CHAPTER – V

DISCUSSION
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The present study investigated the relationship and contribution of several psychosocial factors (attributional style, sense of personal control, stress coping strategy and social support) to depression in two clinical samples belonging to Indian and Iranian populations.

In the remainder of this chapter, the results presented in the previous chapter will be discussed keeping in view the research objectives of the study. The entire discussion will be divided into five parts. In the first part, findings of examining hypothesis 1, 2 – there are significant differences in attributional styles, sense of personal control, stress coping strategies and social support between depressed and non-depressed groups – will be discussed. Auxiliary hypothesis, i.e., there are significant differences between Indian and Iranian depressed groups in terms of attributional style, sense of personal control, stress coping strategies and social support, will be discussed in the second part.

The third hypothesis – there are significant influences of the psychosocial variables (attributional styles, sense of personal control, stress coping strategies and social support) in their relative contribution for depression – will be discussed in part three. Implications of these findings for psychosocial theories of depression and treatment interventions are discussed in part four. In the final part, suggestions for future research and limitations of the current study will be discussed.

5.1 Discussion of Hypotheses 1, 2.

As results section revealed, Indian depressed group significantly used more of internal, stable, global and uncontrollable attributions (personality traits) for failure events and used less of effort and strategy attributions (internal and controllable causes) for bad outcomes in comparison with non-
depressed group. Iranian patients also used more of internal, stable, global and uncontrollable attributions (ability and personality traits) for bad outcomes and made less effort and strategy attributions for failure events compared with non-depressed sample. In other words, depressed patients tend to blame themselves (ability and personality) for failures.

For success outcomes (events), Indian depressed patients used more of other external circumstances attributions (external, unstable and uncontrollable causes) and made less ability and effort attributions in comparison to normal group. Iranian depressed individuals also used more of other external circumstances attributions for success outcomes and used significantly less of effort and strategy attributions (internal and controllable causes) for success events compared with non-depressed people. Above findings confirm first part of hypotheses 1, 2, i.e., depressed people use more of maladaptive attributional style in comparison to non-depressed individuals. These results are consistent with attributional theories of depression (Abramson, Seligman & Teasdale, 1978; Abramson et al., 1989) and several earlier research, especially in Western countries (Alloy et al., 1999b; Anderson, 1999; Alfano, Joiner & Perry, 1994; Joiner, 2001; Joiner & Wagnor, 1995; Sweeny et al., 1986).

However, some have argued that differences between depressed and non-depressed individuals are smaller and less consistent than expected (Cole & Turner, 1993; Edelman, Abrens & Haagya, 1994; Follette & Jacobson, 1987; Michelson, Bellanti, Testa & Machione, 1997).

Differences between the findings of the different studies have been attributed to many factors including inappropriate research designs, sample size, inadequate conceptualization of attributional styles, and differences in timing of assessment of depressive symptoms, insufficient statistical power and lack of congruence between the domains of individuals' inferential style – interpersonal vs. achievement – and the type of negative events encountered (Abramson et al., 1995; Robins, 1988).
Another important finding of current study is about not using "self-serving bias" (Miller & Porter, 1988) by depressed people. As results revealed, depressed patients from both countries attributed failure to internal and personal causes, whereas they attributed success to other external circumstances. According to attribution theory, normal people tend to credit themselves for success and to attribute failure to external circumstances. Blaming failures on one’s own personality traits while avoiding trait attributions for success events is especially problematic, leading to low self-esteem and high depression scores (Anderson, 1999).

An interesting finding is about temporary mood state attributions. Depressed participants (from both countries) used more of this internal and uncontrollable attributions for both failure and success outcomes compared with non-depressed group. This means participants with clinical depression used more of uncontrollable causes like mood attributions as explanations for life events. Such a process may lead to decreasing self-efficacy in depressed patients. Thus, future research will need to explore more, the interaction of attributional style and self-efficacy in clinical depression particularly.

In summary this study showed clinical depressives exhibit more negative attributional styles compared with non-depressed counterparts. Researches (Brewin, 1988) revealed that there is evidence that people's mood affects their causal judgments, attribution for negative events being more internal, stable and global during depressive episodes and become more "normal" after the episode is over. Attributions help to predict who will be more depressed weeks and months later, even when it is taken into account that not every one is equally depressed to start with (Brewin, 1988). In addition, it is noteworthy that in this study result of attributional styles were very similar across two samples from different countries belonging to collectivistic culture. This means the relationship between some kinds of attributional styles and depression especially in clinical population are relatively the same regardless of culture and background.
Second part of hypotheses 1, 2 was to compare sense of personal control in depressed and non-depressed groups. The results revealed both Indian and Iranian depressed patients showed significantly more negative sense of personal control. Indian patients expressed more "desire for sense of personal control" compared with non-depressed group. Both revealed significantly lower score on positive sense of control in comparison to normal participants. Results suggest that the Western construct of personal control functioned somewhat similarly in these non-Western samples.

