CHAPTER – II

REVIEW OF LITERATURE
CHAPTER 2

REVIEW OF LITERATURE

In this chapter, first the researches on sense of personal control and depression will be reviewed, followed by attributional style and depression. Then previous researches about stress coping strategies and depression will be reviewed. Finally literature on social support and depression will be considered.

2.1 Sense of Personal Control and Depression

"Perceptions of control refer to beliefs about one's ability to produce desired outcomes in the face of effort. Contemporary models construe perceived control as the joint function of judgments about the extent to which outcomes are dependent on certain behaviours and judgments about one's own ability to display these behaviours (Bandura, 1986; Skinner, Zimmer-Gembeck & Connell, 1998; Weisz, 1990). Thus perceptions of control incorporate beliefs both about one's efficacy as well as about the responsiveness of the environment" (Rudolph, Kurlakowsky & Conley, 2001, p. 448).

It was only in the late 1950s and the early 1960s that psychology began to seriously reexamine issues of personal control (Shapiro et al., 1996). Control appears to be one of the most critical variables involved in psychological health and well being (Bandura, 1989; Kiran Kumar, 1986; Seligman, 1991). It is a central concept in many psychological theories of emotional well being (White, 1959).

Seligman (1975) was among the first contemporary theorists to advance the role of control in the onset and maintenance of depression. Subsequent animal studies using Seligman's "Learned helplessness model" confirmed profound behavioural and neurobiological effects of exposure to uncontrollable compared to controllable stress, which were consistent with
depressive states (Mazure et al., 2001). Abramson, Metalsky and Alloy (1989) proposed the hopelessness theory of depression. This theory suggests that the belief in one’s inability to control the effects of untoward events induces hopelessness, which is likely to be a proximal cause of the onset of depression.

The past thirty years have seen a dramatic increase in research directed toward issues of control and self-control. For example, there have been efforts to develop and refine non-pharmacological self-regulation strategies to provide individuals with increased control over their affect, behaviour and cognitions (Bandura, 1989; Beck, 1976; Frank, 1982; Rehm, 1977; Rehm, Kaslow & Rabin, 1987; Shapiro & Zifferblatt, 1976; Shapiro & Astin, 1998). In addition, several different controls related constructs have been developed and explored, such as learned helplessness (Seligman, 1975); internal/external locus of control (Rotter, 1966, 1990); self-efficacy (Bandura, 1977); desire for control (Burger & Cooper, 1979; Burger, 1985), hardiness personality theory (Kobasa, 1979), and two cognitive personality characteristics — sociotropy and autonomy (Beck, 1983).

Research supports the idea that beliefs about control have important implications in a number of areas. For example, across a wide variety of situations, perceived control is associated with better emotional well being, more successful coping with stress, better health psychological outcomes and better adjustment to illness (Bandura, 1986; Bandura, Pastorelli, Barbaranelli & Caprara, 1999; Lazarus & Folkman, 1987; Liu et al., 2000; O’Leary, 1984; Taylor & Brown, 1988; Thompson et al., 1993;).

New work also suggests that feeling defeated and entrapped (the impossibility of escape from a difficult situation) is especially associated with depression, and more so than loss events (Gilbert, 2000).

In Lachman and Weaver study (1998), results of hierarchical multiple regression analyses showed that higher perceived mastery and lower perceived constraints were related to better health, greater life satisfaction
and lower depressive symptoms. However, control beliefs played a moderating role. Participants in the lowest income group with a high sense of control showed levels of health and well being comparable with the higher income groups.

In another study, Miller, Campbell, Farran, Kaufman and Davis (1995) investigated the relationship between races, psychological resources of sense of control and caregiver mastery, and distress outcomes of caregiver depression and role strain among 77 African American and 138 white spouse caregivers of persons with dementia. Sense of control had a direct negative relationship with depression. Caregiver mastery moderated the effects of stressors on depression and was the only significant psychological resource predicting role strain.

Rudolph, Kurlakowsky and Conley (2001) investigated the precursors and emotional consequences of maladaptive control-related beliefs and behaviour during adolescence. Two cohorts of fifth and sixth grades (N=471 and 587) participated in a short-term longitudinal design. Results supported the proposal that both family disruption and recent stress contribute to concurrent and future deficits in perceptions of control and helplessness. Decreased perceptions of control and increased helplessness in turn were associated with higher levels of depressive symptoms. Researches have noted that this study advances cognitive models of depression by identifying processes underlying the development of control-based vulnerability during childhood.

