CHAPTER II
REVIEW OF RELATED LITERATURE AND
FORMULATION OF HYPOTHESES

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

Disorders in which anxiety or depression is the predominant feature constitute a large part of contemporary psychiatric practice. As such depression is a matter of social and public health concern. Although there is considerable agreement regarding depression as a common and significant problem for the general population and the client in psychotherapy in particular, the literature regarding possible symptoms and correlates of depression is extensive and sometimes conflicting. There are theories and research in the literature which stress or examine particular symptoms and factors related to depression which has been recognized for thousand of years.

Serious depressive disorders were among the earliest diseases described in the history of medicine. References to serious depression appear in Pharaonic medical texts such as the Eber Papyrus, the Old Testament, and the writings of the Classical Greeks. In general, most of these writers appear to have assumed that depression was endogenously or biologically caused. Greek physicians, for example, referred to depression as “melan-cholia”, or a disease due to an excess of black bile. The Book of Job illustrates the profound mood alteration, loss of interest, social
withdrawal, self-deprecation, self-blame, and sleep disturbance that characterize depression. A 3,900-year-old Egyptian manuscript provides a distressingly accurate picture of the sufferer’s pessimism, his loss of faith in others, his inability to carry out the everyday tasks of life, and his serious consideration of suicide (Thacker, 1958).

In the historical perspective, deranged behaviours were typically considered curses from the gods by the Ancients or as a sign of moral or personal weakness. Hippocrates, the first clinician to describe depression carefully, argued that psychiatric problems originated from natural rather than from supernatural causes. He emphasized the critical role of the brain in the development of these disorders (Beck, Brady, & Quen, 1977).

Aretaeus of Cappadocia (A.D. 120-180) was the first to recognize organic (more recently called endogenous) and external (situational) depressions as two separate illnesses. He also described both manic and depressive episodes, noting that some disorders included only recurrent episodes of depression (now called unipolar depression), whereas others involved episodes of both depression and mania (now called bipolar depression).

During the Dark Ages, Western civilization returned to beliefs in possession and supernatural forces as explanations for psychiatric disorders. Not until the Renaissance was there a return to enlightened empiricism, observation, and reasoned thought. Johann Weyer (1515-1588), a 16th century physician noted for his opposition to witchcraft, was one of the first to focus his studies on mental illness. He considered depression to be linked to somatic or bodily symptoms. Timothy Bright, a physician at London’s St. Bartholomew’s Hospital, was the first to recognize suicide as a manifestation of despair. In his Anatomy of Melancholy (1630), Robert Burton summarized the existing theories and depicted the range of depressions as extending from natural grief at death or separation to depressive disorders.

A wider recognition of specific psychiatric disorders, as well as a tendency toward humane and enlightened treatments, unfolded in the 18th and early 19th
centuries. In the late 19th and early 20th centuries, European clinicians focused their attention on both descriptive diagnosis (diagnosis based on the recognition of specific signs and symptoms) and on unconscious factors.

Emil Kraepelin (1856-1926) distinguished manic-depressive insanity, an episodic nondeteriorating disorder, from dementia praecox — later called “Schizophrenia” — a more progressive deteriorating disorder. Eugen Bleuler (1857-1939), a Swiss neurologist, further differentiated the concept of manic-depressive insanity. He coined the term “affective disorders”, in which he included manic-depressive insanity, psychoneurotic depressive reactions, and involutional melancholia. He was, however, unable to delineate clearly the specific subtypes of affective disorder, a problem of separation that persists even today.

In more recent times, the concept of depression has been broadened to include milder forms. Clinicians and researchers have debated whether the concept of depression refers to a single disease that varies from mild to severe along a continuum or whether it consists of a set of discrete subtypes that differ in phenomenology, pathophysiology, and ultimately etiology (Everett, 1981; Kendell, 1968, 1976; Eysenck, 1970; Hamilton & White, 1959; & Lewis, 1938). This debate has yielded a number of different methods for subtyping depressive disorders, such as endogenous vs. reactive, psychotic vs. neurotic, and primary vs. secondary (Nelson & Charney, 1980; Akiskal, Rosenthal, Rosenthal, Kashgarian, Khani, & Puzantian, 1979; Andreasen & Winokur, 1979a; Bhrolchain, 1979; Bhrolchain, Brown, & Harris, 1979; Akiskal, Bitar, Puzantian, Rosenthal, & Walker, 1978; Winokar, Behar, VanValkenburg, & Lowry, 1978; Lewis, 1971; Kendell & Gourlay, 1970; McConaghy, Joffe, & Murphy, 1967; Rosenthal & Klerman, 1966; Kiloh & Garside, 1963).

In spite of considerable agreement on the phenomenology of the clinical syndrome of depression, no completely satisfactory explanation has yet been offered to account for the mechanisms underlying the wide variations in symptomatology and course. The identification of psychosocial factors that may cause depression has proven to be an arduous task. The difficulty of demonstrating causal relationships in
naturalistic research has been compounded by an over reliance on cross-sectional methodology. Cross-sectional research has been successful in demonstrating differences between depressed and non-depressed individuals; that is, it has identified abnormalities in the functioning of depressed individuals that are present during depressive episodes. Many of these abnormalities, such as dysfunctional cognitions, distressed relationships, anaclitic personality types, and deficits in social behaviors, have been implicated in the etiology of depression by theorists of various orientations (e.g., Abramson, Seligman, & Teasdale, 1978; Brown & Harris, 1978; Beck, 1976; Hirschfeld, Klerman, Chodoff, Korchin, & Barrett, 1976; Lewinsohn, 1976). However, some of these problems in functioning may be symptoms, or concomitants, of depression that appear with the onset of a depressive episode and disappear with remission.

The number of competing viewpoints and nosological systems (Wing, 1976; Akiskal & McKinney, 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 psychosocial variables with depression or related psychological disorders (e.g., Coyne, Kahn, & Gotlib, 1987; Gotlib & Colby, 1987; Sweeney, Anderson, & Bailey, 1986; Cohen & Wills, 1985; Akiskal, Hirschfeld, & Yerevanian, 1983), 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.

(A) Cognitive Vulnerability and Depression

The cognitive view of behavior 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 behavior and resultant conclusions determine what
people feel and do and how they act and react. This view of behavior 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; Craik, 1952). The increasing emphasis on the role of cognition in behavior 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; Mischal, 1973; Kelly, 1955). Depression is one area of theory and research in which cognitive factors, that is, the manner of perceiving, construing, anticipating, and evaluating events, behaviours, and their 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 states to a low rate of response – contingent positive reinforcement. The cognitive approach focuses on self-castigation, exaggeration of external problems, and hopelessness as the most salient symptoms. Beck (1967, 1976) has provided the most comprehensive exposition of the cognitive view of depression. Beck proposed that dysfunctional cognitions are at the core of depressive phenomena. He has posited a “cognitive triad” of negative constrictions about the self, the environment, and the future. The depressed person is seen as having a negative view of him, of the world, and of the future. The depressed affective state is secondary to these negative cognitions.

Three cognitive theories of depression

The idea that men can control their emotional reactions by the process of thought is ancient, being, for example, a central tenet of stoic philosophy. In recent years, these ideas have entered the empirical realm of psychopathology. They have been developed over a number of years, but the formulations analyzed here are those put forward by Beck and his colleagues in 1980, by Brown & Harris in 1978 and by
Abramson and her colleagues in 1978. The central postulate of all the theories is that in many, if not all, instances certain depressive cognitions precedes and lead to depressed mood. They also propose that these cognitions, in turn, arise from the particular circumstances and history of the subject. The theories represent a convergence of ideas in the disciplines of psychiatry, sociology and psychology, being developed largely by a psychiatrist, sociologists and psychologists respectively, and they have already resulted in a great deal of research into their theoretical and clinical implications.

The authors of each of these theories are quite clearly aware of the other two and there has obviously been some cross-fertilization. Nevertheless, each theory will initially be described in isolation, following which their similarities, differences and deficiencies will be reviewed.

**BECK'S THEORY**

Beck is a psychiatrist whose first interest in cognition developed during his psychoanalytical training as a consequence of his dissatisfaction with the belief that people became depressed as a result of a need to suffer. In particular, he noticed that interventions based on this point of view were not effective. He began to see self-laceration as the result of cognitive distortion, not of masochism. Beck was influenced by his reading of Adler's individual Psychology, of Kelly's Personal Construct Theory and of Ellis' Rational-emotive Psychotherapy, which all emphasized the significance of the constructions which we place on reality. He states that the major factor in the development of his cognitive model of depression was systematic clinical observation and experimental testing. He has expanded his ideas in a series of publications (Beck, 1967, 1976, 1983; Beck et al. 1980).

The essential elements in Beck's model are summarized in Fig. I. The first limb of the cognitive triad is the depressive's negative view of himself, that he is defective, inadequate diseased or deprived. He is therefore worthless, he criticizes himself, and sees himself as lacking the wherewithal to achieve happiness. The depressive also has a negative view of current experience: the world is making exorbitant demands upon him and places insuperable obstacles in his way. All his
dealing with it lead to defeat or deprivation. Finally, the depressive has a negative view of the future. His expectations are of continuing difficulties and suffering, of unremitting hardship, a litany of failure.

![Cognitive triad diagram](image)

Negative view of self

Cognitive triad

Negative interpretation

Current experiences

Negative view of future Schema

Cognitive errors (faulty information processing)

Fig.1. Beck's model of depression

A close examination of the cognitive triad reveals that its elements are not equivalent. The view of the future obviously describes the interaction of the self and its world, that is, of the first two elements. It comprises their extension in time.

In order to explain why the cognitive triad is maintained in the face of contrary evidence, Beck postulates that people have relatively stable styles of cognition which he terms schemas. They form the structural organization of depressive thinking and Beck located their origins in early, usually childhood experience. They underlie the selective attention and abstraction which result in a particular interpretation of circumstances. At the same time, particular situations may serve to activate a given schema. A schema may be inactive for long periods of time but can be energized by specific environmental inputs (for example, stressful situations) (Beck et al. 1980, p. 13). Beck emphasizes this reciprocity of thought and circumstance. He goes on to argue that in depression there are ‘prepotent dysfunctional schemas’ which are evoked by a wide range of inappropriate stimuli and ‘the patient loses much of his voluntary control over his thinking processes’ (Beck et al. 1980, p. 13). In severe depression this idiosyncratic organization becomes ‘autonomous’, that is virtually independent of external stimuli.
The cognitive triad and the schemas which underlie it are maintained by a process of distortion: the depressive tailors contrary facts to fit his preformed and negative conclusions. The final limb of Beck's cognitive model describes the mechanism behind this in terms of faulty information processing, typified by one stimulus set and five types of response set. The stimulus set is the process of 'selective abstraction' whereby a negative circumstance is removed from its context. The response sets include: 'arbitrary inference', that is, deduction unrelated to the evidence; 'overgeneralization' arguing from one instance to a general rule; 'magnification' and 'minimization', errors of assessment with a negative bias; 'personalization', self-reference without evidence; and 'dichotomous thinking', thinking in extremes, with the self at the negative extreme.

Beck sees the thinking of the depressive as primitive, whereas mature thinking involves a view of the self in the world which is moderate and multidimensional. In this model, depressive cognitions are also characterized by attributions of self-blame and by persistence in time and across situations. As well as being moralistic, they are also absolutist.

**BROWN & HARRIS' MODEL**

The second model to be considered is that described by Brown & Harris in their book Social Origins of Depression, published in 1978. The book is a report of their community study of women Camberwell, South London. On the basis of this survey, they developed a complex account of the interaction of social factors in the precipitation of depression. They identified three types of factors: 'provoking factor', such as recent life events and chronic difficulties; 'vulnerability factor'; and 'symptom formation factor'. There were four vulnerability factors: early loss of mother, involvement in the care of young children, the lack of an adequate confidant, and the absence of gainful employment. Vulnerability factors did not of themselves increase the risk of depression but they made the women more susceptible to the impact of a supervening life event.
The description of the precipitation of depression outlined above was based on certain types of statistical relationship. This empirically based account can be termed the ‘vulnerability model’. However, Brown & Harris developed a further, cognitive model of depression, in terms of which they sought to explain these findings, they emphasized that this model was speculative: ‘claims that we make for the causal model cannot be made as yet for the more speculative theory’ (Brown & Harries, 1978, p. 233). Nevertheless, the authors quite clearly indicate their support for a cognitive aetiology: ‘in most cases, a cognitive appraisal of one’s world is primary’ (Brown & Harris, 1978, p. 235). Indeed, they go on to emphasize that, unless physiological abnormalities can be shown to predate depression, they may merely form part of the dependent variable- although this obviously also applies to their concept of hopelessness.

