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A Study on Depression in Adults as Related to Sex, Socio-Economic Status and Residential Background

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A STUDY ON DEPRESSION IN ADULTS AS RELATED TO SEX, SOCIO-ECONOMIC STATUS AND RESIDENTIAL BACKGROUND.

A Thesis submitted for the degree of
M.Phil

In Psychology
BY

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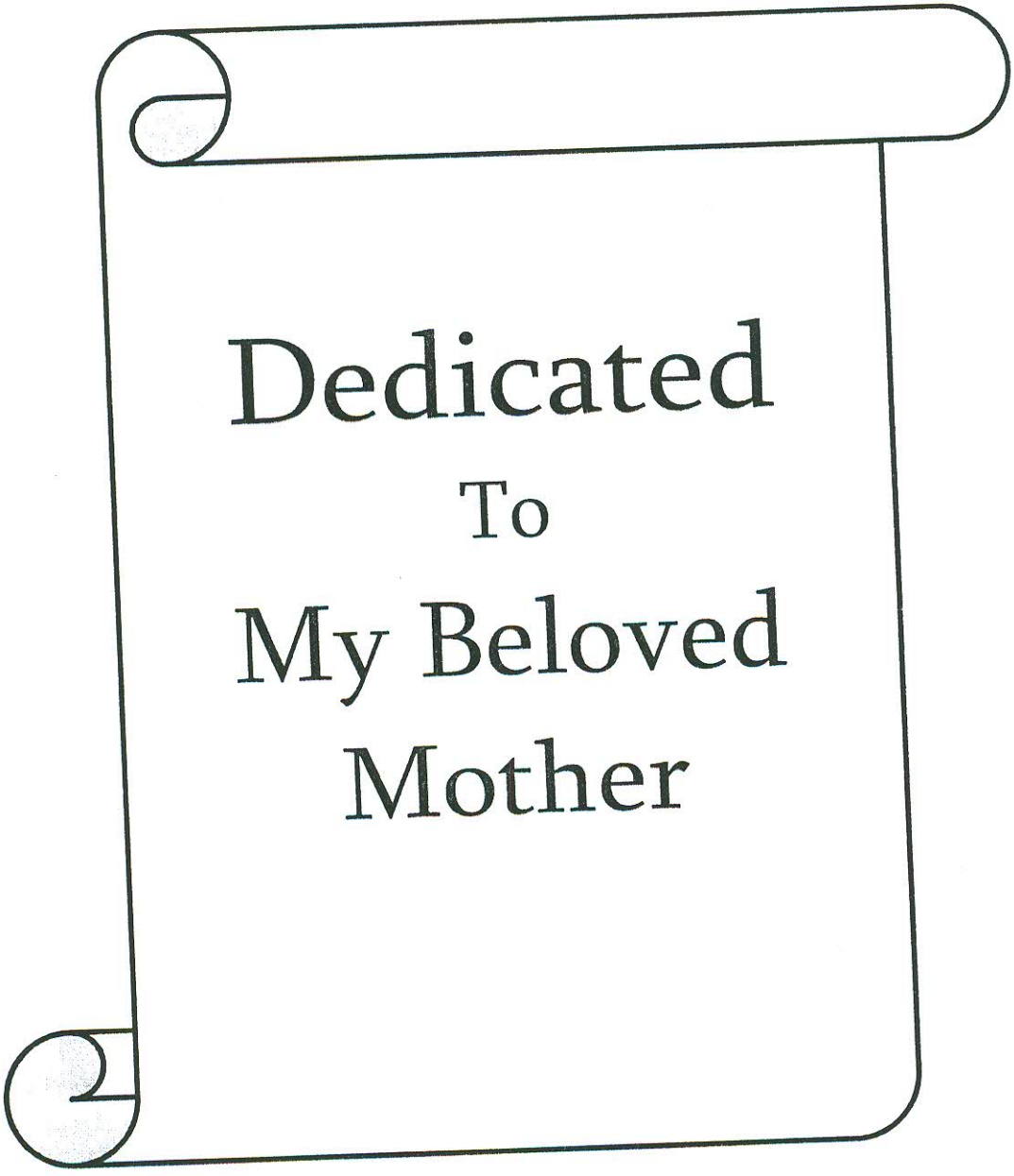
Dedicated
To
My Beloved
Mother

DECLARATION

It is my humble declaration that this dissertation for the degree of Master of Philosophy in Psychology entitled "A study on depression in adults as related to sex, socio-economic status and residential background." is a completely new and original work of mine. Furthermore, this dissertation has not been submitted before to any other University or Institute for any degree or diploma.

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CERTIFICATE

It is my great pleasure to certify that this dissertation entitled "A study on depression in adults as related to sex, socio-economic status and residential background." has been conducted by Md. Mizanur Rashid for the degree of Master of Philosophy in Psychology. He has completed this thesis under my supervision and it constitutes his own work. I have read the thesis thoroughly and pointed out required corrections and changes. I found Md.Mizanur Rashid to grasp my thought and critical evaluations correctly and have made appropriate alterations to my satisfaction. I recommend the thesis for submission in the University of Rajshahi for the M.Phil degree in Psychology.

Supervisor

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ABSTRACT

This study deals with depression in adults. The independent variables were gender, socio-economic status and residential background. The dependent variable was amount of depression expressed by the males and females with reference to their socio-economic status and residential background. A total of 240 respondents constituted the sample of the present study. They were equally divided into males and females. Each subgroup was equally divided into high, middle and low socio-economic status. Each category was then equally divided into urban and rural on the basis of residence.

The study described several theories of depression. These were (i) Learned helplessness theory, (ii) Defective social skill model, (iii) Development process model, (iv) Social class vulnerability model, (v) Cognitive model and (vi) Self-Control model. These theories of depression provided adequate explanation about the causes of depression. Relevant literature was also reviewed with proper care. Previous findings provide empirical support in favor of the present investigation.

The study was based on several objectives. These are as follows:

(1) To highlight the stage of life span as adulthood and to provide on analytical presentation of depressive affects in these stage of life span.

(2) To provide a theoretical construct of depressive affects as mental disorder in the life style of old generation in Bangladesh.

(3) To reflect on various agentic factors of depression for a comprehensive understanding of the phenomenon of depression.

(4) To make a short review of previous empirical studies in its multi-facet aspects of depression.

(5) To focus on gender discrimination in depressive affects. Thus depressive affects have been accumulated for empirical verification and analytic presentation of depressive disorder.

(6) To study depressive affects in adult population as a function of high, middle and low socio-economic status.

(7) To focus an residential background in terms of urban and rural origin as independent variable leading to the growth of functional inability and emotional instability and old age flexibility in the form of depressive affects.

(8) To make a profile of relevant predisposing and precipitating factors associated with depressive mode of the adults in the social context of Bangladesh.

(9) To survey the adult population in Bangladesh with reference to their old age problems, depressive affects and situational condition at homes.

(10) To examine the empirical data relating to adult depression using statistical concepts and techniques.

The present study was explorative in nature. In site of this several specific hypotheses were formulated. These are given below:

H1: Female respondents would express more depressive affects than the male respondents at their adult stage of life span

H2: Respondents with low socio-economic status would express higher depressive affects followed by the respondents with middle socio-economic status and least by the respondents with high socio – economic status in the life cycle of adulthood.

H3: Respondents with rural residential back ground would express more depressive affects than the respondents with urban residential background

The study used Depressive Experiences Questionnaire for collection of data. A 2x3x2 factorial design involving two levels of gender (male / female), three levels of socio-economic status (high / middle / low) and two levels of residential background (urban / rural) was used in the

study. The results were computed using analysis of Variance (ANOVA). The results provided support to all the hypotheses. It was found that females expressed more depression than males. Again, respondents with low socio-economic status expressed more depression than the respondents with high and middle socio-economic status. Lastly, respondents from rural residential background expressed more depression than the respondents from urban residential background.

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Introduction

Introduction

Depression constitutes the sad times of our lives. When our self-esteem is threatened and we fail to attain our goals, we become frustrated leading to depression. Depression affects the whole entity of the individual. Depressed person withdraws himself from the external world and concentrates within himself. He can not think logically and systematically. He is surrounded by hopelessness, and helpless conditions haunt him constantly. The present study would reflect on depression in adult as related to sex, socio-economic status and residential background in the context of Bangladesh.

Causes of depression

Most important causes of depression might be helplessness and hopelessness. Being frustrated many times is surely depressing. Seligman (1975) studied escape learning and found that dogs, forced to stay in a box where they were repeatedly shocked, soon gave up and stopped trying to escape. Moreover, 65% of the dogs did not try to escape the next day when the box was modified so they could easily escape. They just laid down and whined. They had learned helplessness. Selingman

said human depression with its passivity and withdrawal might be due to learned helplessness.

Carson and Adams (1981) found the helplessness theory of depression as inadequate. Many people in helpless circumstances do not become depressed. Moreover, this theory does not explain the guilt, shame and self-blame that often accompany depression. Consequently Abramson, Seligman and Teasdale (1978) gave the cognitive theory of depression. Thus they came to the rescue the helplessness theory. The helplessness theory was reformulated as attribution theory or cognitive theory of depression. According to this theory, the depressed person thinks the causes of depression as internal, stable and global. When the person feels that it is his own fault, it is internal causes of depression. When the person perceives that it can not be changed, it is stable causes of depression. When the person thinks that this affect is universal, it is global cause of depression

Costello (1982) showed that most depressed people see the causes of their depression as being outside forces and they do not blame themselves. Moreover, both the hopeless self-blamer and the hopeful self-helper see the causes of their behaviour and feelings as being internal.

Considerable research has supported parts of the hopelessness theory. For example, Metalsky Joiner

(1992) found that three cognitive views may be stated as follows.

a) Attributing bad events to unavoidable and far reaching causes.
b) Drawing negative conclusions about yourself from a negative event. It means I am worthless.
c) Assuming one bad event will be bad to others in the future, when combined with high stress, are associated with depression.

In another study, they found that low self-esteem was another crucial ingredient in order to produce depression. (Metalsk, Joiner, Hardin and Abramson, 1993). According to this new model of depression, it is said that depression might be avoided by reducing negative thinking habits, avoiding high stress and by building the structure of self-esteem. Segal (1992) found that recovered dependent depressives were plunged back into depression by a loss or conflict in interpersonal relationships. But self critical depressive relapsed when they failed at school or work. Thus the most dreaded problems seem to set of depression.

This new hopelessness theory explains depression to a considerable extent on the basis of pessimistic expectations of the future. Traditional thinking and

theories say depression is caused by obsessing about losses in the past. Selective perception of the past is also thought to be important. Thus self-critical people do not see their successes. Both back ward-looking and forward -looking theories are probably true. Some people regret the past and others dread the future and some do the both. It is likely that the negativism of some depressed people extents to the past, the present and the future. It pervades the whole entity of the individual.

Yapko (1992) stated that depression not only results from an "illusion of helplessness" but also from and "Illusion of control". For example, if a baby is taught that he could have good education, great job, wonderful family, nice house and car, fantastic travel etc, and in reality these were not true, then the baby would have an unusually high rate of depression. Thus unrealistic expectations in both directions can cause depression.

Beck (1973) developed cognitive theory of depression to identify cause of depression. He gave emphasis on negative views about the world. He stated that somewhere in childhood the depressed person develops a negative view of the self, the world, and the future. Each of the negative views gets expanded into detailed beliefs. These negative assumptions seem to be held on a very primitive level. Facts do not influence

these beliefs. So they never questioned and tested these beliefs against reality. These negative views just lie dormant even while more rational evaluations of self, world, and future may also be developed and used as we mature into adults. Then later in life, when the self is hit with some serious loss or stress, the old unreasonable and destructive negative ideas suddenly take over and dominate our thinking. Thus it is not the stressful triggering event that produces our depression. It is our negative ideas that produce our depression. The deeper the depression, the more the negative ideas replace rational thinking (Coleman and Beck, 1981).

Research has confirmed that sad-prone people notice the negative aspect of an event. (Carson and Adams, 1981). They remember their grief's but they forget the grief's of other peoples. They overlook what they do right. They assume too much of the responsibility when things go wrong. It has also been experimentally demonstrated that thoughts can influence feelings and behaviour. It is not just the depressive event that makes them sad. They remember and fantasize about the disappointing event in the past or imagine a similar thing happening in the future. Thus they create more and more depressive mood. It is true that remembering thought of negative cognition clearly accompanies depression but it has not been proved that

negative thinking is the exclusive cause of depression. Other factors may be involved in causing depression (Barnett and Gotlib, 1988).

According to Mowrer et al, (1975), guilt is an important source of depression. Depression-prone people are super aware of their wrong doing and they feel specially guilty. The feeling of guilty does not necessarily involve some highly immoral behaviour such as intense hostility or vile impulses. Guilty feeling may be the accumulation of many ordinary sins such as selfish acts, hurtful comments, just not thinking of others, doing inconsiderate things etc.

Some psychoanalysts and interpersonal therapists (Zaiden 1982; Brown and Harris, 1978) have looked into the history of depressive and found over- protective, indulging, overly involved or over-controlling and restrictive parents as the cause of depression. They found dependency as the source of depressive syndromes. A child who is dependent and has low frustration tolerance become desperate to have people like them. They are submissive, manipulative, demanding and so on. Before becoming depressed, they are described by therapists as "Love addicts perpetual state of greediness sending out a despairing cry for love" (Chodoff, 1974). Their self-esteem depends on the

approval of others. When their dependency needs are not met, they become depressed and cry, just as they did as infants.

An over-dependent depressed person may resist help and become hostile. Thus the loss of love is triple threat to a dependent person prone to depression. Thus sadness and panic occur because our vital, life-long struggle for security has been lost. Low self-esteem and hopelessness occur because the person has lost everything and he does not deserve anything. Anger and resentment occur because "they have deserted me, a helpless child." It means that you can not live with them and you can not live without them. This condition is the source of depression. Relationship such as marital problems and stress with children are the most common stresses associated with depression in women. Such relationship as good, caring, intimate etc. are the best protection against depression (Klermen and Weissman, 1982).

Thus the interpersonal, psychodyamic, and psychoanalytic therapists would say that explaining depression as a results of negative thoughts or a lack of social skills is superficial. The earlier theories foolishly ignore the life-long, internal struggle for love and survival. This theory sound very similar to the currently

popular feminists description of social pressures put on traditional women to give up their individuality. Evidence is accumulating for this kind of theory including relying on others for one's self esteem (Barnett and Gotlib, 1988).

Hirsch and Keniston (1970) study 31 dropout from Yale during the time of drug counter-culture, hippies, flower people and antiwar demonstrations. They reported that demanding parents who are critical, perfectionistic and harshly punitive tend to have anxious, withdrawn, and sometimes hostile children.

A critical problem with several theories is that the origin of the depression is not clear. They have pointed out that the previous theorists failed to locate the exact position of helplessness, negative views, irrational ideas, faulty thinking, self-criticism and low self-esteem. The same theory of depression can adequately explain these concepts. This theory conflicts identifies the origin of depression as early childhood experiences. Shame is the feeling of inadequate and inferiority. Shame is an inner torment. It indicates the feelings of cowardice, stupid, unloved, and worthless. It is the feeling of bad person.

The origin of shame is usually assumed to originated in our infancy or childhood. Shaming is used

for control by parents, friends, and society. Children are slapped and whipped, over powered and humiliated. All of these may make a child feel ashamed or depressed.

There is some data to support the shame- based theories. Andrews (1995) found that deep shame lies in women about their bodies. Thought of dissatisfaction are powerfully related to shame and they bring severe depression. If a female is physically or sexually abused as a child or as an adult, it increases the likelihood of depression four or five times. Moreover, childhood abused may cause shame about the body in women (Lisak, 1995).

The memory of our past, our childhood and adolescence form our identity or our basic sense of self. Because we have shame- based families and cultures, shame gets connected with many things, such as our basic drives, inter personal needs, feelings, and life purposes. We are deeply hurt and made ashamed of our needs for closeness and security. Whenever a basic bond is broken rejection abuse, neglect divorce or something over protection and over control. Sometimes shame is connected with our bodies, our lack of competence, our life goals. Also, emotion shame connection are made and we become ashamed of crying, anger, fear, and self-centeredness. In extreme cases, a person can become

shamed of his own evaluation as worthless. Thus shame is a powerful force of depression.