Thompson, Sobolew-Shuhin, Galbraith, Schwankovsky and Cruzen (1993) reported from 71 cancer patients, those with greater perceptions of controls were less depressed, even when physical functioning, marital satisfaction, and negative affectivity were controlled for. The results indicated that even patients who were physically or psychosocially worse off were better adjusted if they had higher perceptions of control.
Moreover, initial cross-sectional findings suggested that psychological outcomes are influenced by the fit between appraisals of controllability and the choice of coping strategies. 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. The above-mentioned relation between controllability attributes and emotion suggests that judgment of control may be critical for understanding the nature of the relation between causal perception and depression (Brown & Siegel, 1988).

Such findings suggest that one is affectively better off with the perception of more, not less, control. However, there are several investigations demonstrating that this is not always the case. Some studies with humans, for example, had indicated that helplessness inductions sometimes lead to subsequent facilitation of performance (Brewin, 1988). In addition many depressed people hold themselves responsible for their failure. If they regard themselves as helpless, how can they blame themselves (Davison & Neal, 2001).

In a related series of experiments, "Burger, Brown and Allen (1983) gave some subjects a choice of three tasks to work on during a 20 minute testing session. All subjects had been given false feedback from earlier trials indicating that they were likely to do well on one of the three tasks, and hence all chose that task. Other subjects given identical feedback were merely assigned the task for the testing session. In each of three experiments, subjects given the choice of tasks scored lower on measures of self-esteem and higher on measures of anxiety and hostility than did subjects given no choice of tasks. The increase in negative affect with increase in control in each of these studies can be explained in terms of increase in concern for self-presentation that was created in the subjects given a choice, that is, these subjects were probably more concerned about making the wrong test
selection, asking wrong questions or performing poorly on the upcoming examination than were the no choice subjects. This concern then translated into increased negative affect, particularly anxiety (However, it remains unclear why this manipulation would also reduce self-esteem, presumably a relatively stable personality trait” (Burger, 1989, p. 249).

These findings provide consistent evidence that increases in perceived control will not always result in positive affect. Some degree of control may help people avoid learned helplessness and depression, but the increase in responsibility and concern for a poor performance that accompanies control can also lead to an increase in anxiety and depression. In too much control, persons who tried to control things they cannot may become angry or anxious when they realize things are not happening the way they wanted. They may also take responsibility for things outside their control. This adds to the emotional arousal that maintains depression (Pahlavian & Mhjub & Zarabian, 1999). 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).

Recent researches (Shapiro et al., 1996) have suggested that for certain people there are mismatches between the amount of control available to them in their environment and personal variables. These personal variables include (a) behavioural competencies (skill and ability), (b) control cognitions (self-efficacy and responsibility), and (c) control motivation (desire for control). Indeed, Evans et al., (1993) cited more than 60 studies of mismatches falling into two sets of conditions. The first set of conditions involving high environmental affordances, indicates that giving more control to an individual who does not want it (low desire for control, high external locus of control, and low belief in self-efficacy) or who cannot effectively utilize it (low behavioural competencies) is damaging. The second set of conditions occur when low environmental affordances exist, that is, when there is no opportunity to effectively exert active control but the person has a high need for control, a high belief in his or her ability to gain control, or high behavioural
competencies. This set of mismatches directly counters the dominant psychological paradigm by indicating when seeking or having active control is not helpful, thereby moving beyond an overly simplistic linear function between active control and well-being (Burger, 1989).

From above findings, it can be understood that relationship between the sense of personal control and psychological well-being is somewhat well established, but this may be specific to Western cultures. Compared with individualistic Western culture, Asian cultures emphasize selflessness, subordination to family and community, which may decrease level of personal control.

2.2 Attribution Styles and Depression

Attributional style (or explanatory style) is a relatively new concept in psychology, especially in clinical studies. Attributional style refers to characteristic way that a person explains personality relevant events. For instance, some people usually attribute their occasional achievement failure to use of poor strategy, whereas others usually attribute such failures to lack of ability (Anderson, 1999). Theoretically, attributional styles differ in adaptiveness because of their impact on subsequent success expectancies, motivations, affect and behaviour (Brown & Silberschatz, 1989; Kenworthy & Miller, 2002).