In general, above findings illustrate that sense of control has important role in clinical depression. The results of current investigation are consistent with several previous studies, which reveal concurrent association between low perception of control and depression (Brown, Harris & Hepworth, 1995; Gilbert & Allan, 1998; Mazure et al., 2001; Seligman, 1991; Thompson et al., 1993; Weisz et al., 1994).

Jang, Haley, Small and Mortimer (2002) reported higher level of mastery and greater satisfaction with social support had significantly direct effects on depression and also buffered the adverse impact of disability on depression. Perceived control may positively affect health by increasing coping efforts and persistence, providing one with a positive self-image, and reducing distress (Bandura, 1977; Lefcourt, 1976; Thompson, 1981), but, as our current study revealed (high score on "desire for personal control" in depressed group), there are limits to the benefits of individual autonomy. A high need for control may adversely affect one's intimate relationships. Reinforcement theory would predict that success in gaining control in one area might only increase the desire for more control (Shapiro et al., 1996). In summary, it may be that, depending on the person and the situation, there is a point of balance on the emotional tightrope at which people feel powerful enough to avoid helplessness but not so responsible that they need to worry about it (Burger, 1989).

In conclusion it should be noted, in spite of pivotal role of control in depression, because the construct of control is more complex and
multifaceted than was initially conceived (Shapiro et al., 1996), understanding the mechanisms underlying control-based vulnerability to depression need further researches using multivariate prospective designs.

Another aim of this research was to study the coping responses of depressives and to compare their responses with non-depressed group. The results indicated that coping styles of depressed people differ from that of non-depressed people in most areas.

Both Indian and Iranian depressives used significantly less of problem-focused coping strategies as compared to the non-depressed group. Several earlier studies have concluded that depressed people have a negative problem-orientation and poor problem-solving skills compared with normal people (Billings & Moos, 1984; Bruder-Mallson & Hovanitz, 1990; Ghazinour et al., 2003; Haaga et al., 1995; Nezu & Perri, 1989; Pestonjee, 2002; Sharma et al., 2001). The evidence is not unambiguous, however, because a few other studies failed to find a relation (Chan, 1992; Coyne, Aldwine & Lazarus, 1981; Folkman & Lazarus, 1986; Parker & Brown, 1982).

An unexpected finding was that depressives belonging to both countries used significantly lesser emotion-focused coping compared with non-depressed people. This finding is not in accordance with the most of previous studies in India, Iran and Western countries that have reported that depressives use more emotion-focused coping compared with normal subjects (Ebrahimi, Bolhari & Zolfaghari, 2002; Haghighatgo & Peterson, 1995; McNaughton, Patterson, Irwin & Grant, 1992; Stanton, Danoff-Burg, Cameron & Ellis, 1994; Veena & Rao, 2004; Vollarth et al., 2003). However, some studies have revealed that such strategies can also reduce distress (Coyne & Downey, 1991; Holohan & Moos, 1991).

These inconsistent findings can have two explanations. First, emotional-focused category of "COPE' has several positive (effective) emotional coping strategies like reinterpretation and growth, religion and humor. But emotion-focused coping as defined by other investigators like
Lazarus and Folkman (1984) has mainly negative connotation implying what Carver et al., (1989, 1994) define as "dysfunctional coping" and it is possible that earlier research reports that depressives use more of emotion-focused coping in this sense. Since, in this study emotion-focused coping has no negative connotation, low score of depressed group on this strategies is presumably related to this difference in definition and related measurement scale. Second, the same coping can have distinct outcomes in different situations. Some research has provided evidence suggesting that to be effective a person's coping efforts should be congruent with the controllability of the event (i.e., problem-focused strategies will be more effective if the event has some potential for control, whereas, emotion-focused responses will be adaptive in low control events (Forstyle & Compas, 1987; Vitaliano et al., 1990). For example Vitaliano and his associates (1990) found that in non-psychiatric samples, problem-focused coping predicted less depression and emotion-focused coping predicted more depression only when stressors were appraised as controllable. Similarly, Forstyle and Compas (1987) reported that a higher proportion of active problem-focused coping was associated with less psychological distress only when events were viewed as controllable.