The feeling of shame may pass from parent to child. This is done by parents in a variety of ways. These are follows:

i) 1 `Verbal, sexual and physical abuse.
ii) Physical and emotional abandonment.
iii) Thinking of children as insignificant inferiors to be dominated and blamed or as persons to be controlled by threats of rage, disapproval and withdrawal of love. The shame person may engage in compulsive disorders, physical and sexual abuse, drug and alcohol addiction, anorexia-bulimia and obesity, sex addictions and addictions to certain feelings, intellectualisation, anti-social action out, and other personality problems, including multiple personality

Rehm (1977) found the lack of self-help skills as the basic cause of depression. It causes depressed people to over emphasize the negative, set too high standards, and give too little self-reinforcement.

Psyzczynski and Greenberg (1987) contended that depression is the inability to avoid focusing on one's self. D'zurilla and Nezu (1982) claimed that poor

interpersonal problem solving skills cause depression. The depressed people lack the following skills.

i) The ability to see alternative solutions.
ii) The ability to develop detailed plans for reaching a final goal and
iii) The ability to make decisions.

A sense of self-control is basic to these three skills. This way of viewing depression expands beyond the helplessness theory. It focuses on pessimistic attitude and it emphasizes the importance of skills and cognitive technique.

Mecoy (1982) found that sadness and its associated depressive symptoms can have many causes. Loss of valuable things and loss of loved persons are most important of them. Thus depression is a normal and natural reaction when we lose something we value. A friend or loved one dies and we grieve. A loved one leaves us and we hurt. We miss them and want them back. We fail to reach some important goal and we cry. Thus some teenage depressions may be listed as follows: i) death, ii) separation from a parent by divorce or work, iii) loss of friends by moving, iv) loss of love, v) loss of dependency and childhood by growing up, vi) loss of confidence, vii) loss of traditional value, viii) loss of health, ix) loss of

goal, x) poor communication with family, xi) family conflicts and xii) having depressed parents.

There are some genetic, physiological chemical causes of depression. Ancient drugs, like reserpine, cause depression. These are some causes depression. The environment is also a factor of depression. Like wise genetic factor clearly play a role in the serious forms of depression. Even proneness to minor stress and mood swings may be partially inherited and may be responsible for depression. Thus it is important to note that the causes of depression are complex and may be partially understood. Studies of identical twins fraternal twins, adopts, and several generations within a family, suggest that the general level of depression is partly inherited.

Kendler et. al (1993) estimates that genes account for 41% to 46% of the variance in depression. Clearly then depression runs in family. The genes and the family environment are both involved, but several studies find that it is individual specific environmental factors that influence depression and not shared family events Such as the death of a parent.

Ensel, (1982) observed that genes, environment and drug may influence depression. Current speculation is

that these factors influence the transmission of nerve impulses involving chemicals called neurotransmitters in the brain. Certain neurotransmitters such as norepinephrine or serotonin supposedly result in depression. These chemicals are responsible for Maria or over activity. Experimental findings on animals showed that helpless rats shocked repeatedly act depressed and loss their norepinephine. Weiss et al,(1974) reported that rats in a similar situation are able to turn off the shock themselves do nor get depressed not get deficient in norepinephrine.

Kocsis (1993) found that general adaptation syndrome is an important theory of depression. According to this theory there are several physiological stages of depression and stress. In the process of physiological stages, the person receives an alarm reaction and resistance is put on the body. Thus the general adaptation syndrome refers to exhaustion of the body. When the energy is exhausted, people feel tired and depressed. As a result, several symptoms of depression, physiological in nature, occur. These are poor sleep, poor appetite and poor sex drive. These are regulated by hypothalamus. In other words, the general adaptation syndrome theory of depression states that the malfunctioning of the hypothalamus may be regarded as the physiological cause of depression.

Eagan (1983) observed that there are some other physiology condition of depression. These are postpartum conditions, hypoglycemia, and premenstrual syndrome. It has been observed that premenstrual syndrome is a devastating problem for some women. Thus one woman was found be hospitalised 13th times for suicidal depression before someone noticed that each admission was one or two days before her period. It is estimated that 20% to 80% women experience increased tension, headaches, irritability and sadness prior to their periods.

The social learning theory of depression. (Lewinsohn and Arconad, (1981) proposes that depression is a result of an unrewarding environment and the person's reaction to it. The depressing environment may not be painful. In spite of that it may provide no pleasure and no positive reinforcement. Thus the whole environment may be depressing. Lewinsohn and his associates have shown that depressives respond slower to others. They do not get others to respond to them. Thus they get fewer social rewards and less fun than non depressed people. More importantly, depressed people arouse more anxiety, anger, depression, and rejection in others than the normal (Coyne, 1976).

According to Coyne (1976) there are four sequence of events that occur during depression. These are;

1) Some stressful events happen,
2) Depression -prone people need more social support and nurturance than others when under stress,
3) Depressed people have fewer social skills for getting the extra support. This Worsens the depression.
4) Depressed people start behaving in such a way that drives others away. This helps to maintain depression.

Mclean (1976) states that about 70% depressed people seeking therapy do not get required social support from their spouse.

Metalsky and Joiner (1992) studied the behavior of depressed students. The finding of the study reported that the depression per se is not capable to generate depression. In fact, certain behaviors by self depreciating depressed people may generate depression. For example, a person excessively seeking reassurance from other person may produce depression. This is true especially between males. For instant an empathic tolerant caring person would not be rejected more for seeking support. This is because they are supposed to be self reliant and suffer in silence. Depressed woman, on the other hand,

are rejected for personal reasons. In any case there is clear evidence that a depressed friend is depressing.

Ferster (1981) reported that the depressed person is so overwhelmed by their loss and anger that they can not respond effectively to the environment. This insensitivity may come from early feeding experience. A demanding infant may respond more to the internal urge to eat. In this case, making demands get reinforce. Like wise, the depressed persons becomes fixated on complaints, criticism, demands and loud cries of distress. All these behaviour are punishing or aversive to the listeners. Instead of seeking positive reinforcement, the depressed persons have learned punish and complain to others.

Folkman and Moskowitz (2000) found unpleasant negative emotions such as anxiety, fears, anger ,dependency and so forth may account for depression. These bad experiences accompany irritation of sad thoughts and feeling may be additional factors for the development of depressive affect. Thus the environmental factors may be regarded as the determinants of depression. In other words, depressed persons lack social and cognitive skills to increase positive reinforcement. Thus most emotional problems relating to depression originate in interpersonal relationship. The investigators concluded that a) perceived characteristics

of the upsetting situation, b) personality factors and c) social resources may be regarded as the precipitating causes of depression.

Dixon and Reid (2000) found that the lack of cognitive reappraisal or reforming or benefit finding may lead to depression. The depressed people find no hope in the situation. They explain the situation negatively. They fail to contribute the event. Depressed persons have more negative events and experiences.

Mallinger and DeWyze (1991) found that most of the depressed persons have perfectionist parent who feels badly if his/ her child fails. Then he pressures the child to make no mistake and be a " Little angel ". The child learns that making mistakes leads to the loss of love. Since the child's self- evaluation is based on what others think of him/her, it becomes important to be perfect all the time. As the child gets older, the standards are set higher and higher, increasing the chance of failing. Thus perfectionism leads to depression. Perfectionists tend to be over demanding and have lower self -esteem, poorer relationships. According to David Burns (1980) perfectionists strive for the impossible. They set unreachable goals and then judge themselves to be failures. In addition, constant worry causes health problems. Thus the activities of the perfectionists lead to

express depressive symptoms. Thus the depressives think in a irrational and illogical way.

Hauck (1973) and Maultsby (1976) emphasized that irrational ideas cause all our unreasonable of excessive emotions leading to depression. According to them, depression is closely related with event and belief system. An event may arouse the feelings of intense anger. Belief system, on the other hand , is the directive of the individuals. If the event and belief system do not coincide, it leads to emotional ideas, inconsiderate activities, selfish interpersonal relations and unfair dealings. All these factors account for depression.

Barnett and Gotlib (1988) stated that irrational ideas and faulty logic cause depression. They belief that sad feelings existed before that sad helpless thoughts. Thus the depressing genes hormones and life events lead to negative cognitive styles. Cordes (1984), on the other hand, believes that emotion and cognition are independent systems. Thus depression in terms of irrational behavior is based on emotions and not on irrational thought. In spite of these differences in opinion, it is said that cognitive explanations are the most accepted explanations of depression among psychologists today.

According to Yapko (1992), unreasonable thinking and faulty conclusions are the salient futures of depression. Depressed people are prone to think in several ways that may produce sadness and pessimism. Depressed people are past oriented. Hence if the things have gone badly in the past for depressed person, there may be a tendency to conclude that the future will be awful too. Actually depressed people usually don't think much about future for them or future appears threatening to them. The erroneous belief that things will not get better may lead to suicidal thoughts. This hopeless vision of the future is based on a general global perception that their problems are huge, innumerable, and insolvable. A depressed person may have only a vague motion of future. Depressed people do not have specific plans and they try to attain unrealistic goals without plans for changing. They have no hope and no motivation. They feel like victims, not masters of the situation.

Forrest and Hokanson (1975) did an interesting study supporting the notion that self-punishment could be rewarding. In this study an aggressive partner was permitted to shock depressed and non-depressed subjects. Then those who were shocked were given the choice of shocking their partner, back shocking themselves, or making a friendly gesture to the partner.

If the depressed subjects elected to shock themselves, their autonomic responses (stress) declined more rapidly than if they were aggressive or friendly. Non-depressed got relief only by shocking the other person, not by self-punishment or being friendly. Thus the findings of the study established the fact that depressed persons would hurt themselves more after being hurt by an aggressor. In other words, depressed persons get relief if they punish themselves instead of attacking the aggressor. Thus self-punishment is thought of as substitute for aggression.

Carson and Adams (1981) found that depressed people are especially sensitive to pain and even mildly irritating situations. Because of this sensitivity, some depressed persons have developed unique ways reducing pain or stress in addition to avoiding or withdrawing. Thus they reduce stress by making self- critical or self - hurtful remarks. This may reduce criticism from others or in some masochistic way, reduce the stress.

Monte (1980) found that anger converted into self - hatred causes depression. This explanation of depression is based on the psychoanalytic view point of depression. The psychoanalysts believe that anger towards others gets turned against ourselves. According to them, the basic problem of depression starts with neurotic parents.

These parents are inconsistent in their behaviour. They are both overindulgent and demanding, lacking in warmth, inconsiderate or openly hostile, or driven by their own needs. The child resent these things. The child aware of his or her weakness. The criticism of others, and his or her own hostility and fears, develops a despised self-concept. The resentment of others has been turned against the self. At the same time, the child starts to develop a notion of an ideal self. This ideal self, trying to compensate for weakness and guilt, sets up impossible demands, called neurotic needs. These needs are unconscious, intense, insatiable, anxiety-causing, and out of touch with reality. Karen Horney listed several neurotic needs. These are needs for perfection, power, independence and affection. All are attempts ot handle the primitive hostility from childhood. Persons with these neurotic needs develop depression.

To become traumatized without external trauma is another dimension of depression. Carol Dweck (2000) conducted a series of studies on mastery oriented thinking as correlate of depression. She focused on achievement of the children and identified some factors relevant to depression. She distinguished between hopeless thinking and mastery thinking and emphasized some crucially important factor responsible for depressive affect.

Dweck's findings led her to explore the early childhood sources of hopeless thinking. She found that over one third of children show signs of helplessness, self-blame, frustration, sadness, giving up, losing interest when they fail or are criticized. Through several experiments, it was shown that judgmental criticism of the child increased his/her helpless attitude and negative self-appraisal, including deeply feeling unworthy or bad. Neglect and criticism are the classic sources of a low self-concept. Thus the early childhood experiences of failure may develop depressive symptoms.

Mischel (1988) assumed that a child with a self-degrading, self-hating, defeatist attitude lived in a neglectful or psychologically destructive early environment. This research provides evidence that negative self concepts can come from simple misinterpretations. If the misinterpretation is repeated thousands of times, it might lead to a suicidal teenager or a self injuring 25 year old. Thus depression may be actually develop in the person. In other words, negative and self-destructive thinking may arise from a child's misunderstanding leading to depression. In summary, through no fault of their own, some people in childhood learn to emphasize the awfulness of the problem, culminating in depressive affects in their adulthood.

Freud (1957) spoke of the success of neuroses consisting of four motives, a need to achieve, a fear of success, a fear of failure, and a desire to fail. The motives relating to fear of failure and desire to fail can cause the person to be nervous leading to depressive affects. Tresmer (1974) found that about 50% of both men and women exhibited negative feeling toward achievement or assumed other people had such feelings. According to the investigator, the fear of success and the desire to fail get all confused with (a) opposition to the traditional pressure to succeed and (b) reluctance to accept additional responsibilities following success. Thus a destructive psychological environment is created for the nourishment and nurturance of depression.

Accroding to Carl Menninger (1956) self defeating behaviour of man is the source of depression. Cudney (1981) suggested that self defeating behaviour is caused by our reluctance to face reality. By failing they deny their responsibility. Gilmer (1975) found that feelings of adequacy and inadequacy may co-exist or change frequently in depressive person. He reported that there are six signs of inferiority in the depressive. These are (i) over-reaction to criticism, (ii) tendency to feel criticized, (iii) avoidance of others, (iv) an excessively positive response to flattery, (v) inability to lose graciously and

(vi) urges to put down others. These signs may be used to identify a depressed person in a social context.

A hallmark of depression is pessimism and self-criticism. Blankstein, Flett, and Johnston, (1992) observed that the depressed person's self appraisals are frequently too low. They found in one study of problem-solving ability dealing with interpersonal and emotional problem to be more capable than they think they are. They were found just as capable as non-depressed people. These findings suggest that the depressed person's pessimistic and self-critical nature are used as masked to avoid the society.

There are five levels in the depressed persons to identify the feelings of inferiority. These are given below:

Level I: It involves behaviour. The behaviour analysis shows what initiates and reinforces the negative thoughts or self-defeating behaviours of the depressed persons.

Level II: It involves emotions. In emotional expressions of the depressed persons, the feeling of inadequacy become associated with specific situations.

Level III: It involves skills. the depressed persons fail to achieve new skills. It lead to the feelings of inadequacy.

Level IV: It is related with mental states of the depressed persons. It refers to the feeling of helplessness. It creates such a situation that prevents the building of self-efficacy and confidence in changing behaviour of the depressed person. Thus the feelings of helplessness encompasses the whole entity of the individual leading to development of depressive affect (Cash, 1995).

Level V: It refers to the unconscious. It is related with the understanding of the source of low self-appraisal leading to self-criticism. Driscoll (1982) gives several reasons for self-criticism. These are as follows.

i) To motivate our selves to do better.
ii) To keep ourselves humble.
iii) To avoid doing something challenging.
iv) To avoid disappointment.
v) To discourage others from criticizing us.
vi) To encourage others to admit their faults.
vii) To avoid responsibility.
viii) To imply that our behaviour is not reflective of our true abilities.
ix) To get sympathy and reassurance.
x) To express other feelings indirectly.

The depressed person's self-criticism is reflective of these thoughts. There are reasons to believe that the depressed persons are too self-critical. They try to avoid success and seek failure.

Theories of depression

The phenomena of depression may be understood in the perspective of different theories. These are discussed below.

(i) Learned helplessness theory

This theory of depression has been proposed by Seligman (1974) Seligman conducted experiments on depression using dogs. He observed that dogs were allowled to learn to escape unpleasant experiences. The unpleasant experiences were created with electric shock. It was found that that these dogs did not try to escape when escape was available. But the dogs who were not confined tried to escape the shock when the escape was available. Thus the confined animals passively received the punishment and experienced depression. This model of depression is known as learned, helplessness model of depression. Similar conditions may develop in human beings. When a person is told that events are uncontrollable, the helplessness effects occur. Then the person may become depressed.

The learned helplessness theory of depression has many drawbacks. First the learned helplessness is the results of uncontrollable aversive events but it is not known how much controllability is required to produce helplessness. Again what other emotional and behavioral responses may precede helplessness is not explained. Moreover, the theory of learned helplessness has failed to identify the conditions that may precede helplessness.

Secondly, this theory of depression follow from human experimental work. Hence it may be considered as a cognitive theory. Thus major weight is given to the issue of disruption in learning ability.

Thirdly, it is and appealing view that animal experiment has followed a true design and results. But the experimental work on animals should not be the basis for explaining human behavior. Thus the theory is less convincing.

Fourthly the dependent measures of learned helplessness is assessed in term of responses of correct trials. This con not reflect the concept of aversiveness. This can not be associated with human depression. Thus trivial laboratory behavior can not be generalized to complex behavior of human beings.