The unifying idea underlying the vulnerability model is the central experience of hopelessness arrived at by the woman appraising adverse circumstances which usually take the form of a ‘loss’. The concept of loss used by these authors goes well beyond loss occasioned by death. However, Brown & Harris emphasize that loss is not merely another term for disappointment or adversity. It is conceived as deprivation of sources of value or reward (or, in behavioral terms, of reinforcers). Such loss reflects an inability to hold good thoughts about ourselves, our lives and those close to us. Many of these ideas about loss are developed from those of Bowlby (1971, 1973).

Brown & Harris emphasize the importance of loss because they see it as the most likely cause of hopelessness.Hopelessness results from the inconceivability of restoring a particular source of value, or of having it restored. Events are particularly powerful when they reactivate some previous ‘unresolved’ event. This leads to the generalization of hopelessness and this is seen as crucial in the development of depression.

Why, then, is there variation in people’s response to loss? Brown & Harris argue that this is determined by the current level of self-esteem with the linked ideas of confidence and mastery. The vulnerability factors act as they do because they
lower self esteem. In particular, they operate against that aspect of self-esteem which is of importance in the model and is related to the woman's ability to hold an optimistic view of controlling her world in order to restore some source of value. The hopelessness that vulnerability factors tend to engender is, claim Brown & Harris, typically a generalized hopelessness. In their view, particular importance attaches to the early loss of mother, and they provide evidence from their data (p. 240) that this experience increases or is necessary for the vulnerability status of the absence of a confidential relationship or of involvement in child care.

Brown & Harris believe that the development of a depressive stage may arise because intense mourning can lead to generalization of hopelessness. Painful grief of this type is held to produce denial which is essential for the development of hopelessness and of the depressive stage. Vulnerability factors act by making grief pain and therefore triggering denial. This might be seen as a 'kettle-lid' model of depression if the lid is held on; the eventual release is rendered more violent. The relationships between denial and appraisal, which on the face of it appear to be opposites, is not made clear in the model, although there are empirical grounds for believing that they can co-exist (Horowitz et al. 1980).

The final aspect of this model, which is of some importance for our later discussion, is the postulate of 'symptom-formation factors'. In the group of patients studied by Brown & Harris, but not in their community cases, the pattern of symptoms appeared to be related to the type of early loss. Disorders with a more endogenous pattern were associated with loss of mother by death, while those with a more neurotic pattern were more likely to have experienced such loss through separation. The authors see this as being mediated by the greater degree of hopelessness which results from the death of, rather than rejection by, the mother.

To summarize, Brown & Harris argue that loss of events produce hopelessness, and that vulnerability factors impair self-esteem. Low self-esteem increases the intensity of the response to loss through generalization of the hopelessness triggered by it. The pain of this enhanced response to loss leads to
denial, and denial is the mechanism by which the normal response to loss is converted into depression.

THE REFORMULATED LEARNED HELPLESSNESS MODEL

The original helplessness model of depression is described by Seligman (1975) and proposed that events which the organism attempts to control, but cannot, have peculiarly disruptive effects. The resulting deficits fall into three categories: motivational, cognitive and emotional. The motivational deficit is reflected in retarded initiation of voluntary responses; the cognitive deficit involves erroneously pessimistic expectations of the non-contingency of future outcomes; and the emotional deficit takes the form of depressed mood.

However, there were a number of inadequacies of this model, developed in animals, when applied to account for depression in humans (Depue & Monroe, 1978; Blaney, 1977). This led to a reformulation of the model by Abramson and her colleagues (1978) and by Miller & Norman (1979). The major innovation was the introduction of an attribution framework. In other words, when people perceive that they have failed to control an outcome, they immediately ask themselves why this is so. The answers, according to the reformulated model, determine the generality and chronicity of effect and also the effect on the subject’s self-esteem. The original model did not distinguish between the perception of a task as impossible and the perception of oneself as incompetent and new model brings in the concept of locus of causality to account for this. It must be emphasized that locus of causality is an attribution the subject makes about an outcome which has already happened. In this it differs from Rotter’s (1966) concept of locus of control with which it sometimes appears to be confused. Locus of control, as elaborated by Rotter, concerns the extent to which future outcomes, both positive and negative, are thought to be under the control of the subject. It is therefore more akin to the expectation of future non-contingency. The incorporation of positive outcomes probably accounts for the general empirical finding that depressives show a characteristically external locus of control (see Brewin & Shapiro, 1984).
Abramson and her colleagues (1978) emphasize that contingency and locus of causality are logically orthogonal. They also make the rather belated point that the learned helplessness model of depression has to take into account whether the non-contingent outcome is pleasant or otherwise. Pleasant non-contingent outcomes are predicted to result in the motivation and cognitive deficits of helplessness but not in depressed mood.

The next problems addressed by Abramson and her colleagues (1978) are those of the generality and chronicity of helplessness. Under the old model, objective non-contingency of outcome leads to expectations of future non-contingency. This leads to problems epitomized by what happens in helplessness experiments when subjects are debriefed. Such subjects would be expected to improve in mood and in self-esteem, but they also lose the motivational and cognitive deficits. The old model of helplessness fails to account for this. If anything, the old theory would probably state that helplessness would re-emerge if either the required response or the required outcome was similar to the original situation. Rapidly dissipating helplessness would be due to later or (more likely) prior learning interfering with the expectation of non-contingency.

In order to specify the determinants of the pervasiveness and chronicity of helplessness, Abramson and her colleagues adduce the additional attributional dimensions of globality and stability. These dimensions are again each held to be orthogonal to the other dimensions of helplessness. Under the reformulated model, objective non-contingency will only produce expectation of the same if the subjects attribute failure to stable and global factors. Stable factors are those which the subject sees as being unlikely to change with time, global factors are those which are likely to apply across a variety of situations.

Almost as a propos, Abramson and her colleagues introduce another orthogonal dimension, that of controllability. It is quite possible for a subject to make internal attributions which are either controllable or otherwise- for example, lack of effort as opposed to inherent stupidity. Although logically orthogonal, attributions of controllability are more likely to be made in association with internal
and unstable attributions. However, it is just possible to imagine an internal and unstable attribution which is not controllable. Interestingly, the authors postulate that a further cognitive theme seen in depressives, that of guilt, arises from attributions of controllability. They describe these feelings as being a subset of the phenomenon of low self-esteem.

The author’s reformulation represents an improvement over the old model by explaining the origins of reduced self-esteem and the significance of the internal attributions seen in depressed people. It also gives an account of the persistence of depressed mood in time and its generalization over situations in terms of the interpretations they make of their experience.

This attributional model of depression is elegant and precise, and sufficiently complex to account for the richness of people’s responses to their circumstances. It lends itself to clear predictions, although the authors repeatedly emphasize that it provides a sufficient but not a necessary cause of depression.

Cognitive themes

If these theories are taken together, four groups of attitudes can be identified: low self-esteem, helplessness/hopelessness, self-blame, and what might be called imposition or burden.

Reduced self-esteem is apparent in the first element of Beck’s cognitive triad, although that also covers self-blame. Abramson and her colleagues offer an account of self-esteem in terms of locus of causality. It is seen as originating in a self-perception of relative incompetence. This appears to be a more specific version of the loosely formulated suggestion by Brown & Harris that self-esteem is linked with the related concepts of confidence and mastery.

The second cognitive theme which can be delineated is that of hopelessness, a set of beliefs about future outcomes. It forms the third of Beck’s cognitive triads and has a major position in Brown & Harris’ model. In both of these models hopelessness has a wider reference than helplessness in the model of Abramson and her colleagues. Hopelessness comprehends the
impossibility of rectification both by the person and by other people. It is seen in this way in classical phenomenology, but the precise predictions of the Abramson model probable signify the value of regarding helplessness as a separate theme. In fact, this group has now acknowledged the conceptual distinction between hopeless without being hopeless, but it is not possible to be hopeless without simultaneously being helpless' (Garber et al. 1980, p. 150). Nevertheless, the distinction between helplessness and hopelessness may pose a problem for the revised learned helplessness theory. Helplessness accompanied by hopelessness might remove the adverse comparison with others which is held to underlie reduced self-esteem; in other words, hopelessness might not be associated with a reduction in self-esteem. This hardly accords with clinical experience and there are empirical data which go against this account of low self-esteem (Brewin & Furnham, 1985).

The third theme is that of self-blame, already mentioned as a component of Beck’s first triad. Abramson and her colleagues again offer a precise hypothesis of the origin of this sentiment in terms of the attributional dimension of controllability. However, as Brewin (1986) has argued, their explanation is inadequate as it fails to account for the moral quality of self-blame pointed out by Beck. For us to blame ourselves, it is not enough that we could have controlled an outcome and did not, it must also be an outcome that we should have controlled. Brown & Harris do not lay stress upon self-blame; presumably in the form of pathological guilt it is one of the psychotic features they explain as emerging from the greater degrees of hopelessness.

The final theme which can be identified in depressives is reflected in the idea of imposition which can be seen in both the Beck and the Brown & Harris formulations. In the former, it constitutes the second triad. The depressive’s view of himself and of his world appears in Beck’s model to be one of failure, but to this is joined the expectation of burden: not only will the depressive suffer because of his incompetence but also from an outrageous fortune. To the theme of low self-esteem is added that of persecution, although the former is emphasized in the model.
Because imposed burden if incorporated, the depressive’s world view admits attributions of both an internal and an external nature.

Burden is a particular problem for the reformulated learned helplessness model because of its laboratory origins. In the laboratory, the tasks are usually imposed by the experimenter, and they are usually imposed upon groups of subjects. The outcome of the task varies in contingency but not the task itself. In real life, unpleasant events may be imposed upon us by malign fate, or they may arise because of our mistakes. Moreover, we may apparently arbitrary event. The cognitive response to this is commonly couched in terms of unfairness: “Why me?” The reformulated model does not address the issue of “burden” and therefore offers no explanation of it. This theme, which may be described as the querulous or persecutory, is not given any weight in the diagnosis of depression; nevertheless, it is often seen clinically, both in mild depressives and such concepts as ‘argwonische’ depression and mood-incongruent depression.

The theories discussed here are largely concerned with the subject’s perception of his experience, and it is apparent that they omit other important aspects of perception. Self-esteem may well be determined in part by the subject’s perception of relative incompetence, but it is also likely to be determined by his perception of how others see him.

In their summary of the defects of the old helplessness model which they claim to have remedied by their reformulation, Abramson and her colleagues emphasize that the expectation of non-contingency is insufficient for the development of depression- there are obviously non-contingent outcomes which do not depress us, either because they are unimportant or because they are pleasant. In fact, although the authors imply the contrary, this defect of the old model is not specifically overcome by the attributional model. Both models require a codicil that it is only bad outcomes of some importance which may be associated with depressions.

Each of the theories offers an account of the origins of the themes they identify, and each can be criticized. In Beck’s model, the concept of the schema is
an attempt to link the psychopathological description to an aetiological theory. This is, of course, necessary if it is to be maintained that the disorder of cognition precedes and account for the disorder of mood. For this reason, it is not appropriate for Beck to claim, however disarmingly, that the cognitive model does not address itself to questions of ultimate aetiology, offering only good logical ordering of the mental phenomena in depression.

The schema is an interrelated set of beliefs which can be activated by particular experiences and which then produces a distortion of that experience. It is a hypothetical construct to explain the persistence of the cognitive triad. The schemas of depressives are "prepotent", in the sense that contradictory evidence is particularly unlikely to be acknowledged. For the depressive, the normal interaction between previous and current experience is hopelessly skewed in favour of previous negative experience.

Beck lays emphasis on events as activators of latent schemas and also on early experience as the source of schemas. The early origin of depressive schemas is reflected in the "primitive" nature of depressive thinking. However, so far Beck's major interest has been in the clinical implications of his model and he has not further specified the role of experience.

Their interest in events is, of course, the point of departure for Brown & Harris in the development of their model. Importance is accorded both to early events, exemplified by the premature loss of the mother, and to recent events. The impact of recent events is located in the losses they bring about. The woman's circumstances, as reflected by the vulnerability factors, influence the effect of these loss events. Rather like Beck, Brown & Harris argue that early loss is especially powerful because it occurs at a time when the subject's cognitive organization is primitive; children seem unable to grieve as adults do.

The reformulated learned helplessness model makes precise claims about how the cognitive symptoms of depression rise- helplessness, low self-esteem and self-blame- and explains their persistence through attributions of stability.
and globality. The persistence of cognitions is then adduced to explain the persistence of depressed mood.

In other words, any cognitive theory must take account of the quality of the individual’s persistent cognitions (schema, attributional style, or low self-esteem), of the demand characteristics of events, and of the interaction between the two. Beck and Brown & Harris have emphasized this interaction, and Abramson and her colleagues are obliged to acknowledge it. However, it takes the apparent precision of the reformulated model into areas where its precision is lost; it makes no exact predictions concerning the interaction of attributional style and event, although it may lead to vague statements of probability.

