group of respondents; adults in their 30s who reported that they were attractive teenagers were the happiest. Neither of these studies, however, directly addressed the issue of body image and depression.

A number of recent studies also suggest that positive body image is an important negative correlate of depression in high school and college students (Cash, Winstead, & Janda, 1986; Noles, Cash, Winstead, 1985; Teri, 1982). Marsella, Shizuru, Brennan, & Kameoka (1981) did investigate body cathexis and depression. They categorized college students on their Zung Self-Report Depression Scale scores and found that depressed students were more dissatisfied with 17 body areas.

In addition to a possible link between self perceived attractiveness and depression, physical appearance as perceived by others may contribute to depression. Based on evidence that unattractive persons receive less social reinforcement than do their attractive peers (e.g. Cash & Burns, 1977; Berscheid & Walster, 1974), one might predict from Lewinsohn’s (1974) reinforcement theory that less attractive persons would be more susceptible to depression. Cash & Smith (1982) found that lower physical attractiveness, as determined by reliable observers, was related to significantly higher self-reported depression for male subjects. A similar though non-significant association was found for females.
Noles, Cash, & Winstead (1985) examined body image, physical attractiveness and depression. Accordingly, 224 college men and women completed affective and cognitive measures of body image, the Center for Epidemiological Studies - Depression Scale (CES-D), and a single, self-labeling depression item. Each subject was videotaped and objective raters reliably evaluated a static, full-body pose of each subject on physical attractiveness. The subjects were classified as depressed (n=35) or non-depressed (n=42) on the basis of the conjunctive criteria of self-labeling and extreme groups on the CES-D. As hypothesized, the multivariate and univariate analyses of variance indicated that depressed subjects were less satisfied with their bodies and saw themselves as less physically attractive than was reported by non-depressed subjects. These groups did not differ, however, with respect to observer-rated physical attractiveness. Support was obtained for Beck’s (1973, 1976) cognitive hypotheses that depressed persons negatively distort their body images. The authors further concluded that the hypothesis that depression would be related to lower levels of observer-rated physical attractiveness was not supported. One may expect unattractive persons to be more susceptible to depression on the basis of either a social-behavioral perspective (Coyne, 1976; Lewinsohn, 1974) or a learned helplessness perspective (Seligman, 1975). Unattractive individuals not only receive less response-contingent
positive reinforcement but also perceive their interpersonal environment to be less responsive to their actions, and following rejection, unattractive individuals make more unstable attributions for subsequent social success (Weingberger & Cash, 1982). In addition, both Garner (1981) and Strober (1981) found that depressed anorexics do exhibit a greater tendency to overestimate their body image than non-depressed anorexics.

Mori & Morey (1991) examined the vulnerable body image of females with feeling of depression. They conducted an investigation to develop a greater understanding of the etiology of body image overestimation and to explore some variables that are believed to be associated with Body Image Distortion (BID). One hundred and twenty-one female students participated in a two part experiment that was designed to investigate the impact of external, weight-related feedback on the body image of females with different levels of depressive feelings. As predicted, female participants with greater feeling of depression who were given weight feedback that was too high produced body image estimate that were proportionally larger and significantly different from their depressed counterparts who were given weight feedback that was too low. In contrast, the body size estimations of the participants with low feelings of depression were not affected by the weight-related feedback. These findings
indicate that females with feelings of depression may have a body image that is vulnerable to external feedback (e.g. societal messages), which may have implications about the treatment and prevention of body image disturbances. Although this study offers one explanation of how 'body image disturbance' may develop in some females, the etiology of this disorder is complex and possibly involves the influence of many other personality, developmental, environmental, and physiological factors. Further, although this study was conducted with normal college females, there may be important implications that can be extended to clinical populations and to the prevention of the occurrence of body image disturbance.

(D) Self-report measures of Depression, Anxiety and other forms of Psychopathology

Anxiety and depression are classified as separate disorders clinically through DSM-III and statistically through discriminant function analysis. In recent years, there has been an increased emphasis on the phenomenology of the various disorders of mood. This has received its impetus from attempts to construct a clinically relevant taxonomy of the affective disorders by identifying operationally defined criteria to delineate one disorder from another. This is difficult because of complex symptom patterns in which there is considerable overlapping of symptomatology between two disorders. Such is the case with anxiety and depression. There are many anxious
patients who present concurrent symptoms of depression, and many depressed patients who present concurrent symptoms of anxiety. How these patients are 'diagnosed' has implications for both treatment and prognosis (cf. Stavrakaki & Vergo, 1986, p. 7).