Attributional style is a personality characteristic that was first introduced by Abramson, Seligman and Teasdale (1978) and further elaborated by others (Alloy et al., 1999b; Peterson & Seligman, 1984). Individuals vulnerable to depression supposedly differ from the non-vulnerable in the causal judgments. Abramson et al., (1978) argued that a "depressive attributional style" is characterized by the tendency to view aversion (negative) events as caused by internal factors (in contrast to external factors, such as the environment or the actions of others), by factors that are stable (rather than unstable or temporary), and by factors that exert global influence
across many domain in one's life (rather than specific or narrow influence in only a few situations).

Strong support for this hypothesis was provided by Sweeney, Anderson and Bailey's (1989) meta-analysis, which included 104 studies on this topic. A further tenet of the attributional theory is that this particular attributional style places individuals at 'risk' of developing depression if they experience stressful life events (Luten, Ralph & Mineka, 1997). Most attributional style research has focused on its relation to depression and related motivational problems and has been conducted primarily on participants from Western cultures (Anderson, 1999). In general, evidence for the role of attributional style as a diathesis for depression has been far less conclusive (Luten et al., 1997). The results of several studies have suggested that a pessimistic attributional style (attributing bad outcomes to internal, stable, global and uncontrollable causes – self-blame – and good outcomes to external, unstable, specific and uncontrollable causes) is a risk factor for developing a depressed mood following one or more stressful life events (Alfano, Joiner & Perry, 1994; Joiner et al., 2001; Metalsky, Haolberstadt & Abramson, 1987; Nolen-Hoeksema, Girgus & Seligman, 1992; Metalsky, Joiner, Hardin & Abramson, 1993; Peterson & Seligman, 1984; Robins & Hayes, 1995). Other studies have found little or partial evidence that a pessimistic attributional style serves as a cognitive vulnerability for developing clinical depression (Barnet & Gotlib, 1988; Follette & Jacobson, 1987; Haslam & Beck, 1994; Weisman & Pinto, 1997).

Joiner and Wagner (1995) conducted a meta-analytic review of the attributional style and depression literature as it pertains to children and adolescents, concluding that attributional style are clearly correlated with depression for both depression diagnosis and self-report. In addition, there is some support for the hypothesis that attributional style is specifically associated with depression, at least for symptoms (Lewinsohn, Joiner & Rhode, 2001). Regarding psychiatric diagnoses, most children and adolescents with a psychiatric diagnosis, regardless of type, have a negative attributional style. Most importantly, support for crucial hypothesis that
attributional style is predictive of depression in the presence but not absence of negative events is very mixed (Lewinsohn et al., 2001). Joiner and Wagner (1995) concluded that the empirical literature offers support for some hypotheses related to these theories but does not offer consistent support for the most central prediction. For example, Cole and Turner (1993) found that the diathesis – stress interaction was not significantly associated with depression, and Luten et al. (1997) reported that two studies with college students explored the relationship of a pessimistic attributional style to positive and negative affect, as well as to depressed and anxious mood. Both studies revealed that a pessimistic attributional style was correlated with negative affect and depressed mood, but was unrelated to low levels of positive affect. The second study also showed a correlation with anxiety and that the association of pessimistic attributional style with emotional distress occurs for both depression-relevant (i.e., loss/failures) as well as anxiety-relevant (i.e., threatening) events. The second study also provided a longitudinal test of the diathesis – stress component of reformulated helplessness theory. Results did not support the hypotheses that pessimistic attributional style is a specific diathesis for symptoms of depression.

Another study to examine specificity derives from the Temple-Wisconsin Cognitive Vulnerability to Depression (CVD) project, which used a variant of the perspective design termed the high-risk strategy. This design, as used by Alloy, et al., (1999b), involves monitoring people who have elevated theoretically generated risk factors but currently does not have the disorder of interest, with the expectation that a greater proportion of the high-risk participants than of a low-risk control group will develop the disorder. The CVD project began with a large sample of college students (N=5378) who were screened on cognitive risk factors, but only those who were predicted to be at high (N=173) or low (N=176) risk were monitored prospectively at multiple assessments for approximately 3 years. Having a high or low risk cognitive style was defined as scoring in the upper or lower 25% of distribution on both negative attributional style and dysfunctional attitudes, respectively.