RELATIONSHIP OF NEGATIVE COGNITION WITH ADOLESCENT DEPRESSION

- Negative thinking, particularly in relation to the self and the future, is a well established characteristic of episodes of depression (Haaga, Dyck, & Ernst, 1991). Cognitive theories of depression have been predominant among psychological approaches to understanding depression. Cognitive models (e.g., Ingram, Miranda, & Segal, 1998; Nolen-Hoeksema, 1991; Abramson, Metalsky, & Alloy, 1989; Rehm, 1977; Beck, 1967, 1987) emphasize the role of maladaptive beliefs, inferential styles, or information processing biases as vulnerability factors for depression that increase people’s risk for becoming depressed when they experience stressful life events. Moreover, a growing body of evidence suggests that negative cognitive styles and information processing do, indeed, increase risk for depression (e.g., Abramson et al., 1999; Alloy et al., 1999; Ingram et al., 1998). If negative cognitive styles do confer vulnerability to depression, then it becomes important to understand the origins of these cognitive styles. Such understanding may lead to the development of early interventions to prevent initial onset and recurrences of depression.

Alloy (2001) reviewed and addressed empirically several potential developmental precursors of cognitive vulnerability to depression. Although the
samples included in these studies vary from children to adolescents to young adults, the recurrent theme being exposure to a negative interpersonal context of some kind (e.g., negative parenting practices, negative inferential feedback from significant others, early history of maltreatment, negative appraisals of competence from significant others, low intimacy in romantic relationships, family discord or disruption) leads to the development of personal cognitive vulnerability to depression. Goodman and Gotlib (1999) suggested a variety of factors that may be associated with the development of negative cognitive structures (e.g., modeling negative cognition and exposure to depressive behaviors and affect).

Three types of cognitions are hypothesized to be important to the etiology of depression. A negative view of the self and negative expectations about the future are core parts of cognitive vulnerability according to both Abramson et al. (1989) and Beck (1976). In addition, hopelessness theory (Abramson et al., 1989) highlights the contribution of attributional style to the onset of depression. There is increasing evidence that negative cognitions predict depressive symptoms in both children (e.g., Hilsman & Garber, 1995; Nolen-Hoeksema, Girgus, & Seligman, 1992) and adults (Metalsky, Joiner, Hardin, & Abramson, 1993; Metalsky & Joiner, 1992).

Theories focusing on cognitive schemas in depression (e.g., Beck, 1967) suggest that these schemas develop in response to stressful events in childhood. Once such events are cognitively encoded, schemas sensitize individuals to respond in a dysfunctional fashion to circumstances that resemble those experienced in childhood.

In this regard, Beck (1967) argues that, in childhood and adolescence, the depression-prone individual becomes sensitized to certain types of life situations. The traumatic situations initially responsible for embedding or reinforcing the negative attitudes that compose the depressive constellation are the prototypes of the specific stresses that may later activate these constellations. When a person is subjected to situations reminiscent of the original traumatic experiences, he may then become depressed (p. 278)
Nasby and Yando (1982) investigated the selective influences of experimentally induced mood states on children’s encoding and retrieval of affectively valiant information. Results revealed that a happy, compared to a neutral mood during encoding facilitated recall of positive information; conversely, a sad encoding mood disrupted recall of positive material. The negative mood of anger, like that of sadness, disrupted the encoding of positive information; unlike sadness, however, anger facilitated the encoding of negative material. Findings indicate that selective encoding and retrieval may contribute to children’s cognitive ability to regulate mood states as well as other aspects of social learning and development.

Hammen and Zupan (1984) investigated the applicability of the self-as-schema model to children and examined the extent of negative self-schemas in relatively depressed children. Results supported the self-as-schema model as applied to children, even the youngest group, by indicating superior recall for words encoded under self-reference instructions, compared to semantic or structural orienting instructions. The content-specificity hypotheses were tested with relatively depressed and nondepressed children, and were supported only for the nondepressed children, who recalled mostly positive content words. The relatively depressed children did not demonstrate content specificity in their recall, showing a more “confused” pattern, and the results demonstrated a developmental model of acquisition of depression vulnerability requiring repeated depressive experiences over time.

Blumberg and Izard (1985) examined the affective and cognitive characteristics of depression in 10- and 11-year-old children. The results indicated that the depressed children were like depressed adults in that they reported experiencing a pattern of emotions including sadness, anger, self-directed hostility, and shame, and they tended to explain negative events in terms of internal, stable, and global cause. The similarity between depressed children and depressed adults on theses measures was greater for girls than for boys. The measures of emotion experiences accounted for 78.1% and 46.1% of the variance in girls’ and boys’
depression scores, respectively, after the variance accounted for by attribution style was partialled out.

Mullins et al. (1985) examined the relationship between a number of problem-solving and life event variables and depressive symptoms in a sample of non-referred grade school children. The results indicated that higher levels of depressive symptoms were associated with an external locus of control, increased levels of objective and subjective life stress, and lower performance levels on an impersonal problem-solving task. Levels of depressive symptoms were found to be inversely related to socioeconomic status as measured by father’s occupation. Contrary to prediction, no consistent relationship was found between depression and interpersonal problem-solving ability.

Zupan et al. (1987) explored evidence of apparent self-schemas in samples of children with current or past histories of diagnosable depression. As predicted, clinically depressed children showed even stronger recall of negative self-descriptive adjectives than in previous research. However, extent of previous experiences with depression did not predict degree of negativity of current self-schema beyond that predicted by current mood. The results were compatible with a developmental model of self-schemas in which prior experience may affect accessibility of negative cognitions once the self-schema has been activated.

Deal and Williamson (1988) examined the possibility that cognitive distortions mediate between life stress and depression in an adolescent population in a sample of ninth-to twelfth-grade high school students. Results showed that measures of cognitive distortions were better predictors of depressive tendencies than measures of life stress. It was also seen that cognitive distortions affected the perceived stressfulness of life events. In addition, the three measures of cognitive distortion were correlated and that the measure of immediate negative thinking was a better predictor of depressive tendencies than the measure of dysfunction attitudes and irrational beliefs.

who had histories of depression but were not reporting depressive symptoms when evaluated during the first 2 weeks of hospitalization. When compared with nondepressed controls, depressed children reported significantly more hopelessness, more negative self-perceptions, and negative self-perceptions across a wider variety of domains, and they displayed more dysfunctional attributional styles. While 55% of depressed children scored more similarly to nondepressed children, suggesting that childhood depressive disorders may be heterogeneous with respect to cognitive patterns. Contrary to the notion of trait like depressive cognitive and attributional patterns that persist after the remission of depressive episodes, children with remitting depressions scored similarly to nondepressed children.

Kashani et al. (1989) investigated hopelessness at 3 age levels (8-, 12-, and 17-year-olds) in children and adolescents from a community sample. The major findings of this study included (a) Hopelessness did not increase with age from preadolescence through adolescence; (b) children with a high hopelessness score had a higher depressive symptom score; (c) children with a high hopelessness score reported significantly more school problems; (d) high scorers on the hopelessness had the greatest psychopathology.

Meyer et al. (1989) examined differences in cognitive appraisal and causal attributions in response to a task among school children reporting high and low depressive symptomatology in a sample of fifth- and sixth-grade students. Despite similar performance, the depressed group of children provided lower evaluations for themselves than for others on all three measures of self-appraisal, whereas the nondepressed group did not show this tendency. Further, the attribution results indicated that the two groups differed in their explanations for failure, with the depressed group emphasizing the importance of ability in failure and the nondepressed group emphasizing factors other than ability. The results provide support for the presence of negative cognitions and self-defeating attributional style among depressed relative to nondepressed children, as well as pointing to the importance of social comparison processes in depression.
Bruder-Mattson and Hovanitz (1990) examined how coping styles relate to attributional styles and how the two interact in relation to depression. Problem-focused coping correlated with stable and global attributions for positive events for men. Emotion-focused coping correlated with internal, stable, and global attributions for negative events for women and internal and global attributions for men. Correlations between depression and attributions as predicted by the reformulated model of hopelessness were significant only for women.

Kendall et al. (1990) conducted three studies to evaluate cognitive disturbance and depression in sixth-grade children. Results of study I revealed that depression was associated with a negative style of processing self-evaluative information, while being unrelated to a processing deficit. A second study was initiated to replicate the results of Study I and to extend them to third-, fourth-, fifth-, and sixth-grade children, half of whom were depressed and half of whom indicated a minimum of depressive symptomatology. Results were very similar to those found in Study I. A third study was conducted to test whether the self-perceptions of depressed children were accurately negative or negatively distorted, as judged against their teacher’s observation of them. Results supported the hypothesis that depressed children exhibit a distorted style of processing self-evaluative information.

Curry and Craighead (1990) tested the reformulated learned helplessness theory of depression with adolescent inpatients who were diagnosed by Diagnostic and Statistical manual of Mental Disorders (DSM-III; American Psychiatric Association, 1980) criteria as depressed, or conduct disordered, or both. Adolescents with major depression diagnoses differed from nondepressed adolescents with significantly lower attributional style scores for positive events. Subjects who reported more severe depression had a significantly lower composite score for internal, stable, and global attributions for positive events. The composite of internal, stable and global attributions for negative events was not significantly related to either diagnosed or self-reported depression.
Thurber et al. (1990) examined the relationship between cognitive distortions and depression in psychiatrically disturbed adolescent inpatients. Intercorrelations among measures of cognitive distortions and depression supported the downward extension of Beck’s theorizing to adolescent inpatients. Inconsistencies between data sources (parent vs. child) suggest possible self-report contamination or the insensitivities of adult caregivers to the subjective elements of depression.

Quiggle et al. (1992) compared the social information processing patterns of children who were identified as being aggressive or depressed, to address the issue of specificity and to explore whether children who were comorbid show a unique processing style in children in third through sixth grade. Aggressive children showed a hostile attributional bias, were more likely to report that they would engage in aggressive behavior, and indicated that aggression would be easy for them. Depressed children similarly showed a hostile attributional bias, although they were more likely to attribute negative situations to internal, stable, and global causes. Depressed children also reported that they would be less likely to use assertive responses and that they expected that assertive behavior would lead to more negative and fewer positive outcomes. Children who were comorbid generally showed patterns similar to both aggressive and depressed children.

Sanders et al. (1992) assessed the family interactions of depressed, conduct-disordered, mixed depressed-conduct-disordered outcomes. Children who were comorbid generally showed patterns similar to both aggressive and depressed children.

Sanders et al. (1992) assessed the family interactions of depressed, conduct-disordered, and mixed depressed-conduct-disordered, and nonclinic children. Although all clinic groups had lower levels of effective problem solving than did nonclinic children, their deficiencies were somewhat different. Depressed and conduct-disordered children had higher levels of self-referent negative cognitions than did mix and comparison children, and depressed children also had higher other-referent negative cognitions than did all other groups. Mixed and depressed children
displayed high levels of depressed affect and low levels of angry affect, whereas conduct-disordered children displayed both angry and depressed affect.

Pinto and Francis (1993) examined the relationship between self-reported depression and cognitive style in adolescent inpatients. Adolescents who reported depression also reported significantly more internal attributions for negative events and less internal attributions for positive events evidenced a more external locus of control, and described themselves as significantly more hopeless than did the nondepressed adolescents. Hopelessness and internal attributions for negative events were the strongest predictors of depressive symptoms. In contrast to the findings of most studies using clinical populations of depressed children and adolescents, a maladaptive cognitive style and self-reported depression were highly, positively correlated.

Adams and Adams (1993) studied prospectively the associations among negative life events (NLEs), perceived problem-solving alternatives (PPSA), and depression in adolescents. The dropped group who also selected negative PPSAs increased in depression. No other group differences were found. Results indicated that experiencing a NLE is likely to lead to an increase in depressive symptomatology only for adolescents with primarily negative PPSAs, perhaps in interaction with prior depression, at least for the specific NLE.

Laurent and Stark (1993) tested the cognitive content-specificity hypothesis with anxious and depressed youngsters in youngsters in Grades 4 through 7 and controls. Analysis revealed that the valence of depressive cognitions played an important role in distinguishing the anxious group from the depressed and mixed groups. Specifically, negatively worded items did not differentiate between groups as well as positively worded items. The anxious, depressed, and mixed depressed-anxious groups were not differentiated on the basis of their anxious cognitions. The results provide partial support for Beck’s cognitive content-specificity hypothesis and the broader positive-negative affectivity construct.

Cole and Turner (1993) assessed negative cognitive errors, attributional style, positive and negative events, peer-nominated competence, and self-reported
depression in fourth, sixth, and eighth graders. Data supported theoretical models in which attributional style and cognitive errors mediated the relation of competence to depression. Data did not support models in which attributional style moderated the relation between either life events or competence and depression; however, weak support emerged for a moderational model involving negative life events and cognitive errors.

Garber et al. (1993) examined the generalizability of cognitive models of depression to adolescents and explored developmental differences with regard to depressotypic cognitions in adolescents in grades 7 through 12. Results showed that there was a strong association between negative thinking and depression in adolescents. There was no association between depressogenic thinking and age, nor did the strength of the association between negative cognitions and depression vary from early to middle adolescence. Finally, negative cognitions were associated with self-reported measures of both depressive and anxious symptoms.