Fifthly, it is said that laboratory findings are based an demand characteristics . The experimental design for animals can not be appropriate for human subject. Human beings have intuition. They can think and may take decision on the basis of circumstances. They can feel that they are not supposed to escape. Human beings may think that they are helping others. So they should not utilize the situation. Thus aversive experiences may not lead to depression.

Sixthly, it is important to note that depression involves interpersonal relationship. But Seligman's experiments do not represent interpersonal relationship. This sensitive human factor is important variable in behavioral research. Thus the theory of learned helplessness fails to account for the human elements.

The Theory of depression developed by Seligman has important contribution to clinical psychology. It is said that the learned helplessness hypothesis may offer attributional reformation to the inadequacies of human behaviors. The experimental evidence showed that depressed persons attribute bad outcome to internal factors. The theory of helplessness model may provide insights for the solution of these behavioral problems.

It is expected that this theory may invite new researches in many directions. It also provides explanation for causal factors of depression in a variety of human experiences.

(2) Defective social skill model

This Theory derives from conventional learning theory. It explains depression in terms of functional analysis of behavior and reinforcement. According to Lewinsohn and his associates (1969) depression is a function of individual's behavior maintained by positive reinforcement. . Thus depression is a continuous variable. It ranges from profound to mild states. The occurrences of depression depend an the dynamic processes of response reinforcements .

Lewinsohn (1974) describes the response - reinforcements contingent as a function of three variables. These are (i) Events which are potentially reinforcing to the individual, (ii) The potentially reinforcing events must be available in the environment, (iii) The social skill available as reinforcer to the individual.

According to Macphillamy and Lewinsohn (1974) , depression is a function of positive reinforcement. The total amount of obtained pleasure activity level and

potential reinforcement may account for the intensity of depression . Thus depression varies as a function of the amount of positive reinforcement.

The concept of social skill is the basis of Lewinsohn theory of depression Social skill is the ability to emit behaviors. When a person is receiving adequate social reinforcement, he has social skill. The depressed individuals have less social skill. Hence they are less able to elicit positive reinforcement from the social environment. They perform less social activity. They feel more discomfort and less pleasure in social activity. They express more discomfort for being assertive. They feel discomfort and upset in negative thought . These activities are the measures of deficient social skill.

This theory of depression as defective social skill has several limitations. Firstly, the framework of this theory is wrong. It is not the lack of social skill but a lack of control which is the causal element of the etiology of depression. The theory is incorrect for using extinction.

This is the second criticism of the theory. Infact, the amount of behaviors is determined by an intermittent schedule of reinforcement.

In spite of these criticisms, it is true that the relationship between social skill and depression is well understood through the analysis of defective social skill. Its major contribution is that the elaborate quantification of the theory helps us to conclude that depressed people engage in less social interaction and receive little satisfaction from it.

(3) Development process model of depression

Hokanson (1980) has proposed this developmental process model of depression. This theory states that depression has its relationship with aversive stimuli. When a person is provoked with mild electric shock, it allows to make aggressive response. This is related with psychoanalytically oriented "hydraulic model of catharsis."

According to Hokanson (1980) counter response may be friendly or aggressive. It is used as arousal – reduction. It is an alternative to the hydraulic model of catharsis. Thus response may be instrumental in terminating or avoiding interpersonal aversiveness. This is reinforced and can serve as a classical condition stimulus for arousal reduction. In the same analogous way, a friendly or masochistic behaviors may be reinforced and may serve the same function. Viewed from this perspective, depression is understood as

developmental process. For example, a person finds self punishing behavior to be effective as means of gaining control over a threatening and hostile environment.

(4) Social class vulnerability model of depression

Brown (1977) has proposed this model of depression. The main theme of this model is that personal troubles bear a special relationship of public issues of social structure. This theory of depression is known as social class vulnerability model of depression. This model of depression is based on three factors. These are discussed below.

(i) Provoking agents:- There are some events that can produce depression under certain conditions. These may be losing a job, divorce, separation or alcoholism. These provoking agents may interact with a second set of influences for producing depression.

(ii) Vulnerability factors:- This refers to such conditions that may increase risk of depression in the present of provoking agents. These are (a) Lack of an intimate, confiding relationship. (b) Three or more children under age 14 at home. (c) Loss of mother before age 11 and (d) Lack of employment.

(iii) Symptom formation factors:- These are experiences which help to shape the form and severity of depression. For example, past loss of parent by death may be correlated with psychotic depressive condition and past loss of parent by separation may be correlated with psychotic depressive conditions.

The presence of these vulnerability factors lead to a sense of hopelessness in the presence of provoking agent. This helplessness may generalize to form the core of depressive disorder. In fact, Brown and Harris (1978) strongly support a multi-factor view of depression. It allows for genetic and constitutional as well as social class for depression.

(5) Cognitive model of depression

The cognitive model of depression states that man are disturbed not by things but by the views which they take of them Beck (1963, 1964, 1967) has formulated this theory. This cognitive model of depression has utilized three concepts to account for depression. These are (i) Cognitive triad. (ii) Schemas and (iii) Cognitive errors in terms of faulty information processing.

(i) Cognitive triad:- It has three components. The first component is the negativistic ideas observed in the depressives. The depressed persons have negative view of

themselves. They think that they are defective, inadequate or unacceptable. This is a pervasive self view. It leads to the senses that one is under serving and worthless. This negative view of self can be characterized as self hatred.

The second component involves interpretation of daily experience. The world is seen as a burden. The person experiences a sense of helplessness and hopelessness. He misinterprets events as defeat. The person characterizes his life as totally void of pleasure or satisfaction.

The third component is related with future. The depressed person sees the future as hopeless. So he finds no motivation to work. Thus the depressive maintains an exaggerated negative view of him or herself, the outside world and the future.

(ii) Schemas:- According to Beck, cognitive model of depression consists of schemas. Schemas are like personality traits. They present stable long-standing thought patterns. The depressive is viewed as responding to such situations in fixed, negative ways. Such a negative pattern of thought may lead to social withdrawal and isolation.

It is said that the depressives operate on the basis of a negative self-schema. Such a negative schema prevents the depressive from generating ideas about behavioral contingencies. This leads to actual behavioral deficits. This process has been characterized by Beck as the negative self-schema.

(iii) Cognitive errors:- Negative schemas are maintained through cognitive errors. It is related with faulty information processing. This system of faulty information processing results from the following six basic errors, These are (i) Arbitrary inference, (ii) Selective abstraction (iii) Over generalization, (iv) Magnification and minimization, (v) Personalization and, (vi) Absolutistic dichotomous thinking. Depressives rely on these cognitive errors in evaluating their experiences. This results in extreme, negative, categorical, absolute and judgmental types of thinking. Taken together, the cognitive trial schemas and cognitive errors render the depressive vulnerable to the stresses of life.

(6) Self control model of depression

This theory is proposed by Rehm (1988). This model describes adaptive processes of self. It involves self-monitoring, self-evaluation and self- reinforcement for coping with stress. Following these principles, Rehm (1977) developed his own concept of self-control model as the cause of depression.

Rehm's self-control model states that when depressed people attend to more negative information about themselves they tend to make more frequent negative evaluations. Hence they are less likely to reinforce adequate performance.

In spite of its wide application in clinical research, the self-control model of depression has been criticized on four grounds. First, the model has developed isolated domains of research and no attempt has been made to interrelate the findings of different investigations by a systematic cognitive theory. Secondly, it accounts for only limited clinical and research findings. If contributed a lot within the theoretical perspectives but none of these offers a comprehensive account of depression. Thirdly, concepts have been borrowed from information processing and memory paradigms in piecemeal fashion. Fourthly, this model has focused exclusively on depression without discriminating emotion from other variables.

However, Rehm's self-control model has wide acceptance in the field of clinical psychology. It has great diagnostic value. It gives emphasis on adaptive processes of self-monitoring, self-evaluation and self-reinforcement. These are important prerequisites for coping with stress.

Thus the self-control model has added new parameter to the existing theoretical perspective of depression.

Review of relevant literature

Foster (1986) conducted an exploratory study to examine the coping strategies of elderly depressed and nondepressed persons. The study was divided into two parts. In the first part 32 nondepressed Ss. with the mean age 72.3 yrs. participated in the study. In the second part 32 outpatients with mean age 71.9 yrs. were selected from those undergoing treatment for major depression. Life Event Inventory and coping scales from health and daily living questionnaire were selected for using in this study. The result showed that the depressed Ss. reported a greater use of avoidance coping behavior as compared to the nondepressed Ss. Furthermore, the depressed Ss used emotion discharge as a coping technique.

France et al. (1989) conducted a study for comparing their previous research on chronic pain and major depression. The findings of this study showed a strong correlation between chronic pain and depression.

Ostrov and Offer (1980) conducted a study for the replication of lymphocyte blaslogenesis in depression. Two groups of Ss.were used in this study. One was

experimental group and the other control group. They diagnosed 5 patients as having major affective disorder. Then 5 non patients were selected as matched group. This was used of control group. Then the investigator conducted a pilot study to investigate the lymphocyte function in depressives. The finding reported low T-lymphocyte function in depressed individual. This result supported the previous findings of lower lymphocyte function in major depression.

Oler (1994) examined 40 patients (mean age 45.6 yrs.) undergoing treatment for a major affective disorder. The purpose of this study was to determine prevalence of increased Epstien-Barr virus (EBV) as the cause of infection of mononucleosis (MN). A control group consisting of 25 Ss were also tested. Their mean age was 32 yrs. The results reported elevated serum antibody titers in the clinic population. However, this elevation was not significant. The findings did not indicate that these titers have in association with the systemic symptoms of MN with the symptoms of minor depression.

Nolen-Hoeksema and Girgus (1994) investigated differences in the cerebrospinal fluid (CSF) content of diazepambinding inhibitor (DBI) in patients with neuropsychiatric disorders. They conducted 3 studies.

The study I involved 21 depressed Ss and 28 controls. The mean age of the depressed Ss was 37.4 yrs. and that of control group was 28.9 yrs. The study involved 6 Ss with Alzheimer's disease and 8 depressed Ss and 7 control. The mean age of these groups were 60.2 yrs. 62.1 yrs and 65 yrs. respectively. The study 3 involved 15 Schizophrenics and 27 controls. The mean age of them was 29.6 yrs. and 29.2 yrs respectively. Results showed that the Ss with major depression had significantly higher concentration of DVI immune reactivity in the CSF than did the controls. Findings suggested a functional disinhibition of neurotransmission associated with depression.

Beck and Emery (1985) conducted a study to explain the frequency, quality and impact of life event itself rated depressed, behavioral problem and normal children. The 3rd to 6th grade children were selected as respondents. Thus 60 self rated depressed, behavioral – problem and normal children were closely matched for sex, age and socio-economic status. They were examined for the number, quality and impact of stressful life events in the past year. The results indicated that disphoria reporting Ss. experienced more life events and a higher qualitative index of stress than the other 2 groups. The impact of each event, however, was not greater for the depressed Ss, than for the other 2 groups.

The self-rated depressed Ss appeared to experience more major family disruptions than the other 2 groups of Ss.

Breznitz, (1983) conducted a study on speech patterns of depressed mothers and their young children. The study used 14 depressed and 18 non depressed mothers aged between 22 to 34 yrs. They were observed during conversation with their 3 yrs, old children. It was found that depressed mother responded less quickly to their children's speech than the healthy mother. It was also observed that depressed mother's significantly increased their speech productivity in mildly stressful situation than the healthy mother.

The children of depressed mothers were found to speckles while sitting and eating lunch with their mothers as compared to the children of control groups. On the basis of these findings, investigator suggested that two groups of children were exposed to different patterns of socialization. The children of depressed women kept social interaction to a minimum. They were found to be over action to mild stresses. Those children of the depressed mother trained to keep their interaction with their mother to a minimum. These differences created two types of social environment leading to the development of two types of socialization.

Burke et, al (1991) examined the efficacy of the dexamethasone suppression test (DST) as a diagnostic laboratory test for depression. They collected drug history of 336 psychiatric patients. The analysis of results showed that 60% of the patients used to take one more drugs suspected of altering DST. The results revealed either false positive of false negative. Those investigators found the DST as a biologic marker of affective syndromes in relation to the used of drugs by the patients.

Bagday et, al (1986) examined the dexamethasone suppression test (DST) in bipolar depression. The investigator studied the correlation between post dexamethasone cortisol levels after the dexamethasone suppression test(DST). A total of 31 depressed female patients with primary endogenous bipolar depression participated in this status. The patients were between 29 to 65 yrs, old. It was found that 25 patients showed abnormal DST results.

Hauck (1973) conducted a study to measure the rate of forgetting in dementia and depression. Three groups of Ss were used in this study. These were (1) patients with mild dementia, (2) patients with major depression and (3) normal subjects used as control group. The results showed that depression and mild

dementia patient demonstrated learning impairments. But the mild dementia patient showed rapid forgetting in the first 10 minutes after learning to criterion. This findings suggested that some form of deficient consolidation contributes to memory loss in mild dementia but not in depression. These findings showed there are some factors that account for disruption of different psychobiological mechanisms in these disorder. Thus the rate of forgetting paradigm may be clinically useful for distinguishing patients with memory deficits.

Dressler (1985) investigated the hypothesis that marital and social adjustment deficits would be observed in married women who had been depressed previously. The study used 12 currently depressed, 12 remitted and 12 non-depressed Ss. The Hamilton Rating Scale For Depression and the Beck Depression inventory were used to measure depression in this study. The Ss. were also asked to complete the Dyadic Adjustment Scale (DAS) and the social Adjustment Scale (SAS). The results of this study showed differences in social adjustment between the remitted and currently depressed group.

One most important symptom of depression is loneliness. According to Bowlby (1969,1973), an abandoned infant protests by screaming. Then he withdraws quietly from the environment. He became

detached and apathetic. Thus abandoned feelings, detached and apathetic tendency may be categorized as loneliness. No emotional involvement is in loneliness state of the person.

Lynch (1977) observed that some species of monkeys also die when abandoned by their mother. Even brief separation, infant monkeys from their mothers causes them two years later to cling more timidly and relate more poorly. On the basis of these animal observations, investigator concludes that one can die of procaine heart.

Ostrove and Offer (1980) reported that 20% of American people feel lonely at any one time of their lives. They also found that I in 5 Americans do not have a friend with whom they could discuss personal problems.

Moustakas (1961) described loneliness as solitude. It refers to missing and longing for some kind of human interaction. Thus there may be social loneliness, emotional loneliness, spiritual loneliness or existential loneliness. When an individual is not able to become a part of a group of friends, it is called social loneliness. When individual is not intimate with other person or is not able to depend on any one, it is called emotion loneliness. A feeling of separation from God is called

spiritual loneliness. An awareness of individual separateness is called existential loneliness. All these forms of loneliness, according to Moustaskas (1961), contribute to depression.

Moustakas (1961) believes that aloneness is the human condition. People are born alone. They alone direct their lives. In the same sense, people die alone. Thus an individual remain a separate person. Being alone is an important dimension for gaining perspective and growth. Moustakas (1961) distinguished between two types of loneliness. One is wholesome loneliness and the other is the fear of being alone. It is the dread of being alone and the feelings of emptiness that are closely associated with depression.

Burns (1980) conducted an experiment on depressed patients regarding their motor activity. They monitored wrist motor activity continuously in 10 depressed female patients. The Ss were between 40 to 65 years in age. They were divided into endogenous and non endogenous depressive patients. The numbers of endogenous depressives were 4. They were hospitalized in a psychiatric ward. All Ss received specific antidepressive therapy during hospitalization. The data obtained before the antidepressive treatment and after antidepressive treatment were compared for clinical

evaluations. Several rating scale were used for clinical evaluations. Results showed that motor retardation is related to both fluctuations of activity level and immobility level. It was found that immobility parameters at night and during the day were a good indicator of the severity of the depressive state. Thus the temporal pattern of activity level was related to the subtypes of depression. On the basis of these experimental findings. Benoit and his associates concluded that activity and non-activity levels are good indication of depression.

Newman and Newman (1979) discussed the psychodynamics of major depressions. He found that the border line conditions of the depressive are characterized by severe ego pathology. The depressive individuals found difficulty in building up a consistent self. Thus there is a pronounced emptiness of evaluation in the realm of ego development. The investigation compared between personality patterns of narcissistic and depressive personality patterns. It was found that the ego is basically able to function well in narcissistic personality but there is a lack in the self but the ego of the depressives is severely damaged and the individual becomes alienated from the social environment. The supper ego and the defense mechanisms are completely impaired in the depressive individuals.