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Results from CVD project support the diathesis – stress hypothesis and the specificity corollary. People in the high-risk group were far more likely than those in the low-risk group to develop a depressive disorder during the follow-up period. This finding was true for both first onset and recurrent depression and for both people with and without a self-reported family history of depression. Moreover, consistent with the specificity of the cognitive theories for depression, the results did not apply to anxiety disorders (Levinsohn et al., 2001).

In an interesting finding Riso et al., (2003) reported in contrast to expectations, chronically depressed subjects were more internal for positive events and less internal for negative events.

In another study (Staner et al., 1997), unipolar and bipolar patients with a chronic illness pattern were investigated to evaluate the relevance of clinical and psychosocial risk factors to predict subsequent recurrence. Self-esteem, social adjustment, social support and attributional style were assessed in 27 recovered bipolar patients, 24 recovered unipolar patients maintained on lithium or antidepressant prophylaxis and 26 healthy controls. They were further interviewed every 2 months in a 1-year period in order to diagnose affective episodes according to Research Diagnostic Criteria. Survival analyses and Cox's regressions demonstrated that being a unipolar patient and showing poor social adjustment were the strongest predictors of the occurrence of affective episodes. Self-esteem, social support and attributional styles were not found to be risk factors for further recurrence.

Some explanation is clearly required for the great degree of inconsistency in the literature. Why have some findings supported the attributional models, whereas others have failed to demonstrate such support?. Differences between studies have been attributed to many factors, including inappropriate research designs, inadequate conceptualizations of attributional style, differences in the timings of assessments of depressive symptoms, insufficient statistical power, and lack of congruence between the
domain on individuals' inferential styles (interpersonal vs. achievement) and the type of negative events encountered (Abramson, Alloy & Metalsky, 1995).

Further, the vast majority of studies of attributional style have been conducted on subject populations that may be characterized as having an independent (or individualistic) cultural orientation. To what extent are the main findings and theories involving attributional style limited to this cultural orientation is unanswered.

Markus and Kitayama (1991) noted that cultures differ in two tasks in everyday life: independence and interdependence. Independence refers to tasks related to agency and autonomy, whereas interdependence refers to tasks related to communication and affiliation. In independent cultures, such as in the United States, Canada, and Western Europe, an independent construal is characterized by an autonomous and bounded sense of self relatively distinct from others and environment. In interdependent cultures, usually identified as Asian as well as many Latin American, African, and Southern European cultures, an interdependent construal of self is dominant. There is a much greater emphasis on the interrelatedness of the individual to others and the environment. The self is meaningful only (or primarily) in the context of social relationships, duties and roles.

A potential link between these different self-views and the attribution literature concerns the differences in personal agency. Especially, independent cultures foster a view of self that is very much based on control of efficacy. A positive self-view in such cultures requires the self to be seen as effective and in control. It may be no accident that adaptive attributional styles discovered in studies of independent cultures are those that promote this self-view, whereas maladaptive attributional styles are those that contradict this self-view (Anderson, 1999). On the other hand, there may be cultural differences in what constitutes adaptive and maladaptive attributional styles. For example, attributing occasional achievement failures to other external circumstances may be somewhat maladaptive in interdependent cultures because such attributions may threaten perceptions of ties to self-
relevant groups (Crittenden & Lamug, 1988). The emphasis of interdependent cultures on the group might heighten the importance of attributional styles when assessed for interpersonal situations. The link between interpersonal events, attributional styles and depression may be relatively strong for people from independent cultures when compared to people from interdependent cultures (Anderson, 1999). Replicating this pattern of findings across cultures would add strength to the claim that attributional style effects are basic aspects of human nature rather than culture specific phenomena.

2.3 Stress Coping Strategies and Depression

Research on the role of stress in depression has evolved and taken various forms. Early research relied on questionnaire-based retrospective assessments of life events and symptoms, demonstrating overall statistically significant associations. Recent approaches are considerably more sophisticated in methodology, disentangling symptoms and report of events while also using short term retrospective or prospective designs (Gotlib & Abramson, 1999). Based on such improved methods, there is strong empirical support for an association between significant stressful life events and depressive syndrome, in both community and clinical samples (Dohrenwend, Shrout, Link, Martin & Skodol, 1986; Shrout et al., 1989). Negative life events, especially failure in the achievement domain and actual or threatened loss in interpersonal domain have been found to be particularly salient (Beck, 1987; Champion & Power, 1995; Starder & Hokanson, 1998).