Depressed groups from both countries used significantly more of behavioral disengagement (avoidant) coping strategy in comparison with non-depressed groups. This finding is in line with results of Satija et al., (1997) in India and Ebrahimi et al., (2002) in Iran. "The avoidant coping has important role in depression. "Behavioral disengagement means reducing one's effort to deal with the stressor, even giving up the attempt to attain goals with which the stressor is interfering. Behavioral disengagement is reflected in phenomena that are also identified with terms such as helplessness" (Carver et al., 1989 P.269). Above

Moos and Moos (1999) reported in a ten year follow up of depressed patients that they found that compared with stably remitted patients, partially remitted and non-remitted patients consistently relied more on avoidance coping. More reliance on avoidance coping was associated with higher odds of experiencing a course of partial remission or non-remission. (Cronkite, Moos, Twokey, Cohen & Swindle, 1998).
Another unexpected finding of this study is about dysfunctional coping strategies (focus on and venting of emotions, denial, behavioral disengagement, mental disengagement and alcohol/drug use). The scores of Indian depressed group (exception behavioral disengagement) were not high in any of these dysfunctional coping strategies compared with non-depressed group. Iranian depressed group used significantly more of the most of these dysfunctional coping styles in comparison to non-depressed group. How these differences between two depressed groups can be explained?

First, the literature is absolutely clear that both the source and the effect of coping strategies are contextual (Aldwine, 2000). Mechanic (1974) argued, to a large extent, the efficacy of an individual's coping is dependent upon how well the culture provides a range of coping resources and transmits coping skills. For example, some culture focus on the suppression of emotions while others demand the display of emotions in culturally appropriate patterns (Aldwine, 2000). Second, research findings (Aldwine & Revenson, 1987; Vollrath et al., 2003) argue against simplistic interpretations of the relation between coping and depression. Thus, one way to conceptualize above issue is to think about coping styles as determinants of predictors of coping responses. “Following this logic, dimensions of personality or coping styles derived from the five-factor model, such as extroversion, agreeableness, and conscientiousness, are predictably related to approach and avoidance coping responses (McWilliams, Cox & Ennis, 2003; Shewchuk, Elliot, Macnaire-Semands & Harkins, 1999). In addition, personality dispositions such as self-confidence and an easy going manner have been associated with more reliance on both approach and avoidance coping responses” (Beutler et al., 2003, p. 1163).

Therefore, as Barnet and Gotlib (1988) noted, the elucidation of the relationship between coping style and depression may require further specification or classification of the stressful events that elicit similar responses. It does appear, however, that formerly depressed people may engage in more emotional discharge behavior in response to the demands of
negative events than do non-depressed people. Clearly, additional research is required both to assess the influence of coping style on future depression and to replicate results suggesting that increased emotional discharge coping and using avoidant strategy are an enduring consequence of depression.

The final part of hypotheses 1, 2 was to examine role of social support in depression. The results of the study determined that scores of perceived social support (both number and satisfaction) were significantly less than non-depressed individuals for samples belonging to both countries. It means their social networks are smaller and less supportive than those of people who are not depressed. These findings are in line with earlier research. There is consistent evidence of a negative relationship between many facets of social support and concurrent depression (Bakhshani, Birask, Atefvahid & Bolhari, 2003; Chada, 1995; Gupta, Sharma, Narayan & Gupta, 2002; Hays et al., 2001; Lara, Leader & Klein, 1997; Partow, 2004; Phifer & Murrell, 1986; Zuroff et al., 1995).

Besides above findings, some researches (Nezlek et al., 2000) has suggested that the availability of single, close, confiding relationship can provide a buffering effect against depression, whereas a large number of social contacts per se does not.

5.2 Discussion of Auxiliary Hypothesis

Coming to auxiliary hypothesis, i.e., there are significant differences between Indian and Iranian depressed groups in terms of attributional style, sense of personal control, stress-coping strategies and support. As the results indicated, Iranian depressed individuals made more maladaptive attributions for failure or success situations, used more dysfunctional coping strategies, showed more negative sense of control and revealed less perceived social support compared with Indian depressed group. These findings may be related to differences between the two societies. Each society provides its own unique stresses as well as beliefs and rituals to
reduce psychological tension. Ashley Montague (Trujillo, 2000) has indicated, for example, that cultures that provide adaptive channels for expression of aggression and the satisfaction of dependency needs can significantly reduce personal and interpersonal conflict.

In conclusion, the samples of this study were very small for any cross-cultural interpretation. These findings, therefore, need to be replicated on larger, more representative samples of the communities.

5.3 Discussion of Hypothesis 3

One important aim of this study was to determine the amount of contribution of different psychosocial factors on depressive symptoms among clinically depressed patients. The findings demonstrate that more than one variable contribute as predictors of depression, in both the samples (Indian and Iranian samples). It means that clinical depression is a multi-factorial determinant phenomenon. Becoming depressed is a consequence of an interaction of personal and social factors. A growing literature has documented the pervasive difficulties in psychosocial functioning exhibited by depressed person (Gotlib & Hammen, 1992; Lewinsohn, Gotlib & Seely, 1997; Mazure, Bruce Maciejewski & Jacobs, 2000; Patel et al., 2002; Salkangas & Poputanen, 1998).