Bagley and Mallick (1995) examined negative self-perception and components of stress in Canadian, British, and Hong Kong adolescents (aged 4- to 16-yr-olds). Scores on subscales (Relationship Problems, Abuse at Home, Scholastic and Career Problems, and Loneliness and Social Isolation) were significantly correlated for both sexes with negative self-esteem scores in the three national groups. Differences in stress between cultures were explicable in terms of known cultural differences.

Ostrander et al. (1995) examined the unique and interactive relationships between age and indices of psychopathology (i.e., anxiety, aggression, and depression), with three types of maladaptive cognition: hopelessness, negative cognitive errors, and attributional bias. Some negative cognition was not unique to depression and was associated with broader psychopathology. Developmental considerations also influenced some negative cognition or qualified the association between negative cognitions and depression.

Oliver et al. (1995) examined three factors that may influence cognitive vulnerability to depression and anxiety: (1) subject’s perceptions of their
relationships with their parents and the climate in their family of origin (socialization); (2) self-focused attention (focusing attention inwardly, on the self); and (3) current symptoms of depression and anxiety. Perceptions of unfavorable socialization and public self-consciousness were related to dysfunctional attitudes. However, nearly all these relations disappeared when depression and anxiety were controlled statistically. These results suggest that memories of negative experiences in one's family of origin, self-focused attention, depression and anxiety, and dysfunctional attitudes all may be indicators of latent negative schemas that have been activated, perhaps by recent stress.

Gladstone and Kaslow (1995) presented a meta analytic review of the association between attributional styles and depressive symptoms in children and adolescents. Results showed that the correlations were consistent with those predicted by the reformulated learned helplessness model of depression. For negative outcomes, attributions along the internal, stable, and global dimensions were associated positively with depression. Conversely, higher levels of depressive symptoms were related to more external, unstable, and specific attributions for positive events. Additionally, overall composite maladaptive attributional patterns for positive and negative events were correlated with higher levels of depressive symptoms in youth.

Robinson et al. (1995) examined direct and stress-moderating effects of attributional style and global self-worth on depressive and externalizing symptoms in adolescents. They were assessed in the spring of 6th grade and after the transition to 7th grade. Stressors around the transition predicted both depressive and externalizing behaviours. Perceived self-worth predicted depressive symptoms, but not externalizing behaviours. Attributional style directly and in interaction with stressors predicted depressive symptoms and did not predict externalizing behavior. A 3-way interaction between stress, attributional style, and self-worth suggested that level of perceived self-worth may moderate the effects of attributional style in times of stress.
Hilsman and Garber (1995) tested the cognitive diathesis-stress model of depression in a sample of children in grades 5 and 6. Results revealed that the stressor level and negative cognition predicted depressive symptoms the morning after the event, controlling for initial symptom levels. Depressive symptoms 5 days later were predicted by the interactions of negative cognitions with stressors, supporting a cognitive diathesis-stress model. Students who reported a negative explanatory style or lack of academic control and competence expressed more distress after receiving unacceptable grades than did students without such cognitions.

Stark et al. (1996) evaluated the relationship between children’s depressogenic thinking, children’s depressive symptoms, parent’s depressogenic thinking, and perceived parental messages about the self, world, and future. Results revealed that (1) children’s views of self, world, and future (cognitive triad) were related to severity of depression; (2) mother’s but not father’s cognitive triad were related to their children’s cognitive triad; (3) perceived parental messages to the children about the self, world, and future were predictive of the children’s cognitive triads and ratings of depression; and (4) the relationship between perceived parental messages and depression was completely mediated by children’s cognitive parental messages and depression was completely mediated by children’s cognitive triads. Analyses indicated that the obtained mediational relationship between children’s views of self, world, and future, perceived parental messages, and children’s depressive symptoms was specific to depressive versus anxious symptomatology.

Schlenker and Britt (1996) examined the relationship between depression and the explanation of events that happen to self, close others, and stranger. Depressive and nondepressive college students attributed causality for positive and negative events that happened to either themselves, a close other, or a typical student. Depressives made less optimistic attributions than nondepressives when explaining events that happened to them. However, depressives and nondepressives generally made similar attribution about others; both groups were optimistic when explaining events that happened to their best friend or romantic partner and less optimistic.
when explaining events that happened to the typical student. The results indicate that depressives do not treat close others as extensions of the self, at least in terms of their attributional patterns.

Chan (1997) examined defensive styles and psychological symptoms among Chinese adolescents in Hong Kong. Commonly employed defenses included anticipation, sublimation, and reaction formation, indicating that adolescents tended to deal with stressors and emotional conflicts with relatively mature or adaptive defenses. Factor analysis revealed that a mature or adaptive defensive style could generally be distinguished from an immature or maladaptive defensive style, but a neurotic defensive style was not differentiable for this group of adolescents. Results also indicated that general and specific psychological symptoms were associated with the use of immature defenses characterized by somatization and externalizing emotional conflicts through acting out and misattribution.

Gladstone et al. (1997) examined attributional style, sex and depressive symptoms and diagnosis in high school students. The results revealed that (1) for females and males, higher levels of depressive symptoms correlated with a more depressive attributional style; (2) females and males who met diagnostic criteria for a current depressive disorder evidenced more depressogenic attributions than psychiatric controls, and never had past depressed adolescents; (3) although no sex differences in terms of attributional patterns for positive events, negative events, or for positive and negative events combined emerged, sex differences were revealed on a number of dimensional scores; (4) the relation between attributions and current self-reported depressive symptoms was stronger for females than males; and (5) no sex x diagnostic group status interaction effects emerged.

Kashani et al. (1997) identified critical factors from a set of psychiatric diagnoses, personality traits, and family and social support variables that relate to hopelessness in adolescents. Results indicated that sensitive adolescents and adolescents with less impulse control scored high on hopelessness. Forceful adolescents were less hopeless. Using the neural network models, the authors
suggest that assertive training as well as group activities that increase cooperativeness may ameliorate hopelessness.

Rudolph et al. (1997) investigated the cognitive and interpersonal aspects of depressive symptoms in a community sample of children. Children with elevated levels of depressive symptoms displayed increased negativity in their beliefs about self, family, and peers, as well as distinct patterns of interpersonal information processing. Anxiety symptoms did not make a unique contribution beyond depression to negative representations of family and peers; in contrast, symptom-specific profiles of self-representations were found. Structural equation analysis supported a model linking negative interpersonal representations, peer rejection, and depressive symptoms.

Hankin et al. (1997) examined the relation between self-standards and particular forms of emotional distress during adolescence. Actual-ideal discrepancies and self-oriented perfectionism were found to be associated specifically with depressive symptoms after controlling for anxious symptoms whereas actual-ought discrepancies were associated specifically with anxious symptoms after controlling for depressive symptoms. In contrast, socially prescribed perfectionism was associated with general emotional distress. Compared with boys, girls reported more depressive, but not anxious symptoms. Actual-ideal discrepancies partially mediated gender differences in depressive symptoms.

Roberts and Kassel (1997) examined the relationship between labile self-esteem, stressful life events, and depressive symptoms in a prospective study testing a model of vulnerability. The interaction between labile self-esteem (SE) and life stress predicted increases in depressive symptoms across a 2-month prospective interval, particularly in subjects who were initially low in depression and who had more severe worst lifetime episodes of depressive symptomatology. Interactions between life stress and labile SE were stronger for life stress measures that were based on the subjective appraisal of stress than for those that were based on raw life event counts. In contrast to predictions, depletions in self-esteem failed to mediate the synergistic effects of labile SE and life stress.
Shirk et al. (1998) addressed the hypothesis that interpersonal schemata sensitize dysphoric youngsters to negative social information and contribute to the amplification of depressive symptoms in samples of preadolescents and early adolescents. Results from 3 laboratory-based studies indicated that depressed and dysphoric youngsters evince relatively negative interpersonal schemata, and that these schemata were related to the 3 components of sensitization. A short-term prospective study examined the hypothesis that dysphoric interpersonal schemata moderate the emotional impact of a normative social stressor, the transition to high school. Results indicated that youngsters who entered the transition with relatively negative schema experienced the transition as more stressful than youngsters with relatively positive schema, and that negative interpersonal schema amplified the effects of stress on depressive symptoms.

Johnson et al. (1998) investigated whether attributions for positive life events predict decreases in hopelessness and depressive symptoms among clinically depressed adults. Results indicated that (a) internal, stable, global attributions for positive events mediated a significant association between attributional style for positive life events and decreased hopelessness; (b) decrease in hopelessness mediated a significant association between internal, stable, global attributions for recent positive events and decrease in depressive symptom levels; and (c) depressotypic cognitions were not associated with decrease in either hopelessness or depressive symptom levels.

Dumont and Provost (1999) examined resilience in adolescents and the protective role of social supports, coping strategies, self-esteem, and social activities on experience of stress and depression. The analysis revealed that self-esteem, problem-solving coping strategies, and antisocial and illegal activities with peers helped to discriminate groups: Well-adjusted adolescents had higher self-esteem than adolescents in the 2 other groups; in addition, resilient adolescents had higher self-esteem than vulnerable adolescents. For the second significant discriminating variables, antisocial and illegal activities with peers, both resilient and vulnerable adolescents had higher scores than well-adjusted adolescents. Finally, resilient
adolescents had higher scores on problem-solving strategies than adolescents in the 2 other groups.

Taylor and Ingram (1999) compared the information processing of children of depressed mothers with that of children whose mothers were not depressed. Results indicate that when primed, at-risk children showed a less positive self-concept and more negative information processing than did the children in the other groups. This may offer potential clues into the mechanisms of cognitive vulnerability in at-risk children.

**Body Image and Depression**

Society places a tremendous emphasis on physical appearance. Many adolescent girls go to great lengths to achieve these unrealistic standards of thinness. Eating disorders have become a prevalent disease in Western society. Dissatisfaction with one’s physical appearance is viewed as a core feature of eating disorders. A negative body image is also a common feature associated with depression. There appears to be a link, although unclear, between depression and a poor body image.

Adolescence is a tumultuous period in one’s life. Bodies of adolescents are dramatically changing, and these physical changes are associated with changes in body image. Body image pertains to how individuals view and assign meaning to their own bodies. It is a reflection of body structure and function, early and continuing body related experience, life long social response to body appearance, and sociocultural values and ideals regarding the body.

**Adolescence: A Period of Dramatic Change**

A normative developmental task for both girls and boys is to assimilate pubertal change into a positively valued body image. This task is more difficult for girls than for boys; girls are more concerned about attractiveness than boys, and they are less satisfied with their appearance. In a list of body areas, girls were more concerned that their thighs, buttocks and hips were too large. Even normal to thin girls were highly likely to desire smaller thighs, buttocks or hips. It is interesting to note that younger girls, aged 10-12 years, were less likely to select areas of sexual
attractiveness, but tended to be dissatisfied with areas such as teeth, face, and feet (Moore, 1993). It is clear that the onset of adolescence produces changes in body image.

**Depressed Adolescent Girls**

During adolescence, depression rates increase, and gender differences in depression are observed. Current data indicates that the depressed girl experiences her body as less satisfactory, and she also views it as deficient along a number of other dimensions. The depressed girl experiences her body as less pretty, less interesting, sicker, weaker, clumsier, and less useful, less familiar and more out of control (Rierdan, 1987). It is possible that girl’s experiencing early onset depression have a body experience that is radically different from other adolescents. This could be attributable to biochemical dysfunction. This dysfunction could be reflected in symptoms such as fatigue, sleep disturbance, eating disturbance, and other bodily complaints. When body attractiveness becomes important in adolescence, the foundation may already be laid for these at risk adolescents to be less satisfied with their bodies and vulnerable to the lowered self-esteem associated with eating disorders (Reirdan, 1988). Very simply, adolescence is a critical time in emotional development. As their body changes, adolescents are faced with the complicated task of reorganizing their body image. For some teenagers, especially those with depression, this proves to be difficult task.

Some adolescent girls develop depression in response to their changing bodies. The heightened attention and critical appraisal of the body, coupled with the greater vulnerability to emotional distress, suggests that body dissatisfaction in young adolescent girls might be an important correlate of depression (Rierdan, 1987). Menstruation causes biological and physical changes in a girl’s body. Studies in menarche support the findings that body image can contribute to depression. A normal part of girl’s development involves a significant increase in fat and weight. Girls at relatively lower stage of ego development are concerned with bodily feelings and it is understandable that the onset of menstruation could disrupt a girl’s sense of well being. These girls are less able to adapt to the bodily changes that
accompany early menarche and depressive symptoms are likely to develop (Rierdan, 1989). Adolescent girls experience a number of bodily changes. They are forced to reorganize their body image. In a society that places a tremendous value on thinness, it is often difficult to assimilate these changes into a positive body image.