Numerous studies have demonstrated that self-report anxiety and depression scales are highly correlated, typically in the range of .40 to .70. This finding is, moreover, both robust and general. Such correlations have been reported in college students (Nezu, Nezu, & Nezu, 1986; Tanaka-Matsuni & Kameoka, 1986; Dobson, 1985; Gotlib, 1984), children (Wolfe et al., 1987; Blumberg & Izard, 1986), normal adults (Orme, Reis, & Herz, 1986), and diverse patient samples (Zurawski & Smith, 1987; Bouma & Luteijn, 1986; Mendels, Weinstein, & Cochrane, 1972). The correlations are, often, high enough to suggest that they tap a single construct. In fact, different measures of anxiety and depression are as highly correlated with each other as they are among themselves, and this often load on a single undifferentiated factor, together with measures of hostility, anger, neuroticism, physical complaints, repression-sensitization, irrational beliefs, and on the opposite poles with ego strength and social desirability (e.g. Tanaka-Matsuni & Kameoka, 1986; Dobson, 1985; Gotlib, 1984; Mendels et al., 1972). Many investigations have concluded that all of these measures tap a common, underlying construct of Negative
or General Psychological Affectivity, Neuroticism, Distress (Zurawski & Smith, 1987; Gotlib, 1984; Watson & Clark, 1984; Eysenck, 1970).

The personality variable neuroticism has also been shown to be related to persistence of depression (e.g., Weissman, Prusoff, & Klerman, 1978; Weissman & Klerman, 1977). Martin (1985) has recently summarized a number of studies showing that the neuroticism is also related to a tendency to recall negative self-referred information. From such evidence she has proposed a cognitive hypothesis of the way in which neuroticism predisposes to persistent depression (Martin, 1985).

Although much research has been devoted to identifying attributes of depression-vulnerable personality structure (Akiskal, Hirschfeld, & Yerevanian, 1983; Chodoff, 1972), these efforts have provided limited insight into the diathesis underlying adolescent depression if only because studies of the character structure associated with depression have typically not focused on the adolescent period. Furthermore, even with respect to age groups other than adolescence, controversy persists over the relative contributions of singular personality attributes such as excessive dependency needs (e.g. Arieti & Bemporad, 1980; Hirschfeld, Klerman, Chodoff, Korchin, & Barrett, 1976; Chodoff, 1972), dysfunctional belief systems (Abramson, Seligman, &
absence of competence (Cicchetti & Schneider-Rosen, 1986), and introversion (Akiskal et al., 1983). In addition, we do not yet have a perspective on the relevance of contemporaneous psychological factors in the genesis of adolescent depression (Robbins & Kashani, 1986).

(E) Gender Difference and Depression

Several studies have identified a gender difference in depression showing more depression among adult women (e.g. Boyd & Weissman, 1986) that appears to emerge by middle adolescence (e.g., Kandell & Davids, 1982). This difference, based largely on cross-sectional data, is particularly interesting given that mental health and behavior problems in general are seen more frequently among boys in childhood (Achenbach, 1982), and given that the only studies finding a gender difference in childhood depression have found a greater prevalence among boys (e.g., Rutter, 1986; Pearce, 1977). Thus, several scholars have hypothesized that something changes in early adolescence to cause this reversal of the gender difference.

Appreciable changes occur in the frequency and nature of depressive symptoms as individuals approach and pass through adolescence. Following puberty, depression becomes more common, especially among girls (Rutter, 1986; Kandell & Davids, 1982). Although depressive states comparable to these seen in adults also begin to appear (Bemporad &
Wilson, 1978; Weiner, 1975), adolescents sometimes seem to express their underlying depression through behaviors differing from the traditional manifestations of adults depression. For example, maladaptive adolescent behavior (e.g., drug abuse) has been viewed as depression related (Weiner, 1975; Malmquist, 1971 a, 1971 b).

Various writers in discussing the psychological dynamics of depression, have conjectured that the basis for depression differs for men and women (e.g. Kaplan, 1986; Nolen-Hoeksema, 1987; Radloff, 1980; Radloff & Rae, 1979; Weissman & Klerman, 1979). These views may be seen as following from more general developmental considerations of the differential socialization of the sexes and from the different self and world views that our culture creates in men and women (Block, 1976, 1979, 1983). Sroufe & Rutter (1984) have noted that depression in young boys often is embedded within the context of conduct disturbances - an externalizing pattern of symptom expression. In young girls, by contrast, depression is manifested in passivity and a turning inward-an internalizing pattern of symptom expression. In a similar vein, Ebata & Peterson (1988) reported that depression among early adolescents was related in boys but not in girls to "externalized" behavior (e.g. getting into trouble at school) and to poor academic performance.