Burke and Reiger (1991) introduced concept of matamorphic psychogenic depression. He investigated the psychogenic factors in depression. He uses the concept of reaction and generalized it to explain depressive affects. He found that some forms of schizophrenia exhibit differential diagnostic symptoms and these may be identified as masked depression.

Johnson, Petzel and Sperduto (1983) reevaluated relationship between depression and attributional style. They obtained the scores of attributional style using appropriate scale. They used the cap of Attributional style (SAS) and Beck Depression Inventory for collecting data. A sample consisting of 144 college students were used as subjects. The time lag between the completion of the depression measure (BDI) and SAS was eliminated and an equal number of depressed and non depressed Ss were included in the correctional analysis. The results provide little support for the existence of a particular attributional style in depressives.

Shapiro et al. (1994) described a rational procedure for arriving at a diagnosis of a depressive state. He conducted an experiment and explained the nature of attention in the depressives. Furthermore, development of symptoms, syndromes and pathologic mechanisms and treatment complications were also explored. It was

found that depressed individuals expressed suicidal inclinations in greater intensity as comported to the non-depressed individuals.

Arterburn (1993) conducted an explorative study for describing masked depression. It was found that affective disorders are concealed in masked depression. It was also found that masked depression is characterized somatic symptoms. Thus sleep patterns are found to change in the depressives. Similarly loss of appetite and changes in sexual expressions are also found as somatic symptoms in the depressive. The investigator emphasized the importance of early detection of the depressive symptoms and suggested the treatment of the masked depression with drugs and psychotherapy.

Cytryn and Mcknew (1980) conducted a study to evaluate suicide risk in depressed and other mentally ill patients. It was found that suicidal gestures, intent, ideation and risk are found in increased intensity in depressed persons in comparison to mentally ill patients. Epidemiological study confirmed that evaluation of suicide risk required multiple variables for identification of multifaceted characteristics of depression.

Brand et al. (1996) adopted a new approach to the diagnosis of depression. It was called the Integrated cap

of Taxonomic Evaluation Criteria (ILTEC) D 100. They discussed the methodological bases and purposes of ILTEC. It was diagnostic instrument for the collection of information required for a diagnosis according to different classification systems. It also provided manual or computerized computation of the diagnosis. The ILTEC is comprised of a total of 100 criteria related to depression and depressive symptomatology.

Lamarime (1995) conducted a comparative study between depression and mysticism. It was found that clinical depression was positively correlated with aridity and suffering experienced by mystics. The issues of loss, guilt, passivity and world view of mystics were found inherently correlated with the depressives symptoms. However the emotional disturbance were medical and profound in the mystics than the depressives. The investigator found some positive connotations in the mystics and believed that these positive characteristics may be necessary in the lives of mystics. But depressive symptoms were considered pathological and harmful in the individual. However characteristics of the mystics were considered as elevate thought leading to higher spiritual sphere.

Kahn (1995) attempted to replicate the research on Alexithymia and examined relationship between

depression and psychosomatic disorders. The investigator used a sample of 90 Ss. They were between 18-53 years old. The Ss expressed psychosomatic disorder, sexual problems or neurotic depression. The reseacher investigated patient's concepts of the jenesis of alexithymia in relation to the frequency of controls alexithymic responses. The results showed that psychosomatic patients out-numbered controls in alexithymic in 2-1 ratio. There was a significant difference in the frequency of alexithymic characteristics between psychosomatic and depressed patients. Moreover, there was a positive correlation between the frequency of alexithymic responses and psychosomatic patient's concepts of zenesis of disease.

Feinstiein et al. (1984) conducted a study to explore the developmental aspect for affective problems of the chronic manic –depressive disease during childhood and adolescence. The purpose of this study was` diagnostic considerations and treatment. The investigator provided genetic and biochemical research literature and reported 3 cases of manic –depressive. The investigator observed rapid and odd changes in thoughts, emotions and behavior of the patients. These symptoms precipitated by a fear of loss. Treatment was provided with Lithium carbonate. When combined with psychotherapy, Lithium was found effective in the treatment of about manic

depressive diseases. The investigator suggested long term psychotherapy or intensive psychoanalytical psychotherapy to prevent the development of severe behavioral fixation.

Gallangher (1975) examined the impact of relationship among 3 kinds of social support and stressful life events of depression and psychotic experiences. Three types of social supports were low, middle and high level of support from a partner, child or friend. The study was conducted in a community sample, of 2729 Ss over age 50 years. It was hypothesized that social support would have a stress buffering effect only of depression. The results were generally consistent to this hypothesis. However, the relationship between stress and social support and their effects on depression was not interactive. Two types of social supports had independently a strong direct effects on depression. Stress influenced depression on all social support levels. But the effect was reduced under the conditions of high level of social support. When children, relatives, friends, neighbours and other non-family members provided social support, then the influence of stress of depression is reduced.

Greenberg et al. (1992) conducted a longitudinal study of live events coping resources and depression. The

research was conducted in a community and mental health center. A total of 676 Ss aged between 18 to 64 years were interviewed. Among them 250 Ss were reinterviewed after 6-8 months later. The causal model in most previous cross-sectional and longitudinal researches assumed that stressful life events might result in depression. Social support and personal resources were found less vulnerable. The findings of the study were consistent with the model of stressful life events resulting in more symptoms of depression.

Hirschfeld (1991) conducted an experiment to find out the relationship between depression and headache. A total of 108 depressed patients constituted the Ss the study. The investigators observed the frequency of association between depressions and headaches. The analysis of result showed that most headaches occurred in those Ss who were between 41 to 60 years old. It was also found that headaches were found predominantly in females. the study used a control group also. The results revealed that 61% of the patients complained of headache in comparison to the control group. The most frequently recorded type of headache was migraine.

Spirzer et al. (1977) conducted a study to analyse to the opposition between depression and hysteria. It was found that hysterical symptomatogy can mask

depression. Furthermore, a distinction between depression of inferiority analytic depression was observed. The analysis of results showed that Freudian psychoanalytic theory on the existence of primary narcissism was positively related with depression

Weller and his associates (1984) conducted a study on 50 hospitalized prepubertal children. They were aged between 6 to 12 years. Diagnostic and Statistical Manual of Mental Disorders (DSM III) criteria was administered on them for the identification of major depressive episode. Then a control group of 18 hospitalized patients with psychiatric disorder of the same age was taken. There was another control group of 18 Ss with same age. They were collected from non-hospitalized normal population. The Dexamethasone Suppression Test (DST) was performed on them. The findings indicated that the depressed Ss demonstrated consistently higher cortisol levels than the control group at baseline and post DST. The DST was positive in 41 depressed Ss 5 psychiatric controls and 2 normal controls. On the basis of these findings, the investigator suggested that prepubertal depressed children may have abnormalities in the hypothalamic pituitary adrenal axis similar to those in adults with a major depressive illness.

Segal (1992) conducted a research on cognitive symptoms in late life depression by comparing these symptoms with these seen in younger depressive Ss. The results of the study discussed and described peculiarities and relationship to the core symptoms of depressive illness. The findings suggested that (i) there are no essential differences between depression in elderly and younger patient, (ii) Elderly patients are characterized by multimorbidity, (iii) There are generalized or global reduction in cognitive performance of the elderly patients, (iv) There are quantitative differences among early and late life depression. This is due to a combination of the detrimental effects of depression on the one hand and on age related reduction in cognitive function on the other.

Hipp (1995) conducted experiment in Australia on mental health. The purpose of this study was to examine the antisocial behaviour as a mask for depression. A total of 46 boys aged between 10 to 12.6 years, participated in the investigation. The Ss were found to manifest antisocial behaviour. The investigators conducted the study to see whether these Ss had underlying depression. The study was conducted in a school setting environment to discriminate between aggressive behaviour with and without depression. The Ss were given to compete Children's Depression Scale.

The results indicated that 39 Ss reported depressive symtomatology. They revealed lower self-esteems, higher levels of guilts, a greater instance of family breakdown and familial psychiatric history, as well as experiencing more cognitive problems than those who were antisocial but not identified as depressed.

Lynch (1977) conducted a longitudinal study of rural Tennessee on chronic medical problems, coping resources and depression. They analysed chronic medical problems as a risk factor for depressive symtomatology. Data were collected 532 rural Tennessee residents in 1977 (Time-I) and 1983 (Time2). An initial investigation found chronic medical problems to be a powerful predictor of depression. Furthermore internal and external resources such as personal resources and social support operated as moderating between the stress of medical problems and psychiatric impairment. The buffering effects of both social support and personal resources were explored. Regression analysis indicated that Time-1 depression level as well as medical problems at Time-2 were significant predictors of depression Time-2.

Metalsky et al. (1993) conducted a study on depression and marital power. An equity model was used for the explanation of data. A total of 680 married

couples was used as respondents. The data were collected using telephone survey. Results showed that each spouse was least depressed when marital power was shared to some extent. There was a U shaped relationship between depression and marital power. The marital power was conceived with reference to the earnings of the spouse. The higher the husband's earning the greater the amount of his marital power. Again the more traditional a wife's sex role beliefs, the greater the amount of her husband's marital power. The husbands had least depression when the marital power is higher. These findings suggest that the division of marital power in the average marriage was closer to the level that minimized his husband's depression than it was to the level than minimized the wife's depression.

McGrath et al. (1990) conducted a study to evaluate the correspondence between teacher ratings childhood depression and child self ratings. It was hypothesized that correspondence between teacher ratings and child self-ratings of depression was due to the teachers using a single, global rating that masked knowledge of the more specific symptoms of depression in children. The investigators allowed 12 teachers to rate 62 white children of 9 to 11 old on affective, cognitive, motivational, withdrawal and negative symptoms of depression. Then the students were given to complete the

Childhood Depression Inventory (CDI). The CDI items were divided into four categories. The results showed that correlations between teacher ratings and CDI component scores were either non-significant or negative.

Myers (1992) conducted a study on depression and suicidal ideation in college students. The study used 149 college students as respondents. They completed the centre for epidemiological study depression scale and a set of questions were designed to measure the respondent's perception of depression. It was found that 17 respondents reported that they were depressed at the time of the severity. However 33 respondents felt that they needed treatment for depression. At the same time, 49 respondents reported some past suicidal ideation and 14 respondents admitted to having contemplated some means of suicide. The results supported the proposition that depression is a significant problem for college students.

Morphy (1988) conducted an experimental on 4 groups of depressed patients. The groups was constituted of 47 unipolars, 21 bipolars, 34 neurotic reactive and 39 unspecified depressive disorder. It was hypothesized that deprivation of love during childhood represents an important psychological risk factor in the

background of depressive disorders. The Ss completed an instrument assessing experience of parental rearing practices. Three factors such as rejection, emotional warmth and overprotection were measured. The results of these factors and the global judgement scores of severity and consistency in rearing attitudes were compared with those obtained from 2005 healthy individuals. Depressed patients in the unipolar and unspecified group rated both parents lower than the control group on emotional warmth. Patient tended to rate their parents as less consistent in their rearing attitude. It was found that 64% of the patients correctly classified emotional warmth and overprotection. These findings provided support to the hypothesis that deprivation of love during childhood is an important psychological risk factor in the background of depressive disorders.

Roos et al (1985) examined differences in self-concept functioning and information processing in depression. The purpose of the study was to conduct experiment on depression and trait distinctiveness in the self-schema. A total number of 22 depressed and 21 non-depressed male college students constituted the Ss in the study. Beck Depressive Inventory (BDI) was used for data collection. This inventory contained 60 trail adjectives. Among these adjectives, 30 were the

characteristics of depressives and the remaining 30 adjacent were non-depressives. Both depressed and non-depressed Ss rated each trait for both the targets. They were also asked to rate both self-descriptiveness and other descriptiveness of each trait. It was found that mild depressed Ss had more negative "self only" traits in their self concepts than the normal Ss. However normal and depressive Ss did not differ for positive "self only" traits nor for positive or negative mutually descriptive features. Moreover negative content in a depressive's self concept was specific and personal. On the basis of these findings, the investigators concluded that the individual's view of his/her personality as a distinctive feature is a factor that can help to understand the nature of the self-concept in depression.

Rook (1984) conducted a study on the distinction between hysteria and depression. The study analyzed the metapsychological and clinical significance of hysteria with reference to Freudian psychoanalytic theory. It was found that the preconscious, unconscious and conversion as counter investment and symbolic capacity influence depression.

Murphy (1988) conducted a study on the recognition of depression syndrome. It was suggested that the recognition of secondary or completing

depression in hysteria is very important for proper treatment of the disease.

Meyers (2000) examined lateralization in depression. Data on subsyndromal bipolar depressive disorder suggested a hypoactivity of the left hemisphere rather than over-activation of the right hemisphere. This finding provides confirmation a model of a relative right hemisphere hyperexcitability in functional affective psychosis.

Dressler (1985) conducted a study on comparability of panic attacks in panic disorder, depression and agoraphobia. The study used both Ss with panic disorder and Ss with agoraphobia and the data obtained from these two groups were compared. The results showed that there some situational factors underlying the process in depression panic disorder and agoraphobia.

Hooley et al. (1986) conducted a study for the assessment of depression in urban adolescent females. Implications for early intervention strategies were also investigated. The purpose of the study was to examine whether demographic or psychological factors are related to depression. A total of 106 Ss participated in this study as Ss. The Ss were 9th to 12th grader females. Among them 84 were Blacks, 19 were Whites, 7 were Hispanics

and 6 were Asian. The Ss were asked to complete Beck Depression Inventory (BDI), self image biographical and demographical questionnaires and a problem checklist. It was found that 44% of the Ss reported feelings of mild to severe depression and 39% reported occasional suicidal ideations. Level of depression was significantly correlated to mother's occupation, household mobility and self reported problems. No significant differences between racial and groups were found. Asians obtained the highest score followed by whites, Blacks and least by Hispanic on BDI scores. When results were analysed for Blacks separately, the following trends emerged.

1) Black Females had the second lowest mean on BDI scores.
2) Among Black females, higher depression scores were associated with more self reported problems in family and personal relationships, finances and general living conditions.
3) Problems of impulse control and negative perceptions of body and self image were found.
4) Emotional feelings of external mastery and all level of psychological maladjustments were also found.
5) Black females with higher BDI scores tended to be less involved in extra curricular activities.

6) Again Black females had lower grade point averages and expressed lower educational and occupational aspirations.

Dressler (1986) studied the relationship between unemployment and mental health to explore the phenomenon of depression. A total number of 179 Ss were used. Among them, 130 were employed and their mean age was 42.8 yrs. The rest 49 Ss were collected from unemployed persons. Their mean age was 30.6 yrs. All the Ss were collected from a Black Community in the southern part of USA. A sub-scale from a shortened version of the Hopkins Symptoms Checklist was used for measuring depressive symptoms. Demographic data and 2 measures of social stressors were also obtained. Multiple regression analysis showed that unemployment was significantly related to higher depressive symptoms. Demographic factors, chronic stressors, other life event and resistance resources were independent of this finding. The effect of unemployment was caused by low household income and the occurrence of other life event. The results supported the conclusion that the unemployment accounts for substantial risk for depressive affect.

Hokanson et al. (1980) tested a model of maternal postpartum depression. Two aspectsof postpartum

depression sere selected. The first part stated that difficult infant temperament was construed as a stressor. The second part of it stated that supporting interpersonal relationship were construed as a protective measure. A total of 55 married women aged between 19 to 38 yrs were selected. They were assessed during pregnancy and 3 months postpartum. Infant temperament was assessed through observation of maternal crying records. The Beck Depression Inventory was used to measure the mother's level of postpartum depression. The path analysis indicated that infant temperamental difficulty was strongly related to the mother's level of postpartum depression. Social support appeared to exert its protective function against depression primarily through the mediation of self efficacy.

Rao (1994) conducted a study to determine whether major depressive disorder might be associated with serologic evidence for a chronic active Epstein Barr (EB) virus infection. Viral-specific antibodies were measured in 43 depressed patients. They were aged between 24 to 65 yrs. A matched health volunteers were selected as control group. They were 46 in numbers and the mean age ranged between 31.4 to 36.9 yrs. No evidence the depression affects cellular immunity was found. A persistence EB virus was not detected to activate

depression. There was no evidence that depression results from an unrecognised chronic active EB virus infection on the basis of these findings. The investigator concluded that the routine clinical determination of expensive commercial EB virus antibody profiles is not indicated in most patients with major depressive disorder in the absence of their signs of chronic active EB viral infection.