Although these studies indicate that most depressions are triggered by a significant negative life event, the obverse raise the critical question of vulnerability. Most people who do experience even major negative events do not become depressed (Gotlib & Abramson, 1999). Life events alone account for a small portion of the variance in the prediction of depression (Rabkin & Struening, 1976; Kuyken & Brewin, 1994). Individuals vary in their responses to stressful life events. Some may develop severe or long lasting depression, others do not become depressed at all or only suffer mild, short-lived
dysphoria (Alloy et al., 1999b). Why do some people become depressed and others do not? While early stress research emphasized the generality or non-specificity of responses to a wide variety of stimuli, subsequent research has recognized that link between stress and illness is far from simple (Gardner, Oslorowski, Morrell & Kocherrar, 1992). To a great extent, these approaches suggest depression is a reaction to adverse life events, mediated by resources for coping with the events; however, mechanisms linking the risk and protective factors specifically to depression have not been clarified (Gotlib & Abramson, 1999).

Coping has been well researched because of its influential role in psychological adjustment (Cheng, 2001). Coping is viewed as a stabilizing factor that can help individuals maintain psychological adaptation during stressful periods (Lazarus & Folkman, 1984; Moos & Schaefer, 1993). Flieshman (1984) defined coping as cognitive or behavioural responses to reduce or eliminate psychological distress or stressful condition. Two major functions of coping – problem management (i.e., problem-focused) and emotion regulation (i.e., emotion-focused) – have been proposed. Problem-focused strategies are directed toward the management of a problem, whereas emotion-focused strategies (including such strategies as escapism, self-blame and avoidance) are directed towards amelioration of the associated level of emotional distress. In addition, there are strategies that can serve both problem and emotion-focused functions. Seeking social support is one such strategy to the extent that others can provide emotional and practical or informational support (Terry, 1994).

Central to research into coping has been an examination of the effects of different coping efforts on individuals' levels of adjustment. Previous findings have shown that problem-focused coping strategies are generally adaptive in mitigating stress-related distress (Folkman, Lazarus, Gruen & Delongis, 1986; Kim, Won, Liu, Liu & Kitanishi, 1997; Marx & Schulze, 1991), but these strategies can also elicit distress (Cheng, Hui & Lam, 1999, 2000; Folkman et al., 1986). Emotion-focused coping strategies are generally maladaptive in magnifying stress-related distress (Aldwin & Revenson, 1987;
Chan & Hui, 1995; Holmes & Stevenson, 1990; Terry, 1991, 1994). However, a few studies (Baum, Fleming & Singer, 1983; Levenson, Mishra, Hamer & Hastillo, 1989) have revealed that such strategies can also reduce distress. These inconsistent findings suggest that the same coping strategy can have distinct outcomes in different situations. Recent research has provided some 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, Dewolfe, Maiuro, Russo & Katon, 1990).

In the mental health field, coping is regarded as an important variable in descriptions of depression. Depressed persons are more likely to employ emotional and avoidance coping responses in contrast to task-coping and problem-solving strategies (Billings, Folkman, Acrec & Moskowitz, 2000; Ghazinour, Richter & Eiseman, 2004; Pestonjee, 2002; Veena & Rao, 2004; Zeidner & Saklofske, 1996). Zeidner (1994) reported that university students scoring high on the Beck Depression Inventory preferred an emotion-focused coping style in contrast to students reporting no depression. In another study, Haghighatgou and Peterson (1995) reported that consistent with the results of studies with U.S. samples, Iranian students who had an active coping style revealed fewer depressive symptoms than the students who had a passive coping style did.

Penedo et al., (2001) evaluated relations between dysfunctional attitudes and depression and examined the role of coping as mediator of this relationship among 115 patients. The use of adaptive coping strategies such as active coping was associated with lower depression, whereas use of maladaptive strategies such as denial was related to higher levels of depression. Both adaptive and maladaptive coping strategies mediated the relationship between dysfunctional attitudes and depression.

In a study in India, it was observed that depressives were using significantly fewer problem solving and more of avoidance coping behavior as
compared to their non-depressed counterparts (Satija, Advani & Nathawat, 1997). These results were also confirmed by Sharma, Rao and Subbakrishna (2001).