Gjerde, Block, & Block (1988) examined the observed and self-attributed personality characteristics associated
with depressive symptoms in non-clinical adolescents. Eighty-Seven, 18 years-old completed the Center for Epidemiological Studies Depression (CES-D) Scale, adjective self-descriptions, and the multidimensional personality questionnaire (MPQ). Separately, California Adult Q-Sort (CAQ) rating of the subjects were obtained. Although mean CES-D scores did not differ for the sexes, dysthymic young men were constantly more negatively evaluated than were dysthymic young women and non-dysthymic young persons of both sexes. Extensive differences were also observed between male and female subjects in observer (CAQ) correlates of CES-D scores: 18-years old dysthymic young men were seen as disagreeable, aggressive and antagonistic - an externalizing pattern of characteristics, 18-year old dysthemic young women, by contrast, were seen as ego-brittle, unconventional, and ruminating - an internalizing pattern of characteristics. In their self-recognition, however, both male and female adolescents described themselves as agressive and alienated. Non-linear relations between CES-D scores and personality were also observed. Thus, both quantitative and qualitative differences in men and women have been reported in the specific area of depression.

Overview

Here, it is worth mentioning that although it is not scientific to compare the results of different investigations in this specific area of research using
different operations and methodology, because the differences in 'methodology' and "operationalisation" of any phenomenon may be the source of discrepancy in results, the studies have been compared with a view to assess the trend revealed by earlier investigations.

The research in this specific area of depression reveals several important aspects. These aspects provided the rationale for the formulation of the present study. Moreover, they provided the guidelines for incorporating possible refinements into the methodology of the present investigation.

1. There is a considerable agreement regarding depression as a common problem for the general population and the client in psychotherapy in particular.

2. Adolescence is a particularly significant developmental period for examining depression. Until very recently, depression research largely focused on adult populations. We, thus, do not know to what extent the multitude of findings that have emerged from the adult literature in the recent past are generalizable to adolescents. The growing literature on adolescent depression suggests that adolescents are substantially more depressed than children and that they may be more depressed than adults (relevant studies discussed earlier). In contrast, a limited number of studies have empirically examined depression in adolescent
populations. Since adolescence has been theorized as the first stage in human development in which psychological problems become more intense, gaining a better understanding of depression in this age group in terms of the amount of depression, symptomatology and consequences may be helpful in counselling adolescents. Persons in the helping professions such as psychology, psychiatry, nursing, counselling and social work who have contact with adolescent populations, need to examine depression in adolescents in greater depth in order to develop better strategies for coping with depression. Allgood-Merten et al. (1990) emphasized that it is critically important that clinical investigators turn their attention to the study of depression in this age group.

3. The greater preponderance of depressed adolescent girls and adult women, relative to boys and men, has received significant attention by scholars and appears not to be explained by factors such as response bias on questionnaires, greater openness to acknowledging psychological difficulties and other attributes apart from actual depression experienced by the individual. Thus, the fact that women comprise about two-thirds of the depressed populations has remained a puzzle without adequate theoretical explanation. Thus, it is imperative to identify the factors underlying depression separately among males and females i.e.,
examining quantitative as well as qualitative gender differences in depressive symptoms.

4. Although, a number of investigators have examined depression among adolescents, this research has generally been less fruitful. A review of more than ten years of such work leads one to conclude that a hazy, confused portrait is all that can be distilled from the investigations during the last ten years. One possible reason for this state of affairs could be that the majority of the prior investigations have examined cognitive and personality variables as predictors of depression, singularly and in isolation. Mostly bivariate correlations have been computed. The use of multivariate analysis has been ignored. This is an important methodological flaw. It is important to determine the interdependence of several factors, for conceptual reasons, because depression and its correlates, typically are not manipulated experimentally. Studies that assess only one or the others of these domains (e.g. cognition, personality, demographic) may overlook unmeasured factors closely associated with variables of interest.

One approach is to include cognitive as well as personality variables within the purview of a single study to investigate their contribution as well as relationship to depression. This is the analytic
strategy that was chosen for the present study which made use of factor analysis for ascertaining the correlates of depressive tendencies among adolescents.

5. Finally, the construct of depression itself requires some discussion. Notwithstanding the diversity of its symptomatology, depression is recognized as an identifiable syndrome. It is typically measured either by self-report instruments or by diagnostic interview. Although the self-report measures cannot claim to give a clinical diagnosis of depression, they have been found to be substantially correlated with each other and with diagnoses based on clinical interviews with adults (Roberts & Vernon, 1983; Lewinsohn & Teri, 1982; Myers & Weissman, 1980) and adolescents (Lewinsohn, Hoberman, & Rosenbaum, 1988). It is with this caveat that the present study made use of self-report instruments to measure depression.