**Negative Body Image: A Core Feature of Depression**

Noles, Cash, & Winstead (1985) indicated that self-evaluations of attractiveness have even stronger implications for depressive symptomology than actual attractiveness. The strongest predictor of CDI scores in regression analyses was dissatisfaction with body’s attractiveness. While depressed adults perceived themselves as less physically attractive and reported less satisfaction with their bodies, objective evaluations of attractiveness did not differentiate the groups. The present findings indicate that depressed individuals do not have a global distortion of body image. It appears that dysphoric children also negatively distort their own attractiveness, while maintaining reality based perceptions of other’s attractiveness. Dysphoria is maintained by a unilateral bias in social comparison; the underevaluation of one’s self, not a distorted evaluation of others. This is consistent with Beck’s model, which implicated a negative view of the self as critical cognitive aspect of depression (McCabe, 1993). In essence, dissatisfaction with physical appearance emerges as a hallmark feature of depression. It is not a global distortion but simply pertains to one’s own body.

Beck’s (1973) cognitive theory of depression includes a distorted body image as a cognitive symptom of depression. Beck (1973) classified 975 individual as non-depressed or as mildly, moderately, or severely depressed based on their Beck Depression Inventory scores. He reported that in each group, 12%, 33%, 50%, and 66%, respectively, suffered from a distortion of body image. Marsella, Shizuru, Brennan, & Kameoka (1981) investigated body image and depression. They categorized college students on their Zung Self-Report Depression Scale scores and found depressed students were more dissatisfied with 17 body areas. It is apparent that individuals with an average body image did not differ in depression from those with a positive body image. For the sample, persons with a poor body image were
significantly more likely to report depressive symptomology than were subjects in
the other two groups (Noles, 1985).

External Influences on Body Image

Mori and Morey (1991) conducted an experiment using students from Vanderbilt University. The experiment was designed to investigate the impact of external weight related feedback on the body image of females with different levels of depression. Participants were asked to estimate their body weight. The Zung Self-rating Depression Scale was used to assess depression levels. Body image estimation was taken by using the Image Marking Technique. In the second session, participants were weighed on a scale that was set in kilograms. Participants were randomly given one of two bogus weights, either 3% lighter or 3% heavier. The body estimations of the participants with low feelings of depression were not affected by the weight related feedback. In contrast, findings indicate that females with feelings of depression are more vulnerable to external feedback which may have implications about the treatment and prevention of body image disturbances. It is conceivable that societal messages in the form of diets and beauty advertisements created a situation where the target female compares her self to an ideal image. Depressive tend not to question the validity of negative inferences about themselves and often incorporate distorted information into their body image. Simply put, women are constantly bombarded with images of the ideal women. This is a precarious situation for depressed individuals, because they are more likely to incorporate these messages into their image, putting themselves at risk for developing an eating disorder.

An Ambiguous Link

A negative body image is a central feature of eating disorders. Since depression is known to cause a negative body image, it is important to study its relation to eating disorders. The link between eating disorders and depression is inconclusive. Many common depressive features such as depressed mood, irritability, low energy, and low concentration have been reported in studies of the physical and psychological effects of semi-starvation. Some psychologists argue that
eating disorders represent a variant or masked form of depression. Over short periods of time, underweight gain and anorexia nervosa tend to show improvements in their depressive symptoms with weight gain and nutritional stabilization. However, a small number of long term follow up study suggest that a disproportionate number of long patients show signs of depression at follow up. Patients who present for treatment may represent a sicker or more depressed subgroup (Devlin, 1989). Although these studies are indecisive, they suggest new options in treating depression and eating disorders. Some psychologists have suggested that treating depression may involve addressing body image issues, whereas eating disorders may respond to treatment with anti-depressants.

Biological markers have also been investigated in order to gain insight into the relationship between depression and eating disorders. The dexamethasone suppression test (DST), widely studied as a potential biological marker for depression, has been found by several groups to show high rates of nonsuppression or early escape in underweight patients with anorexia nervosa. However, because starvation can bring about similar changes in the hypothalamic pituitary adrenal (HPA) axis; an abnormal DST does not necessarily link anorexia nervosa with depression (Devlin, 1989). The cause and effect relationship between depression and eating disorders remains ambiguous.

Of the many conditions that are stigmatized in this culture, including racial membership and physical handicaps, it has been suggested that the stigma associated with being overweight or obese may be most debilitating and harmful (Sarlio-Lahteenkorva, Stunkard, & Rissanen, 1995; Allon, 1982). Indeed, overweight individuals perceive a substantial amount of stigmatization from co-workers, employers, strangers, friends, and spouses (Falkner, French, Jeffery, & Neumark-Sztainer, 1999; Rothblum, 1996; Rand, 1990). Consistently, obese individuals are characterized by others as ugly, stupid, mean, sloppy, lazy, dishonest, worried, sad, self-indulgent, unlikable, and emotionally impaired (Latner, & Stunkard, 2003; Cramer & Steinwert, & 1998; Neumark-Sztainer, 1998; Crandall, 1994; DeJong, 1993; Harris & Harris, 1982; Maddox, 1968). Obese individuals, particularly
women, are less likely to be accepted into prestigious universities (Canning & Mayer, 1966), are underrepresented at colleges (Crandall, 1991), and are less likely to have their education funded (Crandall, 1994). Obesity also negatively affects employment and employment potential (Rothblum, 1990; Rothblum & Miller, 1988; Larkin, 1979; Roe & Eickwort, 1976) and socioeconomic status (Puhl & Brownell, 2001; Rothblun, 1992; Sobal & Stunkard, 1989). Although there is empirical evidence documenting the stigmatizing effects of obesity, little is known about the psychological consequences of stigmatization or whether obese individuals internalize cultural views about weight (Cossrow, 2001; Falkner, 1999; Young, 1985).

Body image refers to the similarity between actual and perceived ideal body shape. Everyone has a body image and it has strong emotional overtones based on his experience in life. Body image is a multidimensional self-attitude toward one’s body, particularly its size, shape and aesthetics. It refers to persons’ evaluations and affective experiences regarding their physical attributes, as well as their investments in appearance as a domain for self-evaluation. Body-image evaluations and emotions derive in part from self-perceived discrepancies from internalized physical ideals. Body image investment includes the extent of intentional self-focus on one’s appearance, its importance or schematic vis-à-vis one’s sense of self and behaviors for the management or enhancement of appearance. Concerns about weight and shape are conventionally associated with women. Fallon & Rozin (1985) reported that women wanted to be thinner than they thought they were. Tiggmann & Pennington (1990) also reported body dissatisfaction in women. In contrast man’s body satisfaction appears to be high but they also show body dissatisfaction (Ridgeway & Tylka, 2005; Cash & Winstead, 1986).

Iqbal, Shahnawaz, & Alam (2006) examined educational and gender differences in body image and depression among students. The aim of the present investigation was to study educational and gender differences in body image and depression among students. Sample consisted of 100 subjects. Out of these 50 were school students and 50 were college students. These two groups were further divided
according to gender; each group comprised of 25 males and 25 females. Thus, a 2x2 factorial design was used. Depression was measured by Beck Depression Inventory and body image was measured by Body Esteem Scale, ANOVA and correlations were used to analyze the results. Results showed significant main effect of gender on body image. Males had significantly more positive body image than females. Negative correlation was found between body image and depression of males and females students. However, in other comparisons, significant differences were not observed.

Young people typically have low rates of serious physical morbidity. However, a large and increasing number of adolescents report on subjective health complaints and health worries (Haugland, Wold, Stevenson et al. 2001). Such complaints increase during a few critical years of adolescence and are strongly associated with a deterioration of self-evaluated health. Self-rated health is therefore an important health measure in adolescence. Prospective studies in adult populations have demonstrated that perceived health may predict morbidity, mortality, the use of health services and disability pensioning (Larsson & Hemmingson, 2002; Manderbacka, 1998; Idler, 1997; Fylkesnes, 1991).

Previous studies suggest that physical appearance and body image may influence perceived health. Adolescence is a period of increased awareness of bodily cues and self-reflection, including evaluation of body and appearance. In Western cultures, adolescents who depart from socially determined norms of attractiveness or individual ideals are vulnerable to body dissatisfaction. Body dissatisfaction may be defined as the discrepancy between an individual’s perceived current body size and perceived ideal body size (Wertheim & Paxton, 2004).

Body dissatisfaction, negative body image, concern with body size and shape represent attitudinal aspects of body image. The concept of body image has been defined in different terms, according to scientific discipline. Body image is also often discussed without a definition, or used interchangeably with other constructs (Wertheim & Paxton, 2004).
Previous studies suggest that adolescents who are dissatisfied with their bodies are more likely to perceive their health as fair or poor and more likely to show depression, low self-esteem and low social functioning (Field, 2004). Adolescents who are overweight are more likely to express weight-specific concerns and engage in dieting and binge eating compared with non-overweight adolescents (Nicholls, 2004; Neumark-Sztainer, 1997). However, causality or direction of effect is not established.

Previous research suggests that there may be age and gender differences in body dissatisfaction. The dual process of sociocultural and peer pressure may contribute to such gender differences. (Field, Camargo Jr et al. 2001, Stormer, 1998), as well as markers of identity. Social comparison is linked to the important but vulnerable process of social identity making (Tajfel & Turner, 1986). Among females, even normal-weight individuals are often concerned about body shape, and the vast majority wants to be thinner (Wertheim & Paxton, 2004).

In a longitudinal study, gender differences in body dissatisfaction emerged between 13 and 15 years of age, and were maintained at 18 years. Throughout this period, girls increased and boys decreased body dissatisfaction (Rosenblom & Lewis, 1999). However, recent research suggests that a growing number of adolescent boys tend to exercise diet or take steroids to adhere to the social and individual ideals of a more muscular body (Anderson-Fye, 2004).

SOCIAL SUPPORT AND PSYCHOPATHOLOGY

Social support is embedded in ongoing social interactions that are part of an ever changing network of social relationships. While a sharp and generally accepted definition of social support as distinct from other types of social interaction is hard to make, it is possible to present taxonomy of perspectives on social support that provides a useful tool in ordering its effects, and in identifying the social psychological processes involved. In a review of the occupational stress literature, Buunk (1990) made a distinction between four different conceptualizations of social support. First, from a sociological perspective, social support has primarily been viewed in terms of the number and strength of the connections of the individual to
others in his or her social environment – in other words, the degree of one’s social integration or the size and structure of one’s social network. According to Rook (1984), social integration may promote health, among others things, by providing stable and rewarding roles, by promoting healthy behavior, by deterring the person from ill-advised behavior, and by maintaining stable functioning during periods of rapid change. A second perspective on social support has been provided by authors who equate social support with the availability of satisfying relationships characterized by love, intimacy, trust or esteem. For instance, Cutrona & Russell (1990) have shown that certain provisions of relationships, including attachment and reassurance of worth, can act as buffers against stress. In the third perspective, the perceived helpfulness view, social support constitutes the appraisal that, under stressful circumstances, others can be relied upon for advice, information and empathic understanding, guidance and support. In this context, there is some evidence for the assumption that the mere perception that one can turn to someone for help already reduces stress (Sarason & Sarason, 1986). Finally, for some authors the concept of social support refers primarily to the actual receiving of supportive acts from others once a stressful situation has come into existence. The foregoing perspectives assume a certain preventive function of actual help when a person is under stress (cf. Barrera, 1986). Although all these conceptualizations may be important for understanding the role of interpersonal relationships in reducing stress, the four levels may bear different relationships to health and well-being. Social support in a broad sense is defined as an asymmetrical exchange of resources between at least two individuals, a recipient and a support provider (s) that is perceived by the recipient to be beneficial (Shumaker & Brownell, 1984). Being loved, liked, preferred, or approved of, could be thought of as instances of these resources. Similarly, having a large circle of friends who are able and willing to provide these resources is viewed as an index of social support.

Social support has been also 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, p. 121). 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 support refers to naturally occurring helping behaviours that are being provided, whereas perceived support refers to the belief that such helping behaviours would be provided when needed. In a nutshell, received support is helping behaviour that did happen, and perceived support is helping behavior that might happen (Barrera, 1986).

Social support refers to information or actions (real or potential) that lead individuals 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 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).

In the recent past, there has been a considerable amount of research showing that support from family, friends, and community networks is related to better physical health and lower levels of psychological symptomatology (e.g., King, Reis, Porter, & Norsen, 1993; House, Landis, & Umberson, 1988; S. Cohen & Syme, 1985).

Individuals with high levels of perceived social support appear to be more resistant to the adverse psychological effects of environmental stressors than do those with relatively low levels of perceived social support (Lepore, Evans, & Schneider, 1992; Cohen & Wills, 1985). The negative effects of environmental stressors can be reduced when individuals have high personal control. When individuals are crowded, an essential feature of the experience is that they lose much of their ability to control what happens to them (personal control). Schmidt and Keating (1979) distinguished three forms of personal control: cognitive, behavioural, and decisional. The foregoing researches believed that, even under high-density
conditions, the stress of crowding may be reduced if one can attain one or more of the three forms of personal control. Individuals with high self-control appraised the stress situation differently from those with low self-control and the different appraisal results in different psychological outcomes (Rosenbaum & Ben-Ari, 1985).