The results also indicated that priorities of different psychosocial factors for contribution on variance of depression are different in two clinical groups. In Indian depressed group, negative sense of control was the first variable to predict depression with 33% of variance and followed by behavioral disengagement coping style and social support with 6% and 5% respectively. In Iranian group, predictive variables of depression were active goal-oriented coping style, behavioral disengagement coping style, ability attributions for failure events and social support with 37%, 12%, 7% and 6% respectively. It means negative sense of control and coping strategies have important role in depression. Besides, as researches have indicated (Garber & Flyn, 2001; Sadock & Sadock, 2000) clinical depression is a heterogeneous
illness and that different interactions of bio-psychosocial factors have a pivotal role in different types of them and it is unlikely that any one theory will ever successfully explain all of the variance regarding who does and who does not become depressed when faced with comparable stressful life circumstances.

One more unexpected finding of this study is about attributional style variable. While attributional theories of depression and the several current researches (Abramson et al., 1989; Alloy & Clements, 1998; Alloy et al., 1999a; Sweeney et al., 1986) reported the important role of explanatory style (as antecedents, concomitants or consequence factors) in depression, in our study attributional styles variables could not predict any portion of variance of depression in Indian depressed group and it just predict 7% of variance of depression in Iranian depressed group. This low contribution of attributional style can be explained with reference to different factors. Segal (1988) pointed out, regarding assessment of cognitive diathesis, evidence is mounting that the cognitive schemas that predispose certain individuals to depression are not stable traits. Persons and Miranda (1992) have postulated that inconsistency in results, is likely to be the result of inadequate assessments of inferential styles. According to Persons and Miranda’s “activation hypothesis” cognitive vulnerability factors, such as depressogenic attributional styles are stable, but they may not always be activated. They are accessible only during mood states. Therefore, it is possible that our assessment of the attributional styles was somewhat compromised.

Our results demonstrate important role of coping style across both Indian and Iranian depressed individuals and also combined depressed group. Avoidant coping strategy (behavioral disengagement) significantly contributed for variance of depression in all depressed groups. Results such as these add weight to the larger pattern found in the literature that, with respect to coping behavior, depressed persons tend to rely less on problem solving and more on emotional discharge and avoidance than non-depressed persons (Cronkite et al., 1998; Vollrath et al., 2003). Reliance on the more general category of avoidance coping at entry to treatment for depression is a significant risk factor for non-remission (Beutler et al., 2003).
Thus, as Moos (1997) suggested “an integrated assessment of coping skills can be useful in formulating clinical case descriptions, treatment planning, and program evaluation. It can help to describe a person's coping responses to a specific stressful life circumstance, monitor stability and change in coping responses, compare individuals and groups, and examine how new life events affect a person's ways of coping as well as how coping responses change an individual's life situation and functioning” (p. 62).

5.4 Implications for Prevention and Treatment Interventions

In a more practical vein, the results of the present study provide some guidance as to what can be done by primary care providers and mental health specialists for depressed patients to improve their mental health, as well as to affect the clinical course of depression over time. The findings of current study highlight the need to use psychosocial and multifaceted interventions, especially cognitive and interpersonal therapy in the management of depressed patients. A combination of techniques that facilitate deployment of effective coping strategies (Meichenbaum & Cameron, 1983; Moss, 1997), enhance sense of personal control (Rehm et al., 1987; Shapiro & Astin, 1998), correct maladaptive patterns of interpersonal relationship (Klerman, Weissman, Rounsaville & Chevron, 1984; Weissman et al., 2000) and change negative cognitive styles (Beck, 1987; Gillham, Reivich, Javcox & Seligman, 1995; Holohon, DeRubeis & Seligman, 1992) should be particularly targeted at depressed patients.

5.5 Limitations and Suggestions

Several methodological considerations have to be mentioned about the present study. First, the causal direction between psychosocial factors and depression cannot be established firmly by our design. As Garber and Flynn (2001) noted, future studies should examine multivariate vulnerability models. Such investigations should test more complex moderator and mediation
models that explore how these vulnerability factors synergistically combine to explain the onset of depression. One fundamental question that remains is whether depressive vulnerabilities are permanent characteristics of individuals and by what internal and external mechanisms are they turned on and off. Second, the sample from each country was very small and was self-selected and therefore cannot be considered representation of the Indian and Iranian depressed population generally. These findings, therefore, need to be replicated on a large, more representative sample of clinical depression.