Greenberg et al. (1992) conducted a study on psychosocial characteristics of double depression. Double depression was conceptualised as the combination of major depression and dysthymia. The study used one experimental group and control group. Experimental group was composed of 39 patients with double depression The mean age was 34.8 yrs. The control group was composed of 38 patients with recurrent major depression without dysthymia. The mean age was 39.2 yrs. These two groups were compared on a number of severity of illness. Psychosocial and biological variables were taken into consideration. Results indicated that dysthymic Ss had more severe course of illness. But no significant differences were found on any psychosocial and biological measures.

Kandel et al. (1982) conducted a study to investigate the effects of clinical depression. The study

used two groups of Ss. One was experimental group and the other was control group. The experimental group was composed of 20 patients aged between 19 to 54 yrs. They were diagnosed with major depression. The control group was composed of 20 no-depressed normal persons. The Luria Nebraska Neuropsychological Battery (LNNB) was administered on both the groups. The depressives were found to perform significantly worse than the normal person on 2 global LNNB summary scales. The profile Elevation Scale and the Impairment Scale. Again the experimental groups did worse than the normals on all 14 LNNB clinical scales. Again the depressive performed significantly slower than the normals on the timed items of the test. No support was found for the relationship between test performance severity and depression.

Kendler et al. (1993) conducted a study on motivational and volitional determinants of depression. The investigators selected 18 hospitalised patients. They used 3 non-depressed control groups consisting of 10 university students, 10 hospitalised schizophrenics and 7 hospitalised male alcoholics. In this study the investigators made an attempt to induce a degenerated intention in depressive patients in the experimental groups. The purpose of this study was to examine whether depressives have an increased tendency to maintain unrealistic intention. Another objective of the

study was to examine the effects of reduced memory capacity following suggestion of an unrealistic goal. The results indicated that the tendency to encode unrealistic instruction appeared to be associated with a personal history of depressive episodes. Furthermore, experimental manipulation produced short term memory deficits in depressive Ss. But memory capacity was unaffected for non-depressed Ss.

Colemen, and Beck (1981) conducted a longitudinal study on maternal depression. The purpose of the study was to examine depression in mothers after 6 yrs. of the birth of a first child. A total of 124 women of mean age 22.8 yrs. was selected as Ss. These women were seen during their first pregnancies at 4, 14, 27, 42 and 82 months after the birth of first child. The results indicated that depression was more likely to occur in the Ss after 82 month of the birth of child. Again Ss who were associated with cross-sectionally with social and familial circumstances were also found depressed. Again Ss associated with social class having marital relationship and child behaviour at home and at school expressed depressive symptoms.

Newman (1979) conducted a study on gender, life stress and depression. The Ss was composed of 460 men and 566 women aged 18+ yrs. The purpose of the study

was to assess gender differences in the development of depression due to stressful life circumstances. The Ss were administered a depression scale. The purpose of the scale was to differentiate between dysphonic mood and other forms of distress with depressive syndromes. The findings of this study showed that women were more likely than men to suffer hardships associated with the absence of a spouse, social isolation, financial difficulties and chronic health problems. However, none of these hardships had significantly greater impact on depressive syndrome levels for women than for men.

Shapiro et al. (1994) conducted an experiment on seasonal variation in mental depression and its correction with occupation. A total of 806 males aged 50+ yrs. participated in this study as Ss. A 12-Item Questionnaire was used as instrument. The investigator examined the seasonal variation in non-psychotic depressive morbidity. The findings of this study revealed a significant seasonal pattern in depressively with its peak in early summer. There was also a significant difference in the pattern of depression depending on occupation. The summer peak for depression was typical of the middle social class and agriculture occupations. The monthly variation in depression showed some association with length of day but not wit air temperature.

Brown (1995) conducted a study on internal attribution and self esteem in depression. This study was based on the attribution reformation or learned helplessness theory. This theory proposed that causal judgement on internal-external dimension led to the depressive deficit of low self-esteem. In support of this theory, Brewin conducted the study on internal attribution and self-esteem in depression. The finding of this study found no evidence to support the theory that low self-esteem in depression is primarily a function of judgment about the causes of negative outcomes. Non-causal cognitions such as self evaluative judgements that are characteristic of depression could provide an alternative explanation of reduced self-esteem. In particular, self-esteem deficits may be associated with a perceived discrepancy between internal standards and actual performance.

Hooley et al. (1986) conducted a study to find out the relationship between expressed emotion and depression. A total of 30 clinically depressed patients was selected as Ss. The mean age of the patients was 46.6 yrs. The investigator investigated the behaviour of these patients and their spouses (mean age 46.6 yrs.) during a 10 minutes face to face interaction. Spouses were classified according to high or low level of expressed

emotion. A Comberwell Family Interview was used for measuring the expressed emotion. The couples were allowed to discuss low conflict issues on which they held different views. The whole discussion session was videotaped. The findings indicated that high expressed emotion spouses were more negative and less positive both verbally and nonverbally for their depressed partners as compared to the low expressed emotion spouses. High expressed emotion spouses made more critical remarks. They disagreed to accept the opinions of their depressed partners.

In the perspective of above analytical presentation of relevant review of literature of previous ~~shows~~ findings, the present investigation would conduct an empirical study on depression in adult ~~is relates~~ as related to sex, socio-economic status and residential background.

Chapter-II

Methods and Procedure

Method and procedure

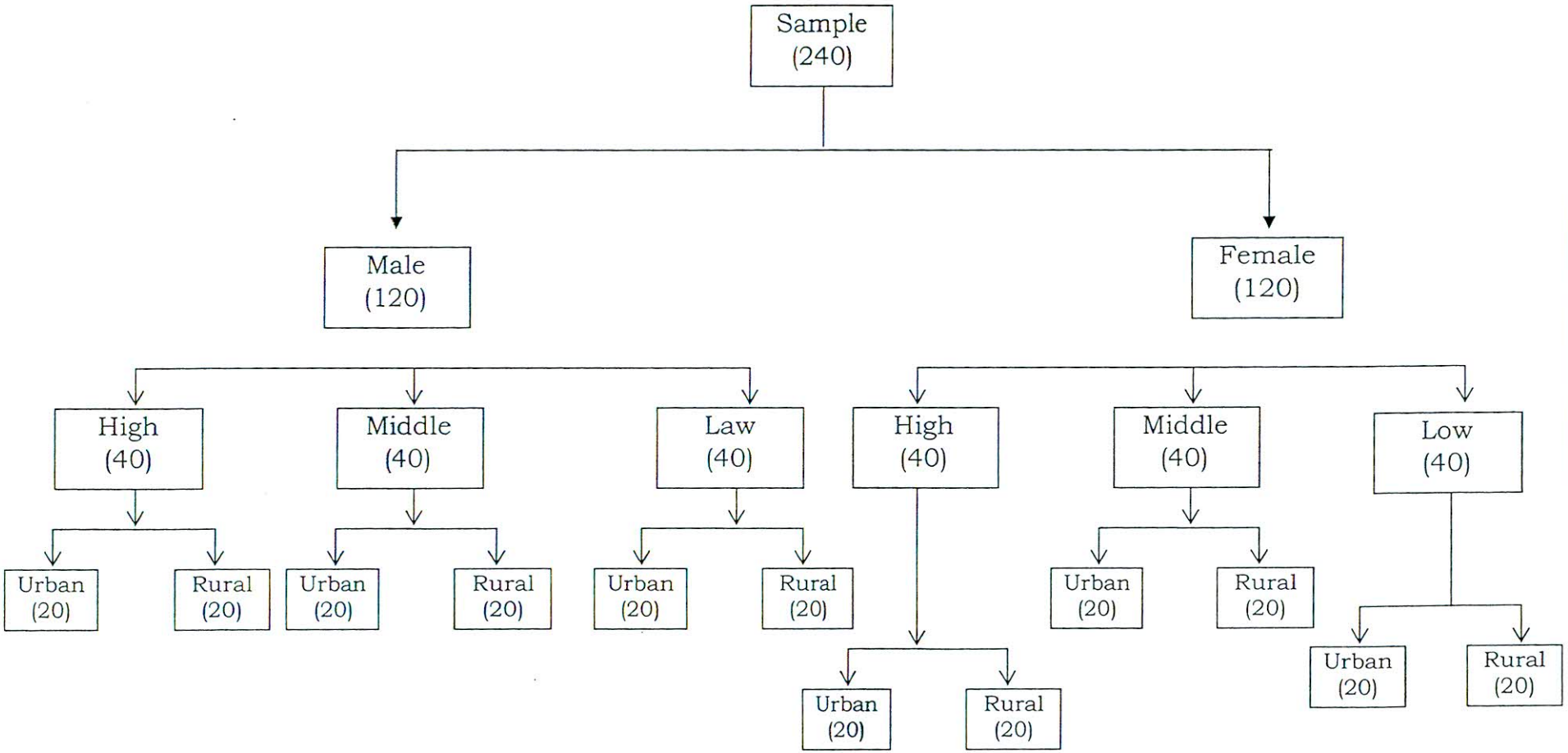
The present section deals with the mode of sample selection. It also describes the Depressive Experiences Questionnaire (DEQ). Finally, it describes the procedure of data collection.

Mode of sample selection

The present study was an empirical investigation in the development of depressive symptomatology in adults as related to gender, socioeconomic status and residential background in the socio cultural context of Bangladesh. In the developmental stages of life span, adulthood has three subdivisions. These are early adulthood extending from age 18 to approximately age 40. Middle adulthood starting at 40 and extends to age 60. Late adulthood begins at 60 and extends to death. The present study has utilized middle adulthood as population for the administration of DEQ and collection of data on depression. Thus the sample of the present study constituted to 240 respondents between 40 to 60 years of age. They were collected from different areas of Rajshahi and Chapai Nawabgonj districts. The areas of Rajshahi districts were Rajshahi city and villages of Poba Upo-zilla. The areas of Chapai Nawabgonj district cover such places as Nawabgonj town and villages of Shibgonj

Upo-zilla. Thus 240 respondents were selected equally divided into males and females. Each category was then equally subdivided into high, middle and low socio-economic status. Each subdivision was again equally divided into Urban and Rural on the basis of residential background. The sample distribution has been schematically presented in the following diagram.

Table-1: Showing a schematic diagram of Sample distribution



The sample of the present study belonged to different occupations. The occupations were teaching in schools and collages and services in Govt. and non-Govt. offices. Educated farmers and businessmen were also included in the sample. The educational qualification of the respondents ranged from class v to post graduation.

Selection of instruments

The present study used Depressive Experiences Questionnaires for data collection. The study also used Socio-Economic Status Scale for sample selection.

The selection of measuring instruments for psychological study depends on several considerations. The basic consideration for instrument selection is based on the objective of the study. The second consideration for the selection of instruments is based on the characteristics of the sample used in the study. The third consideration is related with the amount of time at the investigator's disposal. The fourth consideration is related with the design of the experiment. The fifth consideration in related with the methods used in data collection. The sixth consideration is related with the personal competence of the investigator. Lastly, subject's age, education the amount of money required and ethical considerations may account for selection a particular type of measuring instruments. On the basis of these

considerations and rational, the investigator found Depressive Experiences Questionnaire nadir appropriate for data collection in the present situation of socio-economic context of Bangladesh.

Depressive Experiences Questionnaire.

An extensive review on the construction and development of tests on depression has been made by Shaver and Brennan (1991). According to them, depression is a technical term within psychiatry and clinical psychology. Such terms as loneliness', sadness alienation, low self esteem, external locus of control, helplessness dissatisfaction with life, suicidal ideation and many terms on the line of frustration are found related in depressive symptoms.

Depression is a complex syndrome

According to DSM-111 (American Psychiatric Association, 1980). A major depressive episode is indicated by ``dysphoric mood" or loss or interest or pleasure in almost all usual activities. It is characterized by such adjectives as depressed, sad, blue, hopeless, low, down in the dumps and irritable. The mood disturbance mast be prominent and relatively persistent. As the DSM-lll has stated, a depressed individual must have at least four of the following symptoms. These

symptoms must be present in the individual every day or for a period of at least two weeks. These symptoms are as follows.

(1)Poor appetite,

(2) Significant weight loss,

(3) Insomnia or hypersonia,

(4) Agitation or retardation,

(5) Loss of interest or pleasure,

(6)Decrease in sexual drive,

(7) Loss of energy,

(8) Fatigue,

(9)Feelings of worthlessness,

(10)Self-reproach

(11) Excessive or inappropriate guilt

(12) Evidence of diminish ability to think or concentrate

(13) Slow thinking

(14)Indecisiveness

(15) Recurrent thoughts of death, suicidal ideation,

(16) Wishes to be dead or suicidal attempt.

Differences among depression measures are based on syndrome concepts. Some emphasize behavior ,some emphasize cognitions affect or mood , some emphasize cognitions and some emphasize vegetative processes such as appetite , sexual interest , sleep disturbances etc . The present study have been designed to measure

depression as behavior, affect or mood and cognitions. The depressive Experiences Questionnaire (DEQ) has been constructed by Blatt, D'Afflitti and Quinlan (1976a) in this direction. The investigator found this measure of depression appropriate for the study of depressive symptoms in adult males and females in Bangladesh.

Bengali adaptation of the depressive experiences Questionnaire (DEQ) was done by Huq (1996). This Bengali adaptation was used for data collection in the present study. A short history of depressive experiehees Questionnaire and its procedure for Bengali adaptation has been descried below.

Blatt et al. (1976 a) developed the Depressive Experiences Questionnaire (DEQ) to measure two major dimensions of depression. These are anaclitic depression and introjective depression. Anaclitic depression is characterized by intense feelings of helplessness, neediness, fear of abandonment and dependency on others. Introjective depression is characterized by overly stringent standards for the self, feelings of guilt, worthlessness and loss of selt-esteem. Blatt et al. (1976b) conducted factor analysis and three factors emerged. Factor I corresponded to the anaclitic, interpersonally oriented personality type. Factor II corresponded to the

introjective of self-critical personality type. Factor III presented a positive picture of secure goal striving, pride etc. This indicates invulnerability to depression. Blatt and his associates name the three factors as dependency, self-criticism and efficacy. Dependency stands for DEQ-A (Anaclitic), self-criticism stands for DEQ-I (Introjective) and efficacy stands for DEQ-E (Efficacy).

In the original Blatt et al. (1976b) study, the sample was composed of 500 female and 160 male undergraduates. In the Welkowitz et al. (1985) study, Ss were 55 male and 76 female psychology students at New York University. Klein (1989) revised the DEQ and tested 45 male and 118 female outpatients. Klein also tested 73 adolescent and Young adult palients.

Blatt et al. (1976b) computed reliability through the methods of internal consistency and test-retest reliability. The three factors such as dependency, self-criticism and efficacy provide indirect evidence for the internal consistency of the subscales. Welkowitz, et al. (1985). Reported α coefficients for subscales based on unit-weighted items: DEQ –A, 0.81; DEQ –I, 0.86; and DEQ-E, 0.72. Klein et al. (1989) reported α coefficients of 0.79, 0.82 and 0.59 for clinical patients and 0.86, 0.83 and 0.72 for normal sample. Thus, across different

samples, the α coefficients are comparable and the A and AI factors seem internally consistent.

Validity of DEQ has been worked out. Blatt et al. (1976b) found that DEQ-A (dependency) did correlate with ratings of the real self. DEQ-I (self-criticism) correlated with measures related to depression. Welkowitz et al. (1985) correlated each of the three subscales with the Beck Depression Inventory (BDI) separately for males and females . The correlations for males and females were 0.48 for 0.39for DEQ-A, 0.62 and 0.58for DEQ-I, -0.18and –0.14 for DEQ-E klein (1989) correlated scores between original DEQ scoring and Welkowitz et al .(1985) scoring system. Across sexes and samples, the correlations for the dependency scale ranged form 0.81 to 0.9, for the self-criticism scale 0.58 – 0.92; for the efficacy scale 0.86 – 0.93. These correlations suggest that the original and revised scoring systems yield similar results.