Coyne, Aldwin and Lazarus (1981) asked depressed and non-depressed participants in a community survey to report how they coped with a recent stressful event. No differences were present between depressed and non-depressed persons on the following coping scales: problem-focused, growth-oriented, minimizes threat, and self-blame.

Kleinke (1988) reported a study in which several factors identified by DCQ (Depression Coping Questionnaire) contributed significant variance in predicting participants' BDI scores. Although the coping factors were entered into multiple regression equations for men and women in somewhat different orders, the results were very similar. For both men and women, high BDI scores were correlated with self-blame and escape. Low BDI scores were correlated with social support, problem solving and indulgence.

In another study, investigators (Sherbourne, Hays & Wells, 1995) focused on personal and psychosocial factors to identify those that predict change in functioning and well-being and clinical course of depression in depressed outpatients over time. Data from 604 depressed patients in the medical outcomes study demonstrate the important role of coping style across both clinical and well-being outcomes. Active coping strategies (i.e., talking to a professional, becoming more informed about a problem, thinking about what one needed to do for a problem, talking to a friend or relative, reminding oneself that thing could be worse, making a plan of action) were strongly related to improvements in mental health over time. This is consistent with a number of other studies that document the importance of emotional well-being of individuals playing an active role in managing stress and attempting to deal with problems that are encountered in the environment (Andrews et al., 1978; Kessler, Price & Wortman, 1985). These strategies, however, were found to have less beneficial effects for older than younger depressed patients in this study. Active coping strategies were also important predictors of clinical

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outcome. Patients reporting these strategies were more likely to remit during the year. At the other end of coping spectrum, avoidance coping style (e.g., hoping for a miracle, making self feel better by eating, smoking or drinking; taking it out on other people; deciding to spend more time alone; sleeping more than usual) were related to the development of a new episode of major depression among patients without current major depression at baseline and an increase in symptoms among all patients.

In a recent multifactorial study on 150 pregnant women, Rudnicki, Graham, Habboushe & Ross (2001) reported among several psychosocial factors (socio-economic status, planning of pregnancy, perceived social support and coping style), perceived social support and an avoidant coping style were the most salient psychosocial correlates of depressed mood during pregnancy, accounting for 34% of variance in the model. More specifically, women who reported less social support satisfaction experienced greater avoidant coping strategies that was then associated with higher levels of depressed mood.

Aldwin and Greenberger (1987) examined a number of psychosocial factors thought likely to contribute to depression among ethnic Korean and Caucasian students. Stepwise multiple regression analysis revealed different models for predicting depression in two groups. Two measures of parental values and three coping strategies accounted for 44% of the variance in Korean youths’ depression. For Caucasians, in contrast, only 13% of the variance in depression could be accounted for; and the two significant predictors were academic stress and respondents’ own modern values.

Cronkite, Moos, Twohey, Cohen and Swindle (1998) reported a 10-year follow-up of depressed patients. 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.
In spite of above findings, the studies that have examined the relation of coping to some outcome measures have produced inconsistent results. For example, several studies have found that problem-focused coping decrease emotional distress, whereas emotion-focused coping paradoxically increases it (Felton & Revenson, 1984; Moos & Moos, 1999; Penedo et al., 2001). Others however have reported the opposite pattern (Baum et al., 1983; Lewenson et al., 1988). In other studies, problem-focused coping had little effect on emotional distress (Chang, Chui & Lam, 2000; Meneghan, 1982). Hence, as Aldwine and Revenson (1987) have claimed still there is no clear consensus as to which coping strategies or modes of coping are most effective. That is how well a coping strategy serves to resolve problems, prevent future difficulties, or relieve emotional distress.

2.4 Social Support and Depression

Theorists and researchers in developmental psychopathology have expressed an appreciation for the role that extra individual influences play in human development. Numerous studies have demonstrated that family, peer, school, neighborhood, and community play a central role in the emotional lives of people. An exclusive focus on the individual in the study of etiology or course of behavioural disorders may soon become obsolete. Social scientists have come to acknowledge that every individual exists within a complex set of environmental systems and that these systems affect his or her psychological well being at a fundamental level (Cause et al., 2002).

