CHAPTER I
INTRODUCTION

Depression is a part and parcel of human existence ever since the dawn of human consciousness. It has accompanied him throughout his history and the world's literature had chronicled it with the intensity and care that so ancient and so widespread a condition warrants. Reports of depression have been found in most ancient literary texts. 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. Mendals, 1970).

Descriptions of affective disorders are found among the early writings of the Egyptians, Greek, Hebrews and Chinese; similar descriptions are found in the literary works of Shakespeare, Dostowsky, Poe and Hemingway. The list of historical figures who suffered from recurrent depression is a long and celebrated one, including Moses, Rousseau, Dostowsky, Churchill, Lincoln, Tchaikousky & Freud (cf. Colemen, 1976).

In the contemporary society, mental illness, which now affects between 10 to 25 percent of the Indian population, could be a case of depression, a psychotic illness, substance abuse or a personality break-down. Depression which constitutes almost 70 percent of all mental illness, has taken an alarming proportions, nudging the medical world awake (Mendonca, Prasad, & Ragunatha, 1993).

According to Dr. D.Mohan, Depression, the disease has been present for ages. The only reason why it is more visible now is because the social structure is changing and the nuclear family cannot give the support that the joint family could. Today, the social support network is much smaller with competition becoming the main driving force in today's world, everyone is busy trying to be one-up over the other and striving to keep their image afloat. This can wreck havoc in personal lives, especially now, in an age of eroded trust. With coping skills at a premium, stress, anxiety and depression could be natural outcomes. If not solved in time, the
acuteness may be exacerbated. One can talk a person out of general depression by patient listening, understanding and advice. But depression, the disease, is not so easy to get rid of (cf. Sunday Magazine: The Indian Express, April 18, 1993).

There is sufficient evidence of a growing interest in this topic outside psychiatry. Apart from the enormous disability and economic cost of depression, as well established treatability makes it a priority topic for attention in any public health strategy programme that aims to deliver efficiency (financial) as well as efficacy (clinical, social and economical functioning).

The depressive script as derived from empirical studies of depressive related behaviour (Gotlib & Robinson, 1982) and the description of a major depressive episode (with psychomotor retardation) in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, American Psychiatric Association, 1980) clearly suggests that the person in the depressive condition expresses pessimism (e.g. “Right now I am so far behind, I will never catch-up”), apathy (e.g., “I have given up”), helplessness (e.g., “It does not seem to matter what I do, I just fall further behind”) and sadness (e.g., “Being with other people makes me feel more alone”) regarding their academic and relationship problems. They also limit eye contact and speak slowly in low, monotonous tone, with an increased latency response. Deficits in energy (e.g., “I am really not up to it”) and interest in social activities (e.g., “I have not felt like going out with friends or any one”) are also acknowledged.

Over the last 25 years considerable progress has been achieved in the delineation of the psychological, psycho-social, 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, Akiskai, & McKinney (1984), Mendels (1975), Becker (1974), and Minokur (1969). In particular, previous research has identified 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 Baever, 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).

The number of competing viewpoints and nosological systems (Wing, 1976; Akiskal & McKinney, 1973, 1975; Rush, 1975; Becker, 1974; Klein, 1974; Secunda et al., 1973; Klerman, 1971; Beck, 1967) clearly mirrors the incomplete knowledge of etiological and contributory factors in the depressive disorders. 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. Furthermore, although recent reviews have discussed the relationships of individual psychological variables with depression or related psychological disorders (e.g., Coyne, Kahn, & Gotlib, 1987; Gotlib & Colby, 1987; Sweeny, Anderson & Bailey, 1986; Cohn & Wills 1985) much less consideration has been given to how these variables might interrelate and to how their interactions might affect the development or maintenance of depression.