Most of the studies in this specific area of research investigated one of the following hypotheses (Cohen & Wills, 1985):

1. The direct (main) effect: Social support has a direct positive impact on health. For example, the more direct or emotional help people receive, the less likely symptoms of mental or physical ill-health will appear.

2. The indirect (mediating) effect: Social support has a negative impact on stressors at work and thus has a positive impact on health. If, for example, the stressor is quantitative overload and the individual will receive direct instrumental help when the workload exceeds a certain limit, social support directly reduces the stressor and thus reduces the probability of ill-health. In this case, social support has a stress-preventive effect (Barrera, 1986).

   Methodologically, the social support-health relationship is mediated by the stressors.

3. The moderating (interaction) effect: According to this mechanism, which is also known as the buffering effect, social support moderates the relationship between stressors and strains. There is a strong stressor – strain relation when support is low and a weak or no stressor-strain relation when support is high. Social support works as a buffer and prevents stressors from developing their impact on strains. It is the moderating effect that has received the most attention in the literature. One reason may have been the practical implications: because stressors can sometimes not be reduced, the negative effect of high stressors can be compensated for by increasing social support.

   What makes social support research an interesting field is that many alternative hypotheses are also plausible and have found some empirical support. For example, it has been suggested that healthy and assertive people may receive less support, or that receiving support might decrease self-esteem because it shows
one's weaknesses and, by this mechanism, might also negatively affect mental or 
physical health (Frese, 1999). Using biochemical measure in a study of managerial 
personnel, Howard, Cunningham, & Rechnitzer (1986) found that the number of 
social contacts reinforced the stress reactions instead of weakening them.

Whereas the direct effects of social support on stressors and health have 
found support in the literature (Kahn & Byosiere, 1992; Beehr, 1985, 1995; Cohen 
& Wills, 1985; LaRocco, House, & French, 1980), the effects of the moderating 
mechanism were less clear. Kahn and Byosiere (1992) listed 22 studies in their 
overview and concluded that the pattern of results was consistent for main effects. 
However, there were several studies that did not show any evidence for moderating 
effects, and there were also studies (e.g., Ganster, Fusilier, & Mayes, 1986; 
Kaufmann & Beehr, 1986) that detected a negative moderator effect. According to 
Beehr's (1995) recent overview, the evidence today does not allow the conclusion 
that moderating effects occur.

Stress can also lead to decreased support because others turn away from 
people under stress. Indeed, many stressful situations, particularly stigmatizing or 
strongly traumatizing events, seem to affect social relationships in a negative way, 
such as by alienating others, by depleting their resources or even by causing 
caregiver burnout. Such circumstances may reduce the willingness or ability of 
others to provide support (Cohen-Silver, Wortman, & Crofton, 1990; Coyne, Ellard, 
& Smith, 1990; Hobfoll & Parries-Stephens, 1990; Barrera, 1986; Shinn, Lehman, & 
Wong, 1984). There is also considerable evidence that interacting with depressed 
individual is seen to be aversive (e.g. Coyne, 1976). There findings are in line with 
the literature on social comparison that shows that individuals under stress are often 
avoided by others, a process through which people who are under stress may end by 
being isolated (e.g. Rabbie, 1963).

Indeed, people seem to prefer the company of others who are equally well off 
or better off, as this type of interaction provides them with pleasant interactions and 
the necessary information further to improve their own situation. As a consequence, 
peers of a stressed person may prefer to turn to even better-off others instead of
investing time and effort in helping their troubled peer. From the perspective of equity theory, individuals under stress may actively avoid others in order not to find themselves in the uneven position of having to accept help without knowing when and how they will be able to restore equity. In turn, both lay people and professional helpers may find it difficult to maintain good relationships with individuals under stress because of the extreme or chronic one-sided nature of the interaction. One of the causes of burnout in human service professions is the lack of rewarding interactions experienced by caregivers in their relation with stressed clients (Van Yperen, Buunk, & Schaufeli, 1992). Evidence from the psychiatric literature suggests that psychiatric patients tend to maintain asymmetrical helping relationships, failing to reciprocate the support they receive from others (Gottlib, 1985). As Gottlib has noted, such an imbalance "makes interaction less satisfying for both parties, because the helper is drained and the recipient feels uncomfortable indebted, suffering also a decline in good feelings about him/herself" (p.430.)

Alternative models of perceived support have focused on personality processes (Lakey & Cassady, 1990; B.R. Sarason, Pierce, & Sarason, 1990; I.G. Sarason, Sarason, & Shearin, 1986). According to these models, perceived support represents a generalized perception of others as supportive. B.R. Sarason, Pierce, and Sarason (1990) hypothesized that perceived support reflects a generalized sense of acceptance that has its origins in early childhood attachment. From this attachment, persons develop working models of self and others that represent the world as benign and supportive and the self as worthy of love and respect. Lakey and Cassady (1990) took a social-cognitive approach and hypothesized that perceived support operates, in part, according to schematic processes. In this view, organized beliefs about supportiveness influence information processing by guiding interpretation, memory, attention, speed, and ease of information processing. Like B.R. Sarason, Pierce, and Sarason’s model, this model views perceived support as more closely linked to cognition about the self than to the actual social environment.
After more than a decade of relatively uncritical acceptance, research linking social support to positive health outcomes has come under intense scrutiny. Although hundreds of social support studies have been published, most of which have found some association between support and mental or physical health, almost all have been correlational and are vulnerable to a number of alternative explanations for the obtained results. Social support was originally conceptualized as an environmental variable, a resource that resides outside the individual (e.g., Cassel, 1976). However, more recently the role of personality as a determinant of both appraisals of support and actual support received has attracted increasing attention (Repetti, 1987; I.G. Sarason, Sarason, & Shearin, 1986; Hobfoll, 1985; Rook, 1984). Some critics have implied that measures of social support assess nothing but aspects of the individual's personality.

It is important to distinguish between different effects that personality may have on perceived and actual social support. Personality may determine how people cognitively represent their experiences (i.e., response style, mood, appraisal processes) without affecting their actual social behaviour or that of members of their social network. Two individuals with objectively identical social support resources may describe these resources quite differently. By contrast, an individual’s personality may affect his or her actual social environment. Individuals who are more socially extraverted may behave in a way that draws others to them and that motivates others to behave in a supportive manner. This support from others may serve to protect the individual against the deleterious effects of stressful life events. In this scenario, social support is a mediating factor between individual’s personality and health outcomes. A final scenario that has been proposed is that a third variable such as good coping skills, leads directly to both adequate social support and positive health, with no causal link between social support and health. The association between social support and health is spurious, owing to their mutual association with this third factor.

At the most trivial level, personality may affect people’s manner of responding to questionnaires. Although a few researchers conduct interview
assessments of social support (e.g., Henderson, Duncan-Jones, Byrne, & Scott, 1980), most rely on self-report measures to assess both social support and health related outcome variables. Various response styles could produce association between self-report measures of support and health. Nunnally (1978) defined response style as a systematic individual difference in responding that is artifactual product of the measurement method, and which is at least partially independent of the trait that the scale is intended to measure. Examples of response styles that may affect scores on both social support and health measures (and thus inflate the correlation between them) include expressed self-desirability, acquiescence, extreme response tendency, and deviant response tendency (Nunnally, 1978).

The process by which individuals appraise the quality or adequacy of social support may be influenced by a variety of personality characteristics, including self-esteem; need affiliation, extraversion, and locus of control (I.G. Sarason, Levine, Basham, & Sarason, 1983). The respondent’s mood at the time of assessment may also affect results. For example, when people are depressed, they tend to evaluate themselves and others in a more negative manner than when they are not depressed (Alloy & Abramson, 1988; Beck, 1967). When depression is the outcome variable under investigation, the likelihood of a depressive bias’s inflating the association between social support and mental health is especially problematic, leading many researchers to rely on prospective analyses in which initial depression can be statistically controlled in the prediction of subsequent symptoms. However, this technique may systematically underestimate the effects of social support on depression, as any variance that is shared between these two variables at the initial assessment is attributed to depression.

Beyond the effects of personality on people’s subjective appraisals of social support, the actual quality and availability of support may be affected by the characteristics of the individual. At least these studies have shown an association between social support and various aspects of social competence. In one study, individuals high in social support were found to have higher levels of social skill, as reflected in self-ratings, observer ratings, and performance on a story-completion
task of social competence (B.R. Sarason, Sarason, Hacker, & Basham, 1985). In a second study, people high in social support were judged by observers to be more competent leaders and problem solvers (I.G. Sarason et al., 1986). Social competence, low social anxiety, and self-disclosure were all associated with social support in a sample of new college students (Cohen, Sherrod, & Clark, 1986). These results suggest that individuals who report high levels of social support are instrumental in attracting others and building an effective network of supporters. By contrast, individuals low in social competence may alienate others, or may not know how to communicate their needs (Hobfoll, 1985). Finally, personal characteristics such as negative beliefs about the utility or propriety of help-seeking may limit the utilization of support that is available from others (Eckenrode, 1983). As stated earlier, social support serves as a mediator between the individual’s personality and health outcomes in this model. The individual’s personality affects the extent to which, social support resources are available, which in turn affects the individual’s health outcomes.

Another view of apparent links between social support and positive health outcomes is that both are the result of some unmeasured variable, such as low neuroticism, self-confidence, or good coping skills (Repetti, 1987; Rook, 1984; Henderson, Duncan-Jones, Byrne, & Scott, 1982). As expressed by Reis (1984, p. 26), “Good health and good relationships are more likely in competent people.” In this view, no causal relation exists between social support and health. Their association is simply due to their mutual link to a third causal variable. Although further research is needed to evaluate the feasibility of this model, Cohen et al. (1986) found that among college students, the stress-buffering effect of social support was not eliminated when relevant personality characteristics (e.g., social competence) were statistically controlled (Cutrona & Russell, 1987).

Studies investigating personality and perceived support have found that perceived support is (a) as stable over time as traditional personality characteristics (I.G. Sarason et al., 1986), (b) associated with social competence recollections of parental care (I.G. Sarason et al., 1986), (c) as highly correlated with measures of
self-referent cognition as these latter measures are with each other (Lakey & Cassady, 1990), associated with a positive bias in the evaluation of supportive behaviours and persons (Drew et al., 1995; Lakey et al., 1992; Pierce, Sarason, & Sarason, 1992; B.R. Sarason et al., 1991; Lakey & Cassady, 1990). In addition, the development of perceived support in new settings is strongly predicted by person variables such as negative affectivity and social competence (Lakey & Dickinson, 1994; Lakey, 1989). Although evidence has begun to accumulate that perceived support has some properties similar to individual-difference variables, there are problems with these models as well. For example, although several studies have found that persons with high perceived support tend to interpret the same supportive stimuli more favorably than do participants with low perceived support, these effects have accounted for only a minority of the variance. Furthermore, it seems unlikely that any personality characteristic is completely separate from the social environment. Thus, personality models of perceived support need to articulate how perceived support is rooted in the social world.

As Cutrona (1989) cautioned, however, most investigations of the relationship between personality characteristics and social support have been correlational. Thus, the association between facets of personality and social support are “vulnerable to a number of alternative explanations of the obtained results” (Cutrona, 1989, p. 723). In distinguishing the different influences personality characteristics may have on aspects of social support, Cutrona (1989) posited three interpretative perspectives: the first perspective asks if personality characteristics differentially influence the perception, or cognitive appraisal of social support, regardless of environmental and social network characteristics. Thus, given the same objective level of structural social support (e.g., social role and network size), the perception of support may vary as a function of individual differences in personality characteristics. A second perspective asks if personality characteristics are antecedents of social network characteristics, as well as the dynamics of interpersonal exchange. For example, an individual who is extraverted and outgoing in nature may shape the behavior of others, thereby developing a larger social network and obtaining more social support than one who is shy and resigning. A
third perspective pertains to the effect of social support and personality characteristics on health and well-being. This perspective asks if personality characteristics act as a third variable in relationships involving social support and health and well-being. Accordingly, as described by Cutrona (1989), good coping skills or adaptive strategies may lead to the perception of adequate social support and healthful outcomes, but the link between social support and processes and health and well-being may be spurious to the extent that it is mediated by personality characteristics. Conceptually, however, extraversion may be an important and concurrent influence on both structural and functional aspects of social support (S. Cohen & Syme, 1985). That is, one’s predilection to be extraverted may influence and shape both structural aspects of social support (e.g., the number of people in the social network, frequency of social contact, and the type of interpersonal role each network individual plays) and functional aspects of social support (e.g., receipt of pragmatic aid and assistance, empathy, and feelings of affection, belonging, and esteem). Indeed, as Cutrona (1989) indicated, “dimensions of personality that are associated with successful construction of a supportive social network require further study. Causal models that include both personality dimensions and dimensions of the objective social environment should be constructed and tested in future research efforts in this area” (p.730).