The original form of DEQ developed by Blatt et al. (1976b) has been revised by welkowitz et al. (1985). Items of the Bengali adaptation of DEQ have been selected from the revised form. The original form of DEQ had 66 items. The revised form (Welkowitz et al, 1985) selected 43 items from the original form. These were 20 for anaclitic, 15 for introjective and 8 for efficacy. The

Bengali adaptation of DEQ has taken items from anaclitic and introjective subscales. Thus it selected 20 (anaelitic) and 15 (introjective) items. Thus the Bengali adaptation form initially selected 35 items. These items were translated in Bengali by Z Huq (1996). Then these were corrected by a teacher of English department, Rajshahi University. Then the corrected form of Bengali version was given to experts. The experts were constituted of six teachers of psychology department. Three of them were from Rajshahi University and the remaining three were from Dhaka University. The experts were asked to examine each item as to whether it expresses a depressive symptom. The depressive symptom, their operational definition and the number of items are given below:

Table 2: Showing depressive symptom, their operational definition and the number of items.

Depressive symptom	Operational definition	Number of items
1. Self devaluation	Self-criticism	2(2),3(4)
2. Helplessness	Feeling of loneliness	1(1), 5(7)
3. Sadness	Expression of grief	13(16), 22(27)
4. Hopelessness	Feeling of despair	9(11), 23(28)
5. Cognitive difficulty	Poor concentration, inhibition of thought Process and difficulty in thinking clearly	16(34),
6. Sense of responsibility	Dutiful, disciplined life	15(18), 18(21)
7. Interpersonal difficulty	Problems in making friendly relationship	4(6), 14(17)
8. Anxiety	Apprehension, fearfulness	10(13), 17(20)
9. Social withdrawal	Decreased social activities, avoidance of other people	7(9), 11(14)
10. Guilt	Feelings of sinfulness	20(24), 21(25)
11. Agitation	Restlessness, nervousness or excitedness	8(10), 19(22)
12. Pessimism	Despair about the future	6(8), 12(15)

Note: Numbers in the parentheses indicate original number.

Thus the experts identified 23 items that express depressive symptoms. These 23 items were included in the final selection of the questionnaire. Thus the Depressive Experiences Questionnaire of Bengali version was adopted on the basis of full agreements of the experts. In this sense, the DEQ of Bengali adaptation may be said to attain face validity.

The Bengali from of DEQ was applied on an incidental sample consisting of 20 subject equally divided into males females. This pilot study was conducted in order to find out the internal consistency of test. Inter-item and item-total correlation were computer with selected 23 items. The correlation matrix of inter-item and item-total correlations has been reported in table 3.

Table-3: Showing inter-item and item-total correlation.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
1		-0.08	.67	.33	-.19	.25	.17	.17	.43	.36	-.20	.21	.21	.23	.25	-.33	.20	.28	.07	.007	-.07	.26	.25
2			.02	.22	.006	.23	-.002	-.09	.02	-.07	-.004	.15	.22	.06	-.37	.40	-.26	.30	.12	-.23	.37	-.02	-.36
3				.46	.04	.06	.05	.24	.36	.02	-.09	.04	.21	.28	.09	-.42	-.02	.30	.07	-.06	-.03	.03	.27
4					-.21	.20	.10	-.13	.04	.01	.43	.24	-.39	.34	.01	.10	-.004	.02	-.46	.10	-.16	-.14	-.19
5						-.02	-.03	.47	.58	-.08	.03	-.02	.58	-.003	.27	-.05	-.42	-.19	.46	.20	-.26	.17	.08
6							.41	.22	.08	.34	-.28	.29	.14	.30	.22	.44	.06	.09	-.22	.38	.44	.10	.17
7								-.03	.37	-.07	.04	.40	.03	.05	.16	.13	.41	.21	-.41	-.13	-.04	-.16	.005
8									.19	-.27	-.14	-.24	.48	.14	.09	-.02	-.22	-.20	.12	.61	-.03	.45	.36
9										.22	.08	-.13	.39	-.05	.33	-.20	.05	.02	.30	-.04	-.24	.36	.45
10											-.34	.08	.10	.39	.21	.20	.17	.21	.44	.02	.24	.21	.41
11												.20	.09	-.23	.14	-.11	.02	-.23	-.38	.06	-.50	.09	-.17
12													.09	.23	.06	.34	.09	.43	.04	-.001	.39	-.31	-.14
13														.05	.32	-.19	-.11	.40	.65	-.03	.32	.04	.15
14															.08	.32	.15	.15	.14	.28	.43	.22	.22
15																-.16	.15	.22	.08	.27	.09	-.15	-.26
16																	.15	-.14	-.08	-.04	.35	-.18	-.08
17																		-.24	-.37	-.19	.04	-.40	-.12
18																			.36	.21	.49	.02	.02
19																				-.09	.06	.08	.35
20																					.19	.48	.44
21																						-.02	-.04
22																							.62
23																							
										Item-total correlation													
	.60	.21	.42	.20	.27	.27	.22	.40	.52	.40	.21	.29	.57	.60	.46	.28	.04	.33	.26	.36	.48	.28	.50

It has been found that the coefficient of inter-item correlation ranged from- 0.50 to 0.67 and the item-total correlation ranged from 0.20 to 0.60. The inter- item correlations yielded both positive and negative correlations. This indicated both homogeneity and heterogeneity of items. It also indicated the direction in which each item was found to be differentiated. Furthermore, the item-total correlation showed the size of the correlation and the values of the correlation was found in positive direction. Finally, the method of split-half was used to find out the reliability of DEQ. The criterion of split-half was attained with odd and even numbers of 20 Ss. The coefficient of correlation between the two forms of odd and even numbers were computed and the r was 0.31.Using the Spearman-Brown formula, the coefficient of correlation was found to raise from 0.31 to 0.47. This indicated the high reliability of DEQ. Thus the inter-item correlations obtained from split-half method and the Spearman-Brown formula indicated that the reliability of DEQ is statistically sound and it is highly reliable.

The items of the DEQ were selected on the basis of full agreement of the judges. It indicated its face validity. The judges were asked to give their opinions about each item whether it expresses depressive symptom. This procedure fulfils the criterion of content validity. Furthermore, inter-dimensional correlation have been reported in table 4. it provided the validation of DEQ.

Table 4: Showing inter-dimensional correlation (N=20).

		1	2	3	4	5	6	7	8	9	10	11	12
1	Self-devaluation		0.76	0.29	0.11	0.17	-0.12	-0.29	-0.23	0.02	-0.01	0.19	0.22
2	Helplessness			.068	0.70	-0.09	0.25	0.21	0.08	-0.07	0.07	0.63	0.21
3	Sadness				0.54	-0.16	-0.10	-0.12	-0.34	-0.06	0.33	0.83	-0.19
4	Hopelessness					-0.16	0.30	0.05	0.59	0.06	0.11	0.45	0.002
5	Cognitive Difficulty						-0.19	0.23	0.16	0.01	0.35	-0.07	0.48
6	Sense of responsibility							-0.25	-.005	-0.08	-0.21	0.19	0.29
7	Interpersonal difficulty								0.18	0.01	0.19	-0.12	0.32
8	Anxiety									0.10	0.006	-0.31	0.08
9	Social withdrawal										-0.34	-0.43	0.07
10	Guilt											0.50	0.50
11	Agitation												-0.07
12	Pessimism												

Thus the final form of DEQ contained 23 items. The Highest Possible Score (HPS) was 23 × 7=161 and the lowest possible score (LPS) was 23×1=23. the depression score (DS)was obtained by using the formula:

$$DS = \frac{HPS - LPS}{2} + LPS$$

$$= \frac{161 - 23}{2} + 23$$

$$= \frac{138}{2} + 23$$

$$= 69 + 23$$

$$= 92$$

Following this formula, a subject falling on 92 or above would be assumed to have depressive score.

Procedure of have depressive score

The present investigation utilized the Bengali adaptation of Depressive Experiences Questionnaire for data collection. The questionnaire was administered on 240 subjects. Each subject was approached individually. They were asked to read the instruction attentively and to give their opinions about each statement by giving a tick (✓) mark on the number given below each statement. In order to check the false response, number 16 was repeated in number 24. the subjects who gave the same answer to number 16 and 24, they were supposed to attain consistency in their answers. The subject who gave different answers to numbers 16 and 24, they were supposed to be inconsistent. These subjects were thought as inconsistent and their answer sheets were rejected. The instruction was given in Bengali.

Method of Analysis

The data thus collected have been coded systematically for analysis. Analysis of variance (ANOVA) was computer for the preparation of results.

Objective

The broad objective of the present study was to conduct an empirical investigation on adults with

reference to their sex differences, Socio-Economic status and residential background. Some specified objectives are stated below .

(1) To highlight the stage of life span as adulthood and to provide on analytical presentation of depressive affects in these stage of life span .

(2) To provide a theoretical construct of depressive affects as mental disorder in the life style of old generation in Bangladesh.

(3) To reflect on various agentic factors of depression for a comprehensive understanding of the phenomenon of depression.

(4) To make a short review of previous empirical studies in its multi-facet aspects of depression.

(5) To focus on gender discrimination in depressive affects. Thus depressive affects have been accumulated for empirical verification and analytic presentation of depressive disorder.

(6) To study depressive affects in adult population as a function of high, middle and low socio-economic status.

(7) To focus an residential background in terms of urban and rural origin as independent variable leading to the growth of functional inability and emotional instability and old age flexibility in the form of depressive affects.

(8) To make a profile of relevant predisposing and precipitating factors associated with depressive mode of the adults in the social context of Bangladesh.

(9) To survey the adult population in Bangladesh with reference to their old age problems, depressive affects and situational condition at homes.

(10) To examine the empirical data relating to adult depression using statistical concepts and techniques.

Hypothesis

The present study was explorative in nature. However several specific hypotheses have been formulated. The hypotheses with their justification are given below

H_1: Female respondents would express more depressive affects than the male respondents at their adult stage of life span

This hypothesis has been framed under the theoretical construct and empirical verification of depression in different stage of life span. Several studies (Coryell, Endicott and Keller 1992, Kandel and Davies, 1982) have highlighted the gender discrimination in depression. They reported that women suffer from depression two-times more then men. The identified low self –esteem of the females as the cause of depression. It is found that males are regarded superior and females are regarded as inferior in respect of bodily strength, creativity and social activity. Again the fear of child birth, divorce social equality, economic disparity may lead the women to develop higher depressive affect than men. If is observed that these factors are present in Bangladeshi women also. Hence it is presumed that women in Bangladesh would develop more depressive symptoms than men in the social cultural economic and political context of Bangladesh. On the basis of these empirical findings and personal observation, it is hypothesized that female respondents would express more depressive affects than the male respondents at their adult stage of life span.

H_2: Respondents with low socio-economic status would express higher depressive affects followed by the respondents with middle socio-economic status and least by the respondents with high socio – economic status in the life cycle of adulthood.

This hypothesis in based on the assumptions of social class vulnerability model of depression. This theory of depression states that personal troubles are related with social class. The social class stratification is said to produce varied experiences in the life of the people. It is found that people belonging to low socio-economic status experience provoking agent of depression in many times greater than other social classes. As a result low self-steem and hopelessness become associated with low socio- economic status. These factors are important agents in the development of depression. On the basis of these empirical finding, it is hypothesized that respondent with low socio- economic status would express higher depression followed by the respondents with middle socio- economic status and least by the respondents with high socio- economic status in the life cycle of adulthood.

H_3: Respondents with rural residential back ground would express more depressive affects than the respondents with urban residential background .

It is said that depression occurs due to deficit in interpersonal relationship. But interpersonal relationship varies due to residential background. Urban and rural division of residence may create differences in the living style of the people. It may lead to low self-steem. In fact urban people are supposed to enjoy more privileges than the rural people. As a result, rural people suffer from low self-steem leading to the development of more depression. Again, rural life is simple but urban life is coupler. In the perspective of these arguments, it is hypothesized that respondents with rural residential background would express more depressive affects than the respondents with urban residential background.

Chapter-III

Result and Interpretation

Results and Interpretation

The present chapter contains the results and their interpretation. The results were computed using statistical technique of analysis of variance (ANOVA). The data in the present study were collected using the Depressive Experiences Questionnaire. The Questionnaire contained 23 statements. It was a 7- point scale. The highest possible score was 23×7=161. The lowest possible score was 23×1=23. Accordingly the depression score was calculated using the following formula.

Depression score =

$$\frac{Highestpossiblescore(HPS) - lowestpossilescore(LPS)}{2} + lowestpossielescore(LPS)$$

$$= \frac{161 - 23}{2} + 23$$

$$= \frac{138}{2} + 23$$

$$= 92$$

Hence a score on and above 92 was regarded as depression score. A score below 92 was regarded as non-depression score.

In order to obtain statistical significance of the effects of independent variables, the score Of DEQ were

subjected to a 2×3×2 analysis of variance (ANOVA) involving two levels of gender (male/female) three levels of socio – economic status (high/ middle/ low) and two levels of residential background (urban/ rural) . The results of ANOVA have been reported in table 5.

Table 5 : Showing summary of ANOVA involving gender, SES and Residential background on the scores of DEQ.

Sources of variance (SV)	Sum of squares (SS)	df	Mean squares (MS)	F	Level of significance
Gender (A)	4932.27	1	4932.27	345.15	0.01
SES (B)	2122.11	2	1061.05	74.25	0.01
Residence (C)	1581.07	1	1581.07	110.64	0.01
AB	654.91	2	327.45	22.70	0.01
AC	26.66	1	26.66	1.86	n.s
BC	349.01	2	174.5	12.21	0.01
ABC	88.61	2	44.30	3.10	0.05
W. cell (experimental error)	3258.12	228	14.29		
Total	13012.76	239			

The results (Table 5) indicate that the main effects of Gender, SES and Residential Background were statistically significant. Twoway interactions between gender and SES, SES and residential background were statistically significant. Furthermore, a three – way

interaction involving gender, SES and residential background was also statistically significant.

MAIN EFFECT

Gender

The results of ANOVA (Table 5) reported significant main effect for gender ($F= 345.15$, $df = 1/228$, $p<0.01$).

Table 6: Showing overall mean scores and significant mean difference between males and females on the Scores of DEQ .

Male	104.95 a
Female	114.01 b

N.B. Common subscripts do not differ significantly. Mean difference was computed using Newman – Keuls formula $P<0.01$

The results (Table 6) contains mean scores of male and female respondents on DEQ. An examination of mean scores revealed that regardless of SES and residential background, female respondents (M=114.01) expressed significantly higher depressive affects as compared to the male respondents (M=104.95). An inspection of mean scores showed that both male and female respondents reported mean scores above 92 indicating depression for both the groups. But females reported more depressive affects than the males.

SOCIO – ECONOMIC STATUS

The results (Table 5) reported that the main effect for Socio–Economic Status was statistically significant ($F=74.25$, $df=2/228$, $p<0.01$) .

Table 7: Showing overall mean scores and significant mean differences between high, middle and low socio – economic status on the scores of DEQ

High	106.63 a
Middle	108.22 a
Low	113.58 b

N.B. Common subscripts do not differ significantly. Mean differences were computed using Newman – Keuls formula $P<0.01$.

The results (Table 7) contains mean scores and mean differences between high and middle, high and low as well as middle and low socio – economic status. An examination of mean scores revealed that regardless of gender and residential background, respondents with low socio – economic status ($M=113.58$) expressed significantly higher depressive affect as compared to the respondents with high socio – economic status ($M=106.63$). Similarly, respondents with low socio – economic status ($M=113.58$) expressed significantly higher depressive affect as compared to respondents with middle socio – economic status ($M=108.22$). However, no statistically significant mean difference was obtained

between the respondents with high and middle socio – economic status in their depressive affects. It is important to note that all the comparison groups obtained scores above 92 indicating depressive affects.

Residential Background

The results of ANOVA reported in table 5 showed that the main effect for residential background was statistically significant (F=110.64, df =1/228, P<0.01).

Table 8: Showing over all mean scores and significant mean differences between the respondent with urban and rural residential background on the scores of DEQ.

urban	106.91a
Rural	112.05b

N.B common subscripts do not differ significantly. Mean differences were computed using Newman – Keuls formula p<0.01

The results (table 8) reports mean scores and significant mean difference between the respondents with urban and rural residential back ground. An inspection of mean scores showed that regardless of gender and socio – economic status , respondents with urban residential background (M=112.05) expressed significantly higher depressive affects as compared to the respondents with urban residential background (M=106.91). However, both the comparison groups

reported scores above 92 indicating overall depressive affects .

Interaction effect

Gender × SES

A two –way interaction involving gender and socio – economic status was statistically significant (F=22.70,df=2/228,p<0.01). This has been reported in table 5.

Table 9: showing cell means and significant mean differences representing two – way interaction between gender and socio – economic status on the scores of DEQ.