Factors in the social environment that may modify the effects of social stressors have received increased attention in the epidemiological investigation of both physical and psychiatric disorders. One factor is social support. Akiskal (2000) define social support as the provision of meaningful, appropriate and protective feedback from the social environment that enables a person to negotiate environmental stressors. Social support refers to information leading an individual to believe that they are cared and loved, esteemed and valued and that they belong to a network of communication.
and mutual obligation. The concept of social support is multifaceted, encompassing features of personality, personal relationships, and larger social structures (Pierce, Sarason & Sarason, 1996).

Despite three decades of social support research and a substantial accumulation of findings, the components of social support and the mechanisms of this association are less clear (Bolger, Zuckerman & Kessler, 2000; Flannery & Wieman 1989). We still lack a basic understanding of how social ties are health protective or how support works (Heller, Swidls & Dusenbury, 1986; Thoits, 1986). But two models have received extensive empirical study: main effects and buffering effects (Berkman, 1985; Cohen & Wills, 1985; Kessler & Mcleod, 1985; Taylor, 1991).

The main effects model hypothesizes that social networks, the web of social relationships, in which an individual is embedded, provide beneficial effects with or without life stress. These beneficial main effects are thought to stem from a sense of well-being due to group acceptance, offers of aid, and stable, predictable environments (Berkman, 1985; Cohen & wills, 1985), marriage, the extended family, work, and community ties are examples of possible beneficial social networks. The buffering model hypothesizes that the impact of life stress on health is mitigated under conditions of high support. There is some evidence for pervasive buffering effects (Kessler & Mcleod, 1985) as well as evidence of the importance of specific resources to cope with specific types of life stress (Cohen & Wills, 1985).

There is growing evidence that personal adjustment and social behaviour, as well as health maintenance and recovery from illness, can be influenced significantly by a person's access to supportive others (Sarason, Sarason, Shearin, & Pierce, 1987). Psychological risk factors namely stress, anxiety, depression and perceived availability of social support were assessed in male hospitalized patients in India by Gupta, Shams, Narayan and Gupta (2002). The study showed, the combination of self-esteem, belonging and appraisal components of social support is the best predictor of stress.
In another study (Chadda, 1995) influence of social support on psychosocial dysfunction was studied in fifty newly diagnosed patients with major depression, using Social Support Scale (SSS) and Dysfunctional Analysis Questionnaire (DAQ). Total score on SSS did not affect the dysfunction. A positive relationship was observed between items of SSS relating to care, concern and expectations from others and negative relationship between SSS items referring to socialization and dysfunction in social and familial areas. The relationship of social support and psychosocial dysfunction appeared quite complex with certain elements of social support having a healthy and others having an unhealthy relationship.

In a recent investigation (Johnson et al., 2001) data from a prospective longitudinal study were used to investigate whether hopelessness mediates the association between social support and depression, as hypothesized by Abramson et al., (1989). Measures of hopelessness, social support, and depression were administered to 103 HIV infected men and re-administered six months later. Findings indicated that low baseline social support predicted increases in hopelessness and depression. Increases in hopelessness predicted increases in depression after controlling for baseline social support, low baseline social support did not predict increased depression when hopelessness was controlled statistically.

Community and clinical studies have also implicated the lack of social support as a modifiable risk for disability. Synchrony of change in severity of depression and social support has been observed in disablement pathway (Judd et al., 2000). The interactive effects of affect and social support may lead to disability. For example, in a large population, subjective social support was a more effective buffer against functional decline among elderly patients with clinically significant depression symptoms than among asymptomatic elderly people (Hays, Saunders, Flint, Kaplan & Blazer, 1997). In contrast, the effects of subjective support on stroke patients were generally salutary, whether or not the patients met criteria for major depressive disorder (Shimoda & Robinson, 1998).
In a prospective cohort study design that was conducted by Hays, Steffens, Flint, Bosworth & George (2001), 113 patients with incident and prevalent unipolar depression were followed for 12 months, while they were undergoing naturalistic treatment. In adjusted analyses, instrumental social support provided marginal protection against worsening performance on instrumental activities of daily living, which were primarily functions of baseline depression severity. Large social networks, more frequent social interaction, and the perceived adequacy of social support played a modest buffering role against declines in performance on basic activities of daily living among the most depressed elderly patients.