Depression in Relation to Stressful Life Events

The idea that stress can precipitate illness is part of our common folk wisdom. The relationships between social, psychological, and other environmental factors and illness have been of research interest to medical and social scientists for a long time. This interest has accelerated in recent decades as investigators from a wide range of disciplines have attempted to identify the processes by which stressors act as precursors to physical and/or mental disorders. Although there have been almost as many definitions of stress as there have been researchers, there is a common theme in them. Stress is generally conceptualized as the altered state of an organism produced by agents in the psychological, social, cultural, and/or physical
environments. It is assumed that this altered state, when unmitigated, produces deleterious effects on the physical and/or mental well-being of affected individuals.

Among medical scientists, the early work of Cannon (1928) was very influential. His pioneering efforts to detail the relationships between emotional states such as fear, anger, pain, and anxiety and changes in body function provided a model for early scientific inquiry. In psychiatry, Adolf Meyer (1551) emphasized the role of life events in the development of physical and mental disorders, and Selye’s work (1950, 1956) has made very important theoretical contributions to our understanding of the physiological adaptations to stress.

Hinkle & Wolff (1957); Hinkle (1974); and Wolff & Wolf (1950) working in area of psychosomatic medicine also made early contribution as they investigated the links between stressors and illness. Recently, many researchers have attempted to establish the qualitative and quantitative relationships between particular classes of life events and illness behavior. Stressful life events consistently have been found to be related to psychological problems in both normal individuals and identified patients.

Stressful events and ongoing strains are seen to influence depression directly, as well as indirectly, through their impact on coping responses and family support. Similarly, coping responses are seen to influence severity of depression directly, as well as indirectly, via their impact on family support (Cf. Mitchell, Cronkite, & Moos, 1983). Life events have been shown to be associated with the onset of depression. In both cross-sectional and longitudinal studies of patient and community groups, people who experience more negative life events are likely to display greater levels of depressive symptoms (Dohrenwend & Dohrenwend, 1981; Hendarson, 1981; Paykel, 1979).

The research findings dealing with stress and illness are voluminous, comprehensive, and broadly published. The efforts of Henderson C 1981); Dean, Lin, & Ensel (1981); Lloyd (1980); Paykel (1979); Warheit (1979); Brown & Harris (1978); Pearlin & Schooler (1978); Ilfeld (1977); Lazarus & Cohen (1977); Brown Ni Bhrolchain & Harris (1975); Dohrenwend (1974); Brown, Harris, & Peto (1973);
Paykel, Prusoff; & Uhelenhuth (1971); Myers, Lindenthal, & Pepper et al. (1972); Paykel, Myers, Dienelt, Klerman, Lindenthal, & Pepper (1969); Brown & Birley (1968); Rahe (1968); and Holmes & Rahe (1967) are particularly well known. Paykel, Myers, Dienelt, Klerman, Lindenthal, & Pepper (1969) found that depressed patients reported three times as many life events as a control group in the six months before the onset of a depressive episode; in particular, there were significant increases in life events categorized as exits from the immediate social field of the subject and in events categorized as undesirable. Brown & Harris (1978) also reported a significant increase in life event in depressed women, suggesting that the social environment plays a crucial role in the etiology of depression.

Depressive disorder in a first-degree relative, early parental loss, unemployment and lack of a good marital relationship before onset are thought to be risk factors for the development of reactive depression, and it has been suggested that living alone, low self-esteem, and personality factors may also be risk factors for depression (Roy, 1980,1981a,b). While, Tennant, Bebbington, & Hurry (1981) have criticized the evidence for a substantial causal relation between life events and depressive disorder, Lloyd (1980) concluded that “life events play a precipitating role in the development of depressive disorder.”

Ilfeld (1977) explored the relationship of current social stressors (circumstances of daily social roles that are generally considered problematic or undesirable) to depressive symptoms. Subjects were 2,299 adults aged 18-65 in the Chicago area. Over a forth of the variance in depressive symptoms is accounted for by five social stressors. Depression is most closely related to the social stressors of marriage and parenting, and symptoms increase proportionately to the total number of stress areas, these data suggest that a focus on intervention and prevention in areas of family and marital life is desirable.

Warheit (1979) examined the relationships between life events, coping resources, and depressive symptomatology and analyzed these same variables within the context of longitudinal data that permit comparisons of depressive symptomatology before and after the occurrence of 23 loss-related life events. A
probability sample (N=517) was interviewed three years apart. Respondents with high life-event scores had significantly more depressive symptomatology than those with low scores. Those, with personal, familial, and interpersonal resources had disorder in schizophrenic out-patients well controlled by neuroleptics may occur in those who are at risk for depression and experience an excess of life events. In conclusion, this study points to the need to look more closely at the importance of predisposing and precipitating factors in the aetiology of depression in schizophrenic patients. In particular, it suggests that the chronic schizophrenic out-patient whose schizophrenic illness is well controlled by neuroleptics may be at risk for depression if he had several admissions, has been depressed and treated for depressive disorder in the past, has attempted suicide, is living alone, has low self-esteem, had early parental loss, and had recently experienced undesirable life events.

Kennedy, Thompson, Stancer, Roy, & Persad (1982) studied life events precipitating mania. A consecutive series of 20 manic patients admitted to the Affective Disorders Unit, Clarke Institute of Psychiatry, Toronto, between July 1, 1979 and December 31, 1980 were studied. A study of 20 manic patients, with patient and matched control comparisons, showed a two fold increase in life events during the 4 month period before admission to hospital.

Mitchell, Cronkite, & Moos (1983) conducted an investigation to study stress, coping, and depression among married couples. Community couple (N=157) and couples in which one of the partners was clinically depressed (N=157) were studied within the framework of an expanded stress-illness paradigm that encompassed life events, ongoing strains, coping responses, family support and depression. Depressed patients were found to be at a disadvantage relative to control subjects at each point in the stress process; they experienced more stress and possessed fewer of the personal and social resources that might moderate its impact. Spouses of patients fell between their depressed partners and the control subjects in their, levels of stress, coping and family support. The overall pattern of effects involved in the stress process was similar across patient and non-patient populations. Negative life events, coping, and family support were primarily directly related to depression, whereas
strains exhibited some indirect effects through their relationship with lack of family support.

Billings, Cronkite, & Moos (1983) emphasized that there is a need to examine the role of a wider range of social-environmental factors in depression since there is only a moderate association between stressful life events and depression. They examined the role of stress and coping factors in depression by comparing a group of 409 men and women entering psychiatric treatment for unipolar depression with a socio-demographically matched group of 409 non-depressed men and women. In addition to reporting significantly more stressful events than controls, depressed persons also experienced more severe life strains associated with their own and their family members' physical illness, their family relationships, and their home and work situations. Depressed persons were less likely to use problem-solving and more likely to use emotion focused coping responses and had fewer and less supportive relationships with friends, family members, and co-workers: These group differences were consistent for both depressed women and men.

Roy-Byrne, Geraci, & Uhde (1986) examined the number, type, and effect of life events during the year before the onset of panic attacks in 44 patients with a Research Diagnostic Criteria diagnosis of panic disorder and 44 healthy control subjects matched for age, sex, and time of retrospection. The patients had significantly more life events, and these events had a more adverse impact on them. Furthermore, the types of events experienced by the patients were more typically distressing than those experienced by the control subjects. The patient's reported events involving moves to other neighborhoods and/or cities more frequently than did the control subjects. Although such events have been consistently linked to depression, they have played only a modest role in predicting the onset and severity of depressive symptoms (Billings & Moos, 1982; Tausig, 1982).

**Depression in Relation to Life Events & Cognitive Vulnerability**

Although both the Beck (1972), and the Abramson, Seligman, & Teasdale (1978) models propose that cognitions interact with life events to produce
depression, only few studies (Parry & Brewin, 1988; Persons & Rao, 1985; Metalsky, Abramson, Seligman, Semmel, & Peterson, 1982) explicitly models this interaction. Persons & Rao (1985) conducted a longitudinal study of cognitions, life events, and depression in psychiatric inpatients. They argued that Beck (1972) and Abramson, Seligman, & Teasdale (1978) models of depression predict that stressful life events interact with certain types of cognitions (irrational beliefs for Beck’s model, attributions for the Abramson et al. model) to produce clinical depression. Life events, irrational beliefs, attributions, and depression were measured in psychiatric inpatients when they were admitted to the hospital (N=49), when they were discharged (N=32) and seven months later (N=20). Results of a multiple regression analysis showed that severity of depression was related to irrational beliefs, attributions, the interaction of attribution, the interaction of attribution X life events and the interaction of attribution X session. There was no relationship between depression and the interaction of irrational beliefs X life events. The attributions X session interaction indicates that the relationship between attributions and depression changed over the period of time studied; the relationship between irrational beliefs was stable over time. Attribution and irrational beliefs changed over the period of time studied, indicating that they are not stable, unchanging aspects of personality.

In another study by Parry & Brewin (1988) three models of the relation of negative cognitive style to depression were outlined; (1) a symptom model, where negative cognitions are a symptom of depression, (2) a vulnerability model, where a negative life-event in combination with cognitive vulnerability leads to depression and (3) an alternative aetiologies model, where depression can be precipitated either by stressful life-events or by a negative cognitive style. Differential predictions from the three models were examined in data from a general population survey of 193 mothers where a reliable case identification procedure and life-events interview was used together with measures of attribution style and self-esteem. Results were mostly consistent with the alternative aetiologies model, but also gave some support for the symptom model. In some cases, negative cognitive style may act to increase the risk of depression onset in the absence of life-event stress.
Another study, life events vulnerability and onset of depression (Brown, Biffulco, & Harris, 1987) examined 400 working-class women with a child at home and living in an Inner-city area (Islington, North London). These subjects were selected since research had suggested that they are particularly likely to develop depressive disorders (Brown & Harris, 1978). As a whole the findings of course underline the importance of social environment and cognitive factors in the importance of social environment and cognitive factors in the aetiology of depression. They also offer some support for the conclusion of the earlier research in Camberwell that it is the meaning of particular events that tends to be crucial for depression and that, in so far as generalized hopelessness plays a role in the aetiology, it often stems from a highly particular set of circumstances (Weissman & Myers, 1978; Comstrock & Helsing, 1976, Meile et al. 1976; Radloff, 1975; Dohrenwend & Dohrenwend, 1974; Dupuy et al. 1970).

1. Gender Differences

Over the last quarter century, great advances have been made worldwide in improving all aspects of female lives; yet, women continue to lead complexly difficult lives. Globalization and international capitalism portray the pathological differences between the comforts of the first world woman and the widespread exploitation, dismal social and general living conditions of the third world woman. This blatant disparity led Dr. Mahbub-ul-Haq in the “Human Development in south-Asia, 1997” (WHO, 1997) to say --- “To be a woman in this region (south-Asia) is to be a non-person!!”

According to UNDP (1995) Women constitute more than 70% of the world’s poor and carry the triple burden of productive, reproductive and caring work. Based on all available data, UNDP (1997) concludes that “no society treats its women as well as its men”. Comparing and analyzing the socio-cultural and economic background of the female natives of South-Asia in the context of psychiatric disorders brings forth interesting revelations and peculiarities of the suffering of the women in this region. The women in the region continue to suffer manifold in comparison to their male counterparts as stated in a study by Mumford et al. (1997). Depression
and anxiety was found to be present in 46% of women compared to 15% of men. The problem is further highlighted by the impact it has on the society as a whole. Estimation of Global Burden of Disease indicates that univocal depression among women will be the second most important cause of disease burden by the year 2020! (Murray & Lopez, 1996). It has been projected that problems are bound to increase in coming times. By 2020, univocal major depression alone will account for 8.62 of all DALYS for women. The most disturbing fact is that the impact would be felt by women in their productive years, particularly between the ages of 15 and 44 (Thara and Patel, 1998). The study of various factors and their outcomes may help to develop fruitful strategies by common workforce to create logical solutions.

2. Demography, social status and cultural background

The countries grouped under the umbrella of South-Asia are India, Pakistan, Sri Lanka, Nepal, Bangladesh, Maldives and Bhutan. The majority is located in the Indian subcontinent. A total of approximately 2 billion people reside in the region, out of which nearly 860 million are females i.e. about 48% of native population is female. More than half of the females of the region reside in India. Women, whether they are from Pakistan, the Philippines or India all have similar problems related to domestic and sexual violence, gender discrimination, poor education and health, orthodox customs, and lack of awareness about the use of health services, probably due to differing conceptualizations of common mental disorders in these populations (Jacob et al., 1998). Additionally, a cultural barrier in health care exists across South-Asia as majority of people generally does not discuss personal, physical or mental problems with anyone outside the family. Often, shame and guilt are used to enforce norms in the family (Gosh), which may lead to mental distress.