Since the formulation of the psychoanalytic theory by Freud, most psychological theories of depression have assumed that parental behaviour plays an important role in the development of adult depression. Following Freud (1917/1957), Abraham (1924/1949) postulated that parental rejection in early life produces severe injuries to infantile narcissim, which in turn leads to a sadistic introjection of the parental figures. Hostility toward the frustrating parents is then turned into hostility toward ones own ego in the form of self-abusive cognitions and guilt feelings (Fenichel, 1945). Furthermore, children who are raised by parents who exercise firm control and force their children to live up to severe standards are likely to develop a “sadistic superego” (Fenichel, 1945, p. 399), which is characteristic of depressed persons. Thus, parental rejection, coupled with firm control of the child's
behaviour during the pre-oedipal stages, is postulated to be a precursor of adult depression.

In recent years the psychoanalytic theory has been losing ground in favour of the cognitive theories of depression (Lewinsohn & Rosenbaum, 1987). One of the early cognitivists, Becker (1962) postulated that depressives self-abusive cognitions and guilt feelings stem in part from their parents’ extensive use of guilt-inducing socialization practices. Beck (1967) has advanced a cognitive theory of depression that attaches central importance to negative cognitive schemata that dominate depressed person’s evaluations of themselves, their environment and their future. Beck (1967) was explicit in stating that these schemata develop as a consequence of parental behaviour. That is, depressed persons are assumed to have had parents who were critical and non-approving of their self-worth. These evaluations were internalized and formed the building stones for a negative schema.

Thus, both psychoanalytic theory and certain cognitive theories of depression view parental non-acceptance and rejection as precursors of adult depression (Lewinsohn & Rosenbaum, 1987). Indeed, one can logically infer from these theories that depressed persons, in comparison with non-depressed persons, will remember their parents as having been more rejecting and more negative in their behaviour, as Blatt, Wein, Chevron, & Quinlan (1979), arguing from the psychoanalytic point of view, and Crook, Raskin, & Elliot (1981), arguing from Beck’s cognitive-theory point of view, have done.

The cognitive view of behaviour assigns primary importance to the self-evident fact that people think. It assumes that the nature and characteristics of thinking and resultant conclusions determine what people feel and do and how they act and react. This view of behaviour and psychopathology has a long history that bridges the disciplines of clinical psychiatry, clinical and academic psychology, and philosophy (Wason, Johnson-Laird, 1972; Broadbent, 1971; Adler, 1969; Beck, 1967; Neisser, 1967; Kelly, 1955). The increasing emphasis on the role of cognition in behaviour has been termed the “Cognitive revolution” (Dember, 1974). It can be noted that cognition has played an increasingly important role in recent theories of
personality and psychopathology (e.g., Meichenbaum, 1977; Mahoney, 1974; Mischel, 1973; Kelly, 1955). Depression is one area of theory and research in which cognitive factors, that is, the manner of perceiving, construing, consequences have been emphasized. In this context much of the impetus has come from the theoretical and empirical work of Aaron Beck (1967, 1974), Martin Seligman (1974, 1975), and Peter Lewinsohn (1976). 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 state to a low rate of response contingent positive reinforcement.

It suggests that experience leads people to form assumptions or schemata about themselves and the world, which are subsequently used to organize perception and to govern and evaluate behaviour. The ability to predict and to make sense of one’s experience is helpful, and indeed necessary, to normal functioning. Some assumptions, however, are rigid, extreme, resistant to change, and hence ‘dysfunctional’ or counterproductive. Such assumptions concern, for example, what people need in order to be happy (e.g., “If someone thinks badly of me, I cannot be happy”), and what they must do or be in order to consider themselves worthwhile (e.g., ‘I must do well at everything I undertake’). Dysfunctional assumptions alone do not account for the development of clinical depression. Problems arise when critical incidents occur which mess with the person’s own system of beliefs. So the belief that personal worth depends entirely on success could lead to depression in the face of failure, and the belief that to be loved is essential to happiness could trigger depression following rejection.