	High	**Middle**	**Low**
Male	99.85a	105.35b	109.65c
female	113.42c	111.10c	117.52d

N:B: common subscripts do not differ significantly. Mean differences were computed using Newman- keuls formula p<0.01 .

An inspection of mean scores (table 9) showed that male respondents with low socio- economic status (M=109.65) expressed significantly higher depressive affects as compared to male respondents with high (M=99.85) and middle (M=105.38) socio- economic status. Thus male respondents with low socio- economic

status expressed highest depression followed by middle and least by high socio- economic status. In case of females, it was found that respondents with low socio-economic status (M=117.52) expressed significantly higher depressive affects as compared to high (M=113.42) and middle (M=111.10) socio-economic status. However, no statistically significant mean difference was obtained between female respondents with high and middle socio-economic status .

In case of high socio-economic status, female respondents (M=113.42) expressed significantly higher depressive affects as compared to male respondents (M=99.85). Again, in case of middle socio-economic status, female respondents (M=111.10) expressed significantly higher depressive affects as compared to male respondents (M=105.35). Lastly, it was found that female respondents with low socio- economic status (M=117.52) expressed significantly higher depressive affect as compared to their male counterparts with low socio-economic status (M=109.65). Thus a linear relationship was observed between male and female respondents with high, middle and low socio- economic status resulting in interaction effect. The interaction effect has been graphically plotted in figure 1.

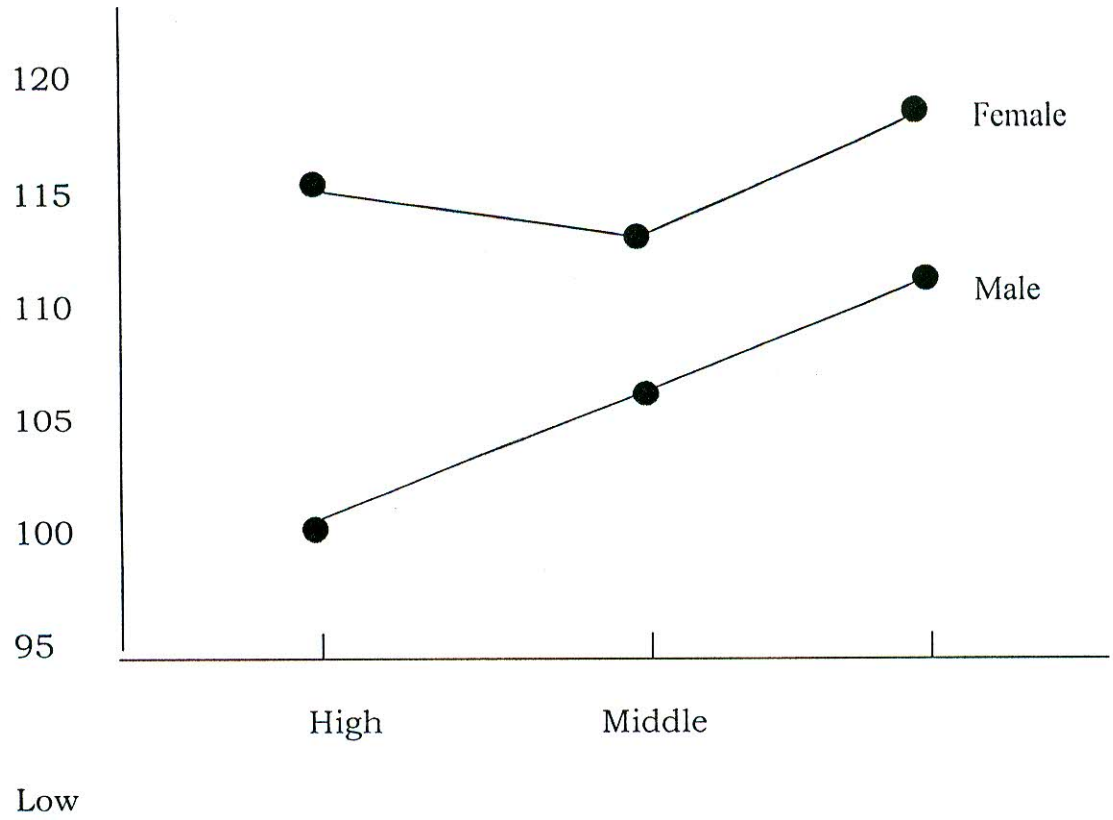


Fig- 1 : A two – way interaction between gender and socio-economic status on scores of DEQ.

SES × Residential Background

The results of the study were computed using the technique of Analysis of Variance (ANOVA).The results of ANOVA have been reported in table 5. A tow-way interaction involving SES and residential back ground was statistically significant ($F=12'21$, $df=2/228$, $p<0.01$)

Table 10: showing cell means and significant mean differences representing two-way interaction between SES and Residential Background.

	Urban	Rural
High	105.45 a	107.82 a
Middle	104.10 a	112.35 b
Low	111.2 b	115.97 c

N.B. common subscripts do not differ significantly .Mean defferences were computed using Newmann –keuls formula P<0.01

The results reported in (Table 10) contains the mean scores and mean differences between socio-economic status and residential background. An inspection of mean scores showed that respondents with low socio-economic status of urban residential background (M=111.20) expressed significantly higher depressive affects an compared to the respondents with high (M=105.45) and middle (M=104.10) socio-economic status of urban residential background. But no statistically significant mean difference was obtained between respondents with high and middle socio-economic status of urban residential background .

It was also found that respondents with low socio-economic status (M=115.97) of rural residential background expressed significantly higher depressive affects as compared to the respondents with middle (M=112.35) and high (M=107.82) socio-economic status

of rural residential background. Again respondents with middle socio-economic status (M=112.35) of rural residential background expressed significantly higher depressive affects as compared to respondents with high (M=107.82) socio-economic status of rural residential background.

Thus in case of rural residential background, respondents with low socio-economic status expressed significantly highest depressive affects followed by the respondents with middle socio-economic status and least by the respondents with high socio-economic status.

In case of middle socio.-economic status, it was found that respondent with rural residential background (M=112.35) expressed significantly higher depressive affects as compared to the respondents with urban residential background (M=104.10). similarly in case of low socio-economic status it was found that respondents with rural residential background (M=115.97) expressed significantly higher depressive affects as compared to the respondents with urban residential background (M=111.20). However, no significant mean difference between the respondents with urban and rural residential background was reported in ease of high socio – economic status. This has effected interaction. The interaction effect has been platted in figure 2.

FIG 2: A Two – way interaction between SES and residential background of the scores of DEQ.

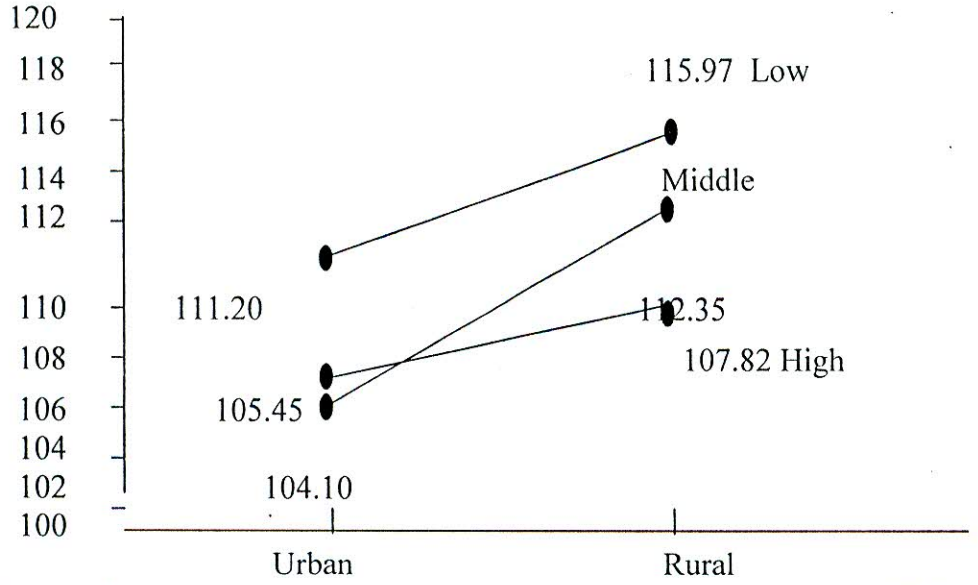


Fig . 2 : A two – way interaction between SES and residential background on the scores of DEQ

GENDER × SES × Residential background.

The results reported in (Table 5) showed that a three – way interaction involving gender, SES and residential background was statistically significant ($F=3.10$, $df=2/228$, $P<0.05$).

Table 11: Showing cell means and significant mean differences representing three-way interaction involving gender, SES, and Residential background on the scores of DEQ.

	Urban			Rural		
	High	Middle	Low	High	Middle	Low
Male	99.55 a	101.85 a	106.75 b	100.15 a	108.85 b	112.55 c
Female	111.35 c	106.35 b	115.65 d	115.50 d	115.85 d	119.40 e

N.B. Common subscripts do not differ significantly. Mean differences in appendix were computed using Newman – keuls formula $P<0.05$.

A Differential pattern of results was obtained for male and female respondents of urban and rural residential background with high, middle and low socio – economic statues. The results (Table 11) reported mean scores and significant mean differences between comparison groups. It was found that male respondents of urban residential background with low socio – economic status expressed significantly higher depressive affects (M=106.75) as compared to male respondents of urban residential background with high (M=99.55) and middle (M=108.85) socio – economic status.

Similarly male respondents of rural residential background with how socio – economic status (M=112.55) expressed significantly higher depressive affect as compared to male respondents of rural

residential background with high (M=100.15) and middle (M=108.85) socio – economic status. Again male respondents of rural residential background with middle socio – economic status (M=108.85) expressed significantly higher depressive affects as compared to male respondents of rural residential background with high socio – economic status (M=100.15).

It was also found that female respondents of urban residential background with low socio – economic status (M=115.65) expressed significantly higher depressive affects as compared to female respondents of urban residential background with high (M=111.35) and middle (M=106.35) socio – economic status. Furthermore, female respondents of urban residential background with high socio – economic status (M=111.35) expressed significantly higher depressive affects as compared to female respondents of urban residential background with middle socio – economic states (M=106.35).

Again, female respondents of rural residential background with low socio – economic status (M=119.40) expressed significantly higher depressive affects as compared to female respondents of rural residential background with high (M=115.50) and middle (M=115.85) socio – economic status. However, no statistically significant mean difference was obtained in

depressive affects between female respondents of rural residential background with high as well as middle socio – economic status.

It is important to note that male respondents of rural residential background with middle socio – economic status (M=108.85) expressed significantly higher depressive affects as compared to their male counterparts of urban residential background with middle socio – economic states (M=101.85). Similarly male respondents of rural residential background with low socio – economic status (M=112.55) expressed significantly higher depressive affect as compared to their male counterparts of urban residential background with low socio – economic status (M=106.65).

In case or female respondents it was found that rural respondents with high socio – economic status (M=115.50) expressed significantly higher depressive affects as compared to urban respondents with high socio – economic status (M=111.35) . Similarly rural respondents with middle socio – economic status (M=115.85) expressed significantly higher depressive affects as compared to urban residents with middle socio – economic status (M=106.35) . Again, rural respondents with low socio – economic status (M=119.40) expressed

significantly higher depressive affects as compared to urban respondents with low socio – economic status.

The results of the study have revealed differential amount of depressive affects for within group and between group comparisons. Thus female respondents of urban residential background with high socio – economic status (M=111.35) expressed significantly higher depressive affects as compared to their male counterparts (M=99.55) of urban residential background with high socio – economic status. Similarly, female respondents of urban residential background with middle socio – economic status (M=106.35) expressed significantly higher depressive affects or compared to their male counterparts of urban residential with middle socio – economic status (M= 101.85). Again female respondents of urban residential background with low socio – economic status (M=115.65) expressed significantly higher depressive affects as compared to their male counterparts of urban residential background with low socio – economic status (M=106.75). Thus it appears that female respondent of urban residential background with high, middle and low socio – economic status expressed significantly higher depressive affects than their male counterparts.

Similar findings have been reported in respect of rural residential background with high, middle and low socio – economic status between male and female respondents. It was found that rural females of high socio – economic status (M=115.50) expressed significantly higher depressive affects as compared to rural males with high socio – economic status (M= 100.15) Similarly rural females with middle socio – economic status (M=115.85) expressed significantly higher depressive affects as compared to rural males with middle socio – economic status (M=108.85). Furthermore, rural females with low socio – economic status (M=119.40) expressed significantly higher depressive affects as compared to rural males with low socio- economic status (M=112.55). Thus it appears that in case of rural residential background with high, middle and low socio – economic status, female respondents in general have expressed significantly higher depressive affect than female respondents. These differential findings effected interaction. The interaction effect has been plotted in figure 3.

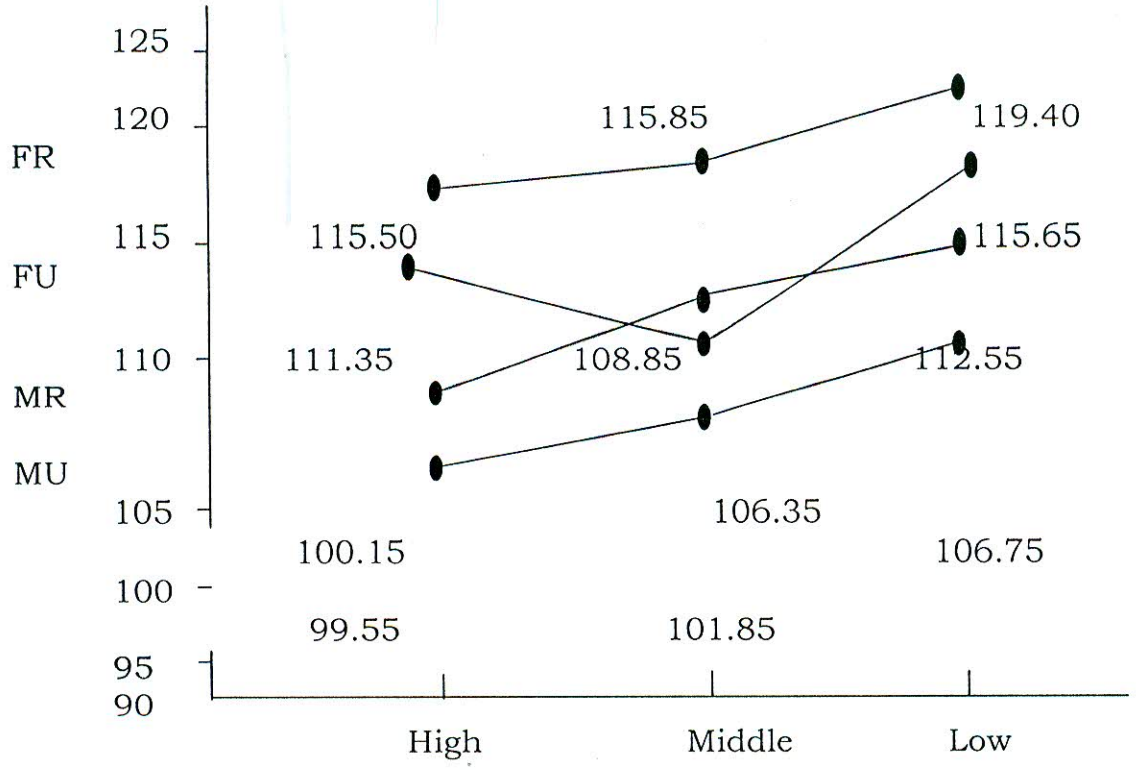


Fig 3: A three way interaction involving . Gender, SES and residential background.

Summary of main findings

1. Regardless of socio – economic status and residence, female respondents expressed significantly higher depressive affect than the male respondents.

2. Regardless of gender and residential background, respondents with low socio – economic status expressed significantly higher depressive affects than the respondents with high and middle socio – economic status.

3. Regardless of gender and socio – economic status, respondents with rural residential background expressed higher depressive affects than the respondents with urban residential background.

4. Female respondents with high socio – economic status expressed significantly higher depressive affects than the male respondents with high socio – economic status.

5. Female respondents with middle socio – economic status expressed significantly higher depressive affects than the male respondents with middle socio – economic status.

6. Female respondents with low socio – economic status expressed significantly higher depressive affects than the male respondents with low socio – economic status.