Various factors play for the condition of the women in South Asia. While, traditional roles of women in these societies expose them to greater stress, they are also less able to change to their stressful environment because of lack of education and support. The factors which further add to the problem are associated poverty, hunger, malnutrition overwork, domestic and sexual violence. The females in this region continue to have expanding and conflicting roles, face significant sex
discrimination and bear the burden of care for the ill within the family (Gosh, Bhugra, & Desai, 2002).

The subjugation of women is a common theme in South-Asia. They are unwanted before birth, as reflected by increasing use of prenatal sex determination and pregnancy termination leading to decreasing male to female ratio. Being a baby girl is a disadvantage entailing a childhood of drudgery that is deprived of education, food and status. There are many child marriages followed by seclusion. The concept of ‘Purdah’ or seclusion, female pollution in terms of sexuality is even more depriving (Gosh). They live in poor health and are uncared for in pregnancy. This cycle of malnutrition is continued with limited family planning measures and frequent childbirths. In addition, they are overworked and unappreciated, working as ‘invisible’ producers, under a shadow of violence throughout their lives. Violence is present in almost all aspects of life and has reportedly been on the rise (Thara and Patel, 1998).

Most South-Asians follow one of the various religious faiths: Islam, Hinduism, Sikhism, Christianity or Buddhism. Religion tends to be considered a natural part of life and most cultural traditions have a religious significance by which people judge themselves and other. The majority of the population is Muslim in Pakistan and Bangladesh. Aggregate-wise, the largest number of Muslims resides in India. Hindus are the predominant population in India and Nepal, while Buddhists or the majority in Sri Lanka and Bhutan. Despite the diversity in South-Asia, the prevalence of many common cultural elements in the region often leads to a more or less similar condition of females in the region.

Islam emphasizes the equality of the all people, and, according to the teachings of Islam, men and women is equal in the eyes of God. Among orthodox Muslims, women are strictly secluded from men; in these societies, women may have little contact outside of the home. Muslim women are often presented as passive, helpless recipients of harsh treatment. Divorced women in Arab societies suffer emotionally and socially (Tumush, 1989). The expression of conflict, whether internal or external, and the expression of negative feelings are not well accepted in
the Muslim culture. Women are perceived as “physically and mentally weak” in comparison to men (Attir, 1985). Ethnic Arab women, particularly in Muslim society, have been viewed as “powerless, subservient, and submissive” (Al-Haj, 1987). The male is the leader and highest authority in the household, the economy, and the polity (Al-Krenawi et al., 1996; Morsy, 1993). A Muslim woman’s physical symptoms are accepted as legitimate and morally acceptable expressions of pain, as pointed out by Bazzouki (1970). Muslim culture condemns suicide, and clients may not divulge suicidal feelings easily. If asked directly about thoughts of killing themselves, most depressed patients reply that they are good people and would never entertain such thoughts (Dubovsky, 1983). Although the wish to die is not uncommon among people with depression in Muslim cultures, it usually remains at the level of wishing that God would terminate their life, and does not progress to the wish to kill themselves (Fakhr el Islam, 2000).

Buddhism, a monastic religion, teaches that right living will enable people to attain Nirvana, the condition of the soul that does not have to live as a body and is free from all desire and pain. The underlying principle of all Buddhism is belief in reincarnation of the soul. Women are considered inferior as there is a notion that a woman must wait a rebirth as a man before she can attain Nirvana.

Hinduism is defined by a wide variety of beliefs held together by an attitude of mutual tolerance, and by the characteristically Hindu conviction that all approaches to God are equally valid. The individual Hindu is, in effect, free to believe or disbelieve what he wants. He regards his religion as a total way of life. Although females are said to be given equal status, males are still assigned a higher status than females. Males are considered the authority, the heirs of the family, and the leaders while females are usually considered to be docile, tender and introverted.

Regardless of the religion, the condition of women is more or less the same. Religion however, should not be considered as a factor behind the problem in females. In fact, religion at times may help to resolve psychological problems and bring solace to people in times of distress.
3. Mental health of women: the determinants in the region

The social milieu, one of the most important determinants of health is characterized by poverty, over-crowded living conditions, unemployment, job insecurity and inequity, a growing number of broken marriages, man-made and natural disasters and wars. A study showed that women with lower levels of education had an increased risk for psychiatric disorder – nearly 66% of women and 25% of men suffered from depression and anxiety disorders (Mumford et al., 1997). Evidence on the specific effect of social factors on mental disorders bears an important role. Data obtained from primary care attainers in Goa (India), showed significant associations between high rates of depression, anxiety and somatic symptoms and female gender, low education and poverty (Patel et al., 1999).

Ethnic and gender violence leads to increased vulnerability to neuropsychiatric disorders as women are more prone to these risks. This is reflected in females in rural areas of these regions (Mumford et al., 1997). Gender-based violence is a significant predictor of suicide in women with more than 20% of women who have experienced violence attempting suicide (Stark, 1996). Gender-based violence is not a lesser known phenomenon; incidences are reported in a significant number and many more of them go unreported due to the interfamilial nature of violence. Violence against women constitutes a major social and public health problem, affecting women of all ages, cultural backgrounds, and income levels. A lifetime prevalence of domestic violence ranges between 16% and 50% for sexual violence (Violence against women, Geneva, WHO, 1997). Widely recognized as a growing public health problem, 50% of women have been physically abused by their partners and half of the abused have been raped by their partners (WHO, 1997). Violence – physical, sexual and psychological – is related to high rates of depression and co-morbid psychopathology, including posttraumatic stress disorder (PTSD), dissociative disorders, phobias, substance use, and suicidality (Roberts et al., 1998). Studies have also stated relationships between domestic violence and contemplation of suicide. Studies on suicidal patients showed that majority of the patients were married women and the major source of conflicts was conflict with husband (80%)

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and conflict with in-laws (43%) (Khan & Islam, 1996). Another study in the region points that among suicide attempters, 70% of them were victims of violence (domestic violence, assault sexual harassment and rape) and 80% cited marital or family conflicts as reasons behind violence (Niaz, 2001). Globalization and economic reform are showing its negative impact on the females of the South-Asian region in the form of a rise in the incidence of reported domestic violence (Subramaniyum, 1999). The understanding of exact psychopathology behind the violence is difficult to identify; however, an approach towards its construct can be attempted. The interplay between various factors, biological determinants, intra-psychic determinants, behaviorist positions and cognitive approaches are said to make up the underlying mechanism. Knowing the specific redressers is desirable in order to deal with this multifactor problem.

The differential understanding of mental disorders among families further jeopardizes the mental health status of females. There is existence of clear evidence of stigma among family members of patients with severe mental disorders (Crisp et al., 2000; Wahl, 1999; Phelan et al., 1998; Wahl & Harman, 1989). Among one of the studies in this regard, 27% of the respondents attributed mental illness to supernatural forces, 14% suggested psychosocial factors were of major importance, and 5% thought substance abuse was a major factor (Shibre et al., 2001). Female and young ages were associated with higher stigma among both patients and caregivers in a recent study from an urban area in India (Thara & Srinivasan, 2000); only a few differences were identified in different socio-demographic groups in this study. Irrespective of class, the concept of mental illness is stigmatizing and an attempt to undermine it with a more socially accepted basis is the primary approach. This problem can get further accentuated when the patient is a female as they are often regarded as second grade citizens and denied basic health care (Thara & Srinivasan, 2006; Davar, 1999; Malik, 1993).

Overview

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

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

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

2. A vast quantum of research has been done to examine cognitive theories of depression.

3. There is overwhelming evidence that affective disorders represent a diagnostically heterogenous group of disorders (Hirshfeld, Klerman, Clayton, & Keller, 1983; Klerman & Rorrett, 1973). The problem is that diagnostic terms, such as neurotic depression, have a variety of definitions and therefore include different patient samples (Akiskal et al. 1979; Klerman et al. 1979). Similarly, dependency, melancholia, and other personality attributes mean different things to different clinicians. As a result, different qualities have been assessed in varying populations and described using the same terms, obviously leading to inconsistent conclusions. Psychological and sociological attributes associated with one type of depression may differ from those associated with another type.

In the present study the diagnostic heterogeneity was reduced by restricting the study to nonclinical, random sample of college students showing depression tendencies/ dysthymia (i.e. depressive symptoms, rather than depression as a psychiatric disorder). Nonetheless, there is evidence that depressive tendencies are continuous with major depressive disorders (Hirschfeld & Cross, 1982; Blatt, D’Afflitti, & Quinlan, 1976) and that
individuals who manifest depression early in life develop clinical depression or other psychological problems later on (Peterson et al., 1987; Kandel & Davies, 1986; Kavacs, Feinberg, Crouse-Novack, Palauskas, & Finkelstein, 1984; Strober & Carlson, 1982).

4. A number of demographic variables have been found to affect psychological well-being, among them age (Roberts et al. 1981; Finlay-Jones, & Burvill, 1977; Comstock & Helsing, 1976; Dupuy et al. 1970); income (Roberts et al. 1981; Blazer & Williams, 1980; Weissman & Myers, 1978; Comstock & Helsing, 1976; Dupuy et al. 1970); education (Roberts et al. 1981; Weissman & Myers, 1978; Comstock & Helsing, 1976; Dohrenwend & Dohrenwend, 1974; Dupuy et al. 1970), and sex (Boyd & Weissman, 1986; Weissman & Klerman, 1977; Boyd & Tudor, 1973). These variables have been taken care of in this study. Moreover, the majority of the subject belonged to upper-middle/middle class.

5. The last decade has brought forth a proliferation of research examining psychological aspects of depression. This growth in research productivity, however, has been accompanied by a change in subject samples. Prior to 1970s, the majority of the patients were used in testing models and theories of depression. Since that time, however, most of the studies in this area have used mildly depressed on the basis of their scores on the Beck Depression Inventory. The working assumption of most of these depression in university students serves as a usual analogue to clinical depression in psychiatric patients. An article by Depue and Monroe (1978) is representative of the growing concern by clinical researchers over this widespread use of students in psychological studies of depression. At the heart of the unease is, of course, the question of generalizability.

Furthermore, recent studies have critically questioned the facility with which clinical researchers have relied on self-report inventories, such as the Beck Depression Inventory to select "mildly depressed" college students. One important issue that has emerged clearly is the difficulty in
differentiating depression from other negative psychological states, such as anxiety, as measured by self-report questionnaires. These findings obviously cause interpretive problems for research involving self-report scales and suggest that they offer little help in differential diagnosis.

Majority of the investigator have reached these conclusions on the basis of using only Beck Depression Inventory. In a meta-analytic comparison of different rating scales as measures of treatment outcome, Lambert, Hatch, Kingston & Edwards (1986) concluded: “Scale content”*, methods of response collection, populations under study and treatments being used all have a bearing an outcome” (p.58). Thus, it was considered desirable to include in the purview of this study the two frequently employed self-report instruments of depression: the Beck Depression Inventory and the Zung Self-Rating Depression Scale, to ascertain the nature of depression as revealed by self-report instruments.

6. 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

Different depression scales do not yield similar results.
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 aspects of self esteem.

In the context of the salience of negative cognition in depression, the present study would make an attempt to examine the intervening role of negative cognition in the effect of social support and body image on depression.

**Hypotheses**

The study starts with the following hypotheses:

1. It is hypothesized that a negative cognition would be positively correlated with depression for both males and females. This hypothesis derives its rationale from several studies reviewed earlier with respect to the role of dysfunctional cognitive patterns in the development and maintenance of depressive symptoms in both males and females.

2. Depression would be associated negatively with social support in both males and females. This hypothesis derived its rationale from the earlier researches which have revealed that either through direct protective effects or by buffering the adverse consequences of life stresses, social support is associated with a decreased likelihood of developing depressive disorder.

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

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

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

   The earlier researchers clearly show that although depression is quite prevalent in the adult population its existence during childhood, though now recognized, is relatively uncommon. Somewhere between childhood and adulthood, its prevalence is assumed to increase dramatically (Rutter, 1986; Rutter, Graham, Chadwick, & Yule, 1976). Moreover, Weissman & Klerman (1977) pointed out that girls do not appear to predominate among the depressed very early in the life span, yet, woman clearly are preponderate among depressed young adults (Lewinsohn, Duncan, Stanton, & Hautzinger, 1986).

   Further, the following four sets of findings deserve attention with respect to the hypotheses mentioned above. Firstly, adolescence is a more stressful developmental period for girls than for boys (Hops, Sherman, & Biglan, 1989; Rutter, 1986); secondly, it is during adolescence that girls begin to report lower body image than boys (Simmons, Rosenberg, & Rosenberg, 1973), thirdly, girls reported higher self-consciousness than boys (Rosenberg & Simmons, 1975); and fourthly, with menarche girls tend to drop culturally prescribed masculine attributes (Hill & Lynch, 1983) associated with lower depression.

5. The relationship of depression with social support and body image would be moderated by negative cognition.