Beck’s cognitive model of depression (Beck 1967, 1976) is illustrated schematically in Fig. 1 below:
Once activated, dysfunctional assumptions produce an upsurge of 'negative automatic thoughts' – 'negative' in that they are associated with unpleasant emotions, and 'automatic' in that they pop into people’s heads rather than being the product of any deliberate reasons process. These may be interpretations of current experiences, predictors about future events, or recollections of things that have happened in the past. They, in turn, lead on to other symptoms of depression: behavioural symptoms (e.g., lowered activity levels, withdrawal); motivational symptoms (e.g., loss of interest, inertia); emotional symptoms (e.g., anxiety, guilt); cognitive symptoms (e.g., poor concentration, indecisiveness); and physical symptoms (e.g., loss of appetite, loss of sleep). As depression develops negative automatic thoughts become more and more frequent and intense, and more rational thoughts are gradually crowded out. This process is helped on its way by the development of increasingly pervasive depressed mood. So a vicious circle is formed. On the one hand, the more depressed a person becomes, the more depressing thoughts they think, and the more they believe them. On the other hand, the more depressing thoughts they think, and the more they believe them, the more depressed they become.
Early Experience

Unfavourable comparisons with twin sister, father (and main supporter) die

Dysfunctional Assumptions

I am inferior as a person. My worth depends on what other people think of me. Unless I do what other people want, they will reject me.

Critical Incident

Marriage breaks down

Negative Automatic thoughts

It’s my entire fault – I have made a mess of everything. I cannot handle my life. I shall be alone for ever – it is going to be dreadful.

I’m Stupid

Symptoms

Thus, 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 attitudes (shoulds 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 cognitive 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, failures and so on); presuming temporal causality or predicting without sufficient evidence (believing that if something had happened in the past then it is always going to be true); making self-references (behaving oneself, especially one's bad performance, to be center of everyone's attention); catastrophizing (always thinking of the worst on the premise that it's most likely to happen to one); and thinking dichotomously (seeing everything as one extreme or other, 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 interpretation and predictions in the lives of some depressed patients (Coyne & Gotlib, 1983), their repetitive self-deprecating quality, and extremely negative character can be still considered dysfunctional or maladaptive (Kovacs & Beck, 1978).

In cognitive theory depression is not simply triggered by adversity, but rather by the perception and processing of adverse events. Research has shown that children with depression have a variety of cognitive deficits and distortions. They often have low self-esteem and cognitive distortions such as selectively attending to negative features of an event (Hammen, 1991; Kendall et al, 1990; McCauley et al, 1988). In addition children with depression are more likely than children without depression to develop negative attributions (Kaslaw et al., 1988), for example, Curry & Craighead (1990) found that adolescents with greater depression attributed the
cause of positive events to unstable external causes. Children with depression also have low self-perceived academic and social competence (Cole, 1990).

Although many studies have documented an association between childhood depression and various cognitive distortions, there are many unresolved questions. In particular, it is unclear whether these negative cognitions are a cause or consequence of depression (Harrington et al., 1998). Moreover it is not known whether some cognitive processes are more important than others. Nevertheless, research on cognitive processes in children with depression has provided a useful theoretical basis for planning treatment strategies.

SOCIAL SUPPORT AND DEPRESSION

"The terms social support and social networks are currently in vogue". This opinion, voiced by Kenneth Heller (1979) several years ago, continues to hold true. Part of the original excitement in the idea of social support lay in its perceived usefulness as both a preventive and a rehabilitative tool (Iscoe, Bloom, & Spielberger, 1977). The supportive relationships that an individual perceives in his or her life have been related by researchers to a variety of physical and psychological clinical status indices (Leavy, 1983). Upto the present time, much of the burgeoning social support literature has been concerned with these health oriented studies and the development of measurement devices.

Social support refers to information or actions (real or potential) that lead individual to believe that they are cared for, valued, or in a position to receive help from others when they need it (e.g. Heller, 1979). Social support has been conceptualized as a coping resource that affects the extent to which a situation is appraised as stressful (Lazarus & Folkman, 1984) and enables a person under stress to change the situation, to change the meaning of the situation or to change his or her emotional reactions to the situation (Thoits, 1986). Social support is associated with better psychological health in general and reduces the negative psychological consequences of exposure to stressful life events (e.g. S. Cohen & Wills, 1985).
Social support has also been defined as “those social interactions or relationships that provide individuals with actual assistance or that embed individuals within a social system believed to provide love, caring or sense of attachment to a valued social group or dyad” (Hobfoll, 1988). This definition eloquently encompasses the two major facets of social support that have dominated research in the last two decades: received social support and perceived social support. Received social support refers to naturally occurring helping behaviours that are being provided. Whereas perceived support refers to the belief that such helping behaviour would be provided when needed. In a nutshell, received support is helping behaviour that did happen, and perceived support is helping behaviour that might happen (Barrera, 1986).