"Abramis and Caplan (1985) investigated the impact of social support and social undermining on measures of anxiety, depression, and quality of life in a sample of young students. They found that both social support and social undermining had opposite effects of about the same magnitude on anxiety, depression and quality of life when the students reported on people in their personal lives. However, when asked about the person closest to them, only the socially undermining behaviours of that person had a significant adverse impact on levels of anxiety, depression, and quality of life. In addition they found that measures of social support and social conflict were not significantly correlated when respondents reported on people in their life in general" (Vinokur & Ryn, 1993, P.35).

Relationship between social support and self-esteem with depression of Teheran's high school students was studied by Partow (2004). This investigation revealed that positive and significant association was found between the social support and self-esteem. Furthermore, the higher level perceived social support and self-esteem associated significantly with the lower level of depression. These findings were supported by Bakhshani, Birashk, Atefvahid and Bolhari (2003) and by the findings of Ghazinour et al., (2004).

Recent data also suggest that a history of depression affects how other factors predict subsequent depression. For instance, in examining
adolescents' self-reported depressive symptoms, Aseltine, Gore and Cotton (1994) found different patterns of effects of relationship variables in the domains of family and friendship according to participants' prior depression levels. Adolescents who previously had chronically high levels of self-reported depression went on to show an association between peer support and depressed mood, whereas previously asymptomatic youth did not. In contrast, previously asymptomatic youth showed an association between depressed mood and family relationship problems, whereas the chronically depressed group did not (Daley, Hammen & Rao, 2000).

In India, Jambunathan (1992) examined sociocultural factors that depressed Indian women report as influencing their depression and how they influence their treatment-seeking behaviour. Analysis of data showed that cultural dictation of female role and lack of continued financial and emotional support predominantly from spouses and other family members, were influential factors in depression. These along with religion and philosophy often influenced the decision to seek health care.

In a multifactorial study, Takakura and Sakiho (2001) determined the psychosocial factors associated with the presence and persistence of depressive symptoms among 3202 high school students in Okinawa, Japan. The psychosocial variables examined were life stressors, perceived social support, health practices, self-esteem and locus of control. The relationship between the psychosocial factors and depressive symptoms was examined using hierarchical multiple regression analyses. Results showed perceived social support, high self-esteem and internal locus of control might be protective factors of depressive symptoms among Japanese adolescents.

Holahan and Moos (1991) constructed a four-year structural model in the study of relationship of life stressors, personal and social resources and depression. Findings with 254 adults showed that adaptive personality characteristics and positive family support operate prospectively over four years in predicting reduced depression, even when prior depression is controlled. Results demonstrate that the pattern of predictive relations differ
under higher and low stressors. Under high stressors personal and social resources relate to future psychological health indirectly through more adaptive coping strategies, under low stressors these resources relate directly to psychological health.

Rook (1987) studied the supportive and problematic (conflictual) relationships of elderly widows. She found that whereas the number of social supports was unrelated to well-being, the number of social problems, that is conflictual interactions, had a significant negative impact. The same results were borne out when the number of supportive and problematic (conflictual) persons was used instead of number of supportive or problematic interactions. In a similar study, Vien (1985) investigated the impact of social support and social undermining on measures of anxiety and depression, and quality of life in a sample of young students. They found that both social support and social undermining had opposite effects of about the same magnitude on anxiety and depression, and quality of life when the students reported on people in their personal lives. In addition, they found that measures of social support and social conflict were not significantly correlated when respondents reported on people in their life in general. In contrast the correlation between support and conflict measures from the person closest to the respondents was significant and substantial.

Some researchers (Nezlek et al., 2000, p. 17) have 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 do not.

Finally, the construct of social support is strongly influenced by the construct of social integration. An integrated society is a social system that ensures the patterns of interpersonal behavior that are essential to the survival and welfare of its members. Social scientists and anthropologists studied each community to determine its relative integration versus disintegration. At all ages, the rates of depressive disorders were higher in disintegrated communities (Akiskal, 2000).
2.5 Need for more multifactorial researches

As the above review reveal in spite of some multifactorial researches, most of the previous studies have examined the relationship between these four psychosocial variables and depression univariately. They are not studied together. Because of this it is difficult to tell with certainty which of them has greater role in depression especially in clinical populations. Hence to understand the relative significance of these psychosocial variables in depression is the main objective of the present investigation.