7. In case of males, it was found that respondents with low socio – economic status expressed significantly higher depressive affects than the respondents with middle and high socio – economic status.

8. Again, in case of males, it was found that respondents with middle socio – economic status expressed significantly higher depressive affects than the respondents with high socio – economic status.

9. In case of females, it was found that respondents with low socio – economic status expressed significantly higher depressive affects than the respondents with high and middle socio – economic status.

10. However, in case of females, no statistically significant mean difference was obtained between respondents with high and middle socio – economic status in their depressive affects.

11. In case of high socio – economic status, no statistically significant mean difference was obtained between the respondents with urban and rural residential background in their depressive affects.

12. In case of middle socio – economic status, it was found that respondents with rural residential background expressed significantly higher depressive affects than the respondents with urban residential background.

13. In case of low socio –economic status, respondents with rural residential background expressed significantly higher depressive affects than the respondent with urban residential background.

14. In case of urban residential background, male respondents with low socio – economic status expressed significantly higher depressive affects than the respondents with middle and high socio - economic status.

15. Similarly in case of urban residential background, female respondents with low socio – economic status expressed significantly higher depressive affects than the respondent with middle and high socio – economic status.

16. Furthermore, in case of urban residential background, female respondents with high socio – economic status expressed significantly higher depressive affects than the respondents with middle socio – economic status.

17. In case of rural residential background, male respondents with low socio – economic status expressed significantly higher depressive affects than the respondents with high and middle socio – economic status.

18. Similarly, in case of rural residential background, respondents with middle socio – economic status expressed significantly higher depressive affects than the male respondents with high socio – economic status.

19. Furthermore, in case of rural residential background, female respondents with low socio –economic status expressed significantly higher depressive affects than the respondents with high and middle socio – economic status.

20. But no statistically significant mean difference was obtained between female respondents with high and middle Socio-economic status in their depressive affects in case of rural residential background .

21. In case of respondents of residential background with high, middle and low socio-economic status, female respondent expressed significantly higher depressive affects than the male respondents.

22. In case of respondents with rural residential back ground of high, middle and low Socio-economic status, female respondents expressed significantly higher depressive affects than the male respondents.

Chapter-IV

Discussion and Conclusion

Discussion and Conclusion

The present study is an attempt to highlight the depressive affects of adults with reference to their sex discrimination, social stratification and residence. Accordingly data were collected using appropriate measures. Analyses of data were made with proper care and results were prepared with the help of standard statistical technique. The present section has utilized the main findings in a coherent way and interpretation has been made for an integrated analysis of the findings. Additionally adulthood depression has been interpreted in several sections. These are (i) Interpretations relating to gender discriminations. (ii) Interpretations relating to social stratification and (iii) Interpretations relating to residence.

An overview of the main findings of the present study indicates that depression is a current problem in males and females with urban and rural residential background. It is important to note that all the respondents obtained depressive scores indicating an overall serious condition in the field of mental health. In the perspective of this background, the present section provides interpretations of the findings in the sequel.

The study has formulated three hypotheses. The first hypothesis states that female respondent would express more depressive affects then the male respondents at their adult stage of life span. The findings of the present study have provided empirical supports to this hypothesis. It was found that regardless of socio-economic status and residence, the females expressed significantly more depressive symptoms as compared to males. A large number of previous studies have reported similar findings. For example, Dobson (1987) found that married women were twice depressed than their counterpart married men. The investigator explained this as the characteristics feature of marital adjustment. According to the findings of these studies, it was found that married women suffer from the anxiety of childbirth. Moreover women think that divorce is a great shock to them. Divorce is regarded as a socially unacceptable event for women. But men can take divorce as a simple event. According to the investigators of Western culture, women express more depressive symptoms due to the fear of child birth and divorce. In the present study, these findings have provided empirical support to the hypothesis that females would express more depression than males.

One probable reason of this finding might be that women in Bangladesh have less financial security in

absence of their husband. Moreover, women are socially, economically and politically dependent on males. Thus they are handicapped in respect of independent livelihood. It is perhaps, due to these economic, social and political constraints and discrimination that have led women to suffer from higher degree of depression than men. It is thus clear that women are regarded as disadvantaged group in society. This may account for higher depression in women than men.

The second hypothesis focused on socio-economic status. It was hypothesized that respondents with low socio-economic status would express higher depressive affects followed by the respondents with middle socio-economic status and least by the respondents with high socio-economic status in the life cycle of adulthood. The findings of the present study have provided empirical support to this hypothesis. It was found that respondents belonging to high, middle low socio-economic status have expressed depressive symptoms in higher intensity but it was found that respondents with low socio-economic status have expressed highest depression followed by the respondents with middle socio-economic status and least by the respondents with high socio-economic status.

In is argued that self-devaluation, helplessness, hopelessness and sadness are positively correlated with depression. Infact, socio-economic status emerged as effective variable in these human affective disorders. In the perspective of these psychological findings socio-economic conditions are found to be related with socio-economic status. It is a simplistic generalization that poor condition leads to frustration. Repeated frustration may be one of the major causes of depression. As the economic condition is very deplorable in case of the people with low socio-economic status, it is possible that the people with low socio-economic status become the victim of depression. People with middle socio-economic status are in better position in terms of economic condition. Hence, it is reasonable to argue that people from low socio-economic status would be more depressed because of their economic constraints. But people from middle and high socio-economic status are in better positions in society and as such they express comparatively less depression.

On the basis of these findings it is important to note that economic condition in terms of socio-economic status may account for depression in the context of Bangladesh. Previous findings on socio-economic status have provided documentary evidences that socio-economic status is positively related with depression.

(Blanchflower and Oswald, 2004). Consistent results have been reported by Kendler et al. (1993) and Silberg et, al (2001). These findings are adequate to make a conclusion that prosperity and depression are negatively correlate High prosperity is found to account for low or mild depression. But low prosperity is supposed to account for high and severe depression.

The third hypothesis of the study states that respondents with rural residential background would express more depressive affects than the respondents with urban residential background. The findings of the present study have provided supports to this hypothesis. This finding has its origin in the theoretical construct of the origin of depression. Shapiro et al. (1994) found that cognitive and behavioral styles cognitive and behavior styles rural population may produce atmosphere for higher intensity of depression than the population living in urban areas.

According to cognitive behavior theory of depression, it is argued that residential background may initiate cognitive and behavioral changes during socialization process. In this case respondents from rural residential background perceive the complexities of life more positively. This produces consequential changes in behavior. Similarly, psychodynamic-interpersonal

relations in rural life may produce acute problems difficult to over come. In fact, these problems create frustration and stressful life events leading to the development of depressive disorders in the respondents living in the rural areas.

Cognitive behavior theory of depression has provided several explanations. According to this theory, residential background may be treated as subculture. Hence, people living in towns and villages develop different ways of life styles. The people of urban residential background enjoy greater facilities in respect of education, living condition and other civic advantages. But people living in rural area are considered as disadvantaged group in respect of education, living condition and economic development.

It is this disparity that might be responsible for initiating differences in depressive affects between urban and rural population.

Several empirical findings may be advanced in support of the present study. For example Greenberg et al. (1992) reported that depression is a developmental process. As the socialization of males and females is different, depression may take varied forms in males and females due to differences in socialization. It is found

that a lot of restrictions are imposed on the females than the males. This subordinate status of females may account for higher depression in them. Furthermore, the dominant role of males may be responsible for creating depression in females. Fisher and Greenberg (1995) have found that many depressive attitudes have a long history of development in society. Differences in sex, residence and socio-economic status play important role for the emergence of depressive symptoms.

It is believed that better homes, better clothes and better education may provide the feelings of superiority. Similarly, bad living conditions, poverty and absence of proper education may provide the feelings of inferiority. Thus a cleavage is created between urban and rural population. Viewed from this perceptive, socio-economic status may be regarded as the demarcation line for depression (Hipp,1995).

Emery (1988) observed that sex differences may cause depression. According to him, the development of secondary sex characteristics have greater impact on females than males. As a result, females develop the feelings of isolation, social withdrawal and become subject to shame. Several psychiatrists (Hirschfeld, 1991; Herskowitz, 1988), identified depressed women emerging from parental residential back ground. They

observed that low self-esteem, over - involvement with friends and opposite sex, little involvement with the members of home are grounded in the residential background. Thus depression may occur.

It is also found that younger people were three times more depressed than the older people Additionally, they observed that females were diagnosed depressed three times more than males.

The experimental findings of previous studies, cited above provide empirical support to the findings of present study. It is suggested that personality traits may interact with the stressful events leading to the development of depression. Emotional dependency, less assertiveness and passivity in males and females may be regarded as roots of depression. Thus the findings of the present study reveal that depression is positively related with personality factors. Moreover residence and socio-economic status provide experiences to males and females leading to the development of adulthood depression.

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Appendices

APPENDIX

DEPRESSIVE EXPERIENCES QUESTIONNAIRE

(Original Form)

Name :

Educational Qualification :

Name of institution :

Age :

Instruction

Listed below are a number of statements concerning personal characteristics and traits. Read each item and decide whether you agree or disagree and to what extent. If you strongly agree, circle 7, if you strongly disagree, circle 1, if you feel somewhere in between, circle any one of the numbers between 1 and 7. The midpoint, if you are neutral or undecided, is 4.

1. Without support from others who are close to me, I would be helpless.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Partially Disagree	Neutral	Partially Agree	Agree	Strongly Agree

2. I often find that I do not live up to my own standards for ideas.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Partially Disagree	Neutral	Partially Agree	Agree	Strongly Agree

3. The lack of permanence in human relationships does not bother me.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Partially Disagree	Neutral	Partially Agree	Agree	Strongly Agree

4. If I fail to live up to my expectations, I feel unworthy.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Partially Disagree	Neutral	Partially Agree	Agree	Strongly Agree

5. Many times I feel helpless.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Partially Disagree	Neutral	Partially Agree	Agree	Strongly Agree

6. There is a considerable difference between how I am now and how I would like to be.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Partially Disagree	Neutral	Partially Agree	Agree	Strongly Agree

7. There are times when I feel "empty" inside.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Partially Disagree	Neutral	Partially Agree	Agree	Strongly Agree

8. I tend not to be satisfied with what I have.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Partially Disagree	Neutral	Partially Agree	Agree	Strongly Agree

9. I do bot care whether or not I live up to what other people expect of me.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Partially Disagree	Neutral	Partially Agree	Agree	Strongly Agree

10. I become frightened when I feel alone.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Partially Disagree	Neutral	Partially Agree	Agree	Strongly Agree

11. I would feel like I would be losing on important part of myself if I lost a very close friend.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Partially Disagree	Neutral	Partially Agree	Agree	Strongly Agree

12. I have difficulty breaking off a relationship that is making me unhappy.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Partially Disagree	Neutral	Partially Agree	Agree	Strongly Agree

21. The way I feel about myself frequently varies: there are times when I feel extremely good about myself and other times when I see only the bad in me and feel like a total failure.

1 2 3 4 5 6 7

Strongly Disagree Disagree Partially Disagree Neutral Partially Agree Agree Strongly Agree

22. Often, I feel threatened by change.

1 2 3 4 5 6 7

Strongly Disagree Disagree Partially Disagree Neutral Partially Agree Agree Strongly Agree

23. Even if the person who is closest to me were to leave, I could still "go it alone"

1 2 3 4 5 6 7

Strongly Disagree Disagree Partially Disagree Neutral Partially Agree Agree Strongly Agree

24. I often blame myself for things I have done or said to someone.

1 2 3 4 5 6 7

Strongly Disagree Disagree Partially Disagree Neutral Partially Agree Agree Strongly Agree

25. I often feel guilty.

1 2 3 4 5 6 7

Strongly Disagree Disagree Partially Disagree Neutral Partially Agree Agree Strongly Agree

26. I worry a lot about offending or hurting someone who is close to me.

1 2 3 4 5 6 7

Strongly Disagree Disagree Partially Disagree Neutral Partially Agree Agree Strongly Agree

27. Anger frightens me.

1 2 3 4 5 6 7

Strongly Disagree Disagree Partially Disagree Neutral Partially Agree Agree Strongly Agree

28. If someone I cared about become angry with me, I would feel threatened that he (she) might leave me.

1 2 3 4 5 6 7

Strongly Disagree Disagree Partially Disagree Neutral Partially Agree Agree Strongly Agree

29. After a fight with a friend, I must make amends as soon as possible.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Partially Disagree	Neutral	Partially Agree	Agree	Strongly Agree

30. I have a difficult time accepting weaknesses in myself.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Partially Disagree	Neutral	Partially Agree	Agree	Strongly Agree

31. After an argument, I feel very lonely.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Partially Disagree	Neutral	Partially Agree	Agree	Strongly Agree

32. In my relationships with others, I am very concerned about what they can give to me.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Partially Disagree	Neutral	Partially Agree	Agree	Strongly Agree

33. Very frequently, my feelings toward someone close to me vary: There are times when I feel completely angry and other times when I feel all-loving towards that person.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Partially Disagree	Neutral	Partially Agree	Agree	Strongly Agree

34. I am very satisfied with myself and my accomplishment.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Partially Disagree	Neutral	Partially Agree	Agree	Strongly Agree

35. Being alone doesn't bother me at all.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Partially Disagree	Neutral	Partially Agree	Agree	Strongly Agree

DEPRESSIVE EXPERIENCES QUESTIONNAIRE

(Bengali Adaptation)

নাম ঃ

স্থায়ী ঠিকানা ঃ

শিক্ষাগত যোগ্যতা ঃ

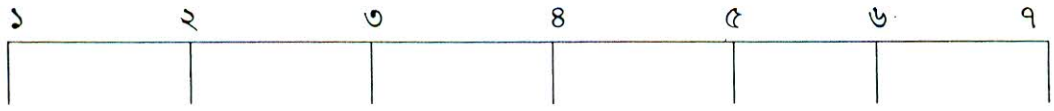
শ্রেণী	প্রাপ্ত নম্বর	বিভাগ

শিক্ষা প্রতিষ্ঠানের নাম ঃ

বয়স ঃ পুরুষ/মহিলা

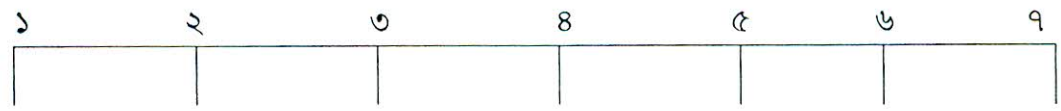
নির্দেশনা

নিম্নে কিছু বাক্য দেওয়া হলো। এই বাক্যগুলোর মাধ্যমে ব্যাক্তির অভিযোজন প্রক্রিয়া বর্ণনা করা হয়েছে। অনুগ্রহ পূর্বক বাক্যগুলো মনোযোগ দিয়ে পড়ুন এবং আপনার মতামত দিন। প্রত্যেক বাক্যের নীচে ৭টি বিকল্প উত্তর রয়েছে। এইগুলো নিম্নরুপঃ

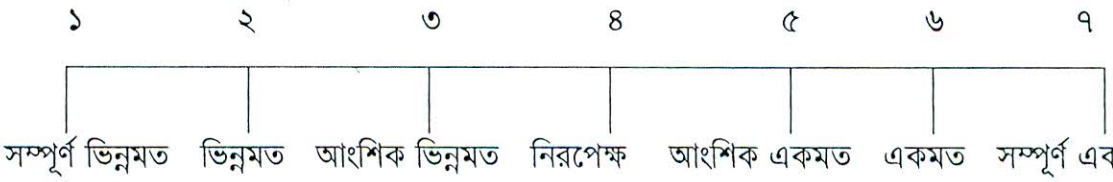


আপনি যদি প্রদত্ত বাক্য সম্পর্কে সম্পূর্ণ একমত হন, তবে ৭ এর উপর টিক (✓) চিহ্ন দিন। আপনি যদি প্রদত্ত বাক্য সম্পর্কে সম্পূর্ণ ভিন্নমত পোষন করেন তবে ১ এর উপর টিক (✓) চিহ্ন দিন। আপনি যদি প্রদত্ত বাক্য সম্পর্কে কোন মতামত দিতে না চান তাহলে ৪এর উপর টিক (✓) চিহ্ন দিন। এইভাবে ভিন্নমত, আংশিক ভিন্নমত, আংশিক একমত এবং একমতের জন্য যথাক্রমে ২,৩,৫ ও ৬ এর উপর টিক (✓) চিহ্ন দিন। গবেষণার কাজে সহায়তার জন্য আপনাকে ধন্যবাদ।