It is equally interesting to emphasize that earlier studies have mostly employed only a single measure of depression. Keeping in view the findings (Upmanyu & Reen, 1991 . . ) that the measures of depression derived from the Beck Depression Inventory, MMPI-D Scale and Zung Self-Rating Depression Scale are not identical, it is not desirable to include only a single measure of depression in studies aiming at the identification of factors underlying depression. Thus, the present study includes in its purview multiple measures of depression.
1. The Beck Depression Inventory,
2. The MMPI-Depression Scale, and
3. The Zung Self-Rating Depression Scale.

There are several reasons for the inclusion of multiple self-report measures of depression in a single study. Firstly, these self-report instruments have been extensively used by researchers working in this specific area of research; second, researchers have reported similarity as well as dissimilarity among these measures of depression; third, the different construction of these scales, and their individual characteristics of items array cause serious difficulties in comparing one study using one scale with another using a different scale. Given some contentual differences among the scales, there may be distinctive patterns of correlation of these scales with several other dimensions of psychiatric disturbance.

6. Studies have failed to ascertain the strategies used by adolescents to cope with depression.

Phase I

The review of the related literature provided the guidelines for the formulation of following hypotheses

Hypotheses

1. The depressive measures derived from different self-report depression scales are not identical.

We do not have any empirical investigation concerning comparability of different self-report measures of depression during adolescence, whereas there has been some investigations of this type in adulthood.
The proposed hypothesis derived its rationale from Upmanyu & Reen's (1990) recent investigation of depression among married women which led to the finding that different measures of depression are discordant. This finding has important implications for a clinician as well as researcher, since comparing results of investigations that have been conducted in different settings with different dependent measures provided through different sources is thus made difficult. The replication of this important finding is essential to have more scientific information about the relationship between different self-report depression measures.

2. It is hypothesized that given gender difference in symptom expression, modest gender difference in mean level of depressive symptoms are expected, with girls likely to score somewhat higher than boys.

The earlier researches clearly show that although depression is quite prevalent in the adult population, its existence during childhood, though now recognised, is relatively uncommon. Somewhere between childhood and adulthood, its prevalence is assumed to increase dramatically (Rutter, 1986; Rutter, Graham, Chadwick, & Yule, 1976). Moreover, Weissman & Klerman (1977) pointed out that girls do not appear to predominate among the depressed very early in the life span, yet, women clearly are preponderate among depressed young adults (Lewinsohn, Duncan, Stanton, & Hautzinger, 1986).
Further, the following four sets of findings deserve attention with respect to the hypothesis mentioned above. Firstly, adolescence is a more stressful developmental period for girls than for boys (Hops, Sherman, & Biglan, 1989; Rutter, 1986); secondly, it is during adolescence that girls begin to report lower body image than boys (Simmons & Blyth, 1987; Rosenberg & Simmons, 1975; Simmons, Rosenberg, & Rosenberg, 1973); thirdly, girls reported higher self-consciousness than boys (Rosenberg & Simmons, 1975); and fourthly, with menarche girls tend to drop culturally prescribed masculine attributes (Hill & Lynch, 1983) associated with lower depression.

3. It is also hypothesized that a negative self-schema would be positively correlated with depression in both males and females.

This hypothesis derives its rationale from several studies reviewed earlier with respect to the role of dysfunctional cognitive patterns in the development and maintenance of depressive symptoms in both males and females.

4. It is further hypothesized that poor body-image would be more strongly correlated (positively) with depression in case of female adolescents than male adolescents.

This hypothesis derived its rationale from a number of recent studies which suggests that positive body-image is an important correlate of depression in high school and college students (Cash, Winstead, & Janda, 1986; Noles, Cash, & Winstead, 1985; Teri, 1982) and it is during
adolescence that girls begin to report lower body-image than boys (Simmons & Blyth, 1987; Rosenberg & Simmons, 1975; Simmons, Rosenberg, & Rosenberg, 1973).

5. Depression would be associated negatively with social support in both males and females.

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

6. Depression would be associated positively with neuroticism, psychoticism and introversion.

This hypotheses derived its rationals from Gotlib (1984) investigation which revealed positive association between depressive measures and psychopathology as derived from self-report measures.

Phase II

Rapport (1972) noted that the social role of adolescents is a sort of "Limbo" in which adolescents are derived of a clear sense of belongingness, attachment, avenues of participation, and a socially affirmed role in the society. Brennan (1982) suggests a major task of intervention seems to be the facilitation of attachments, commitments and new modes of social participation. In the context of lack of research concerning coping strategies...
adopted by male and female adolescents for coping with depression, it is hypothesized that for coping with depression, adolescents would emphasize those strategies of coping which may be effective in dealing with emptiness, boredom, isolation and lack of social contact.