Considering how parallel these aspects of support appear to be, it is surprising that they produce strikingly different effects as variables influencing the stress-to-health process. Over the years, research has proclaimed the superiority of perceived social support over received support, because it more consistently promotes psychological health and protects it in times of stress.


Personal relationships can yield both emotional costs and rewards. Yet, in recent decades, the investigation of detrimental aspects of relationships has been overshadowed by researches on the beneficial aspects of relationships, such as social support (Eckenrode & Gore 1981; Heller 1979; House, Umberson, & Landis, 1988; Riely & Echkenrode, 1986; Rook, 1990, 1992; Wortman & Conway, 1985). This imbalance is redressed somewhat in studies examining simultaneously the emotional impact of positive and negative aspects of social ties. From these studies; it appears that social negativity (e.g. conflicts, rejections and criticisms) may have adverse effects on emotional functioning that exceed the beneficial effects of positive or supportive social ties (Schuster, Kessler, & Aseltine, 1990; Ruehman & Wolchik, 1988; Pagel, Erdly, & Becker 1987; Stephens, Kinney, Ritchie, & Norris, 1987;
Negativity in social relations has many forms and sources. Problematic social exchanges can result from misguided failed or withheld social support (Harris, 1992; Coyne, Wortman, & Lehman, 1988; Wortman & Lehman 1985). Alternatively, individuals can experience social negativity from personal rejection, disagreements, excessive demands and actions that are perceived as offensive (Rook, 1990, 1992; Rook & Pietromonaco, 1987; Shinn, Lehmann, & Wong 1984).

Social support also has many forms and sources, for example social support can come from either the actual receipt or perceived available of emotional, practical or material aid from others (Kessler, 1992).

**Body Image, Physical Attractiveness and Depression**

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 standers 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 there 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; Learner, 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 towards 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 inspite of severe emanciation. 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 (1976, 1973) 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 them and tend to interpret and distort incoming information about their appearance and personality so that it reinforces their pervasive negative beliefs about themselves (Beck, 1976). Thus, in Beck’s (1976, 1973) cognitive theory of depression, “distortion of body image” (Beck, 1973, p.24) is included among the cognitive symptoms of depression.

Beck (1976, 1973) 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 60% 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.

A number of 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, Shizueu, Brennan, & Kameoka (1981) did investigate body cathexis and depression. They categorized college students on their Zung Self-Report Depression Scale scores and found that depression 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 person 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.

The present findings with respect to the role of body image and social support demand consideration of what they might mean in terms of adolescent depression. The previous studies demonstrating the salience of body image and social support in depression have considered these variables in isolation or singularly and mostly employed bivariate analysis. This is an important methodological flaw since depression results from the complex interplay of many variables. These factors while important interact with the cognitive factors. This assertion gains support from Allogood- Merten, Lewinsohn, & Hops (1990) findings which revealed that the shared variance of the body image variables with depression was eliminated when self-esteem was controlled for. The authors concluded that body image as it relates to depression is not a separate construct but important aspect of self-esteem.
In the context of the salience of negative cognition in depression, the present study made an attempt to examine the intervening role of negative cognition in the effect of social support and body image on depression, separately for male and female adolescents, and separately for two self-report measures of depression, namely Beck Depression Inventory and Zung Self-rating Depression Scale.

OBJECTIVES OF THE STUDY

1. To study the effect of social support on depression.
2. To study the effect of body image on depression.
3. To examine gender differences in depression.
4. To examine the intervening role of negative cognition in the effect of body image and social support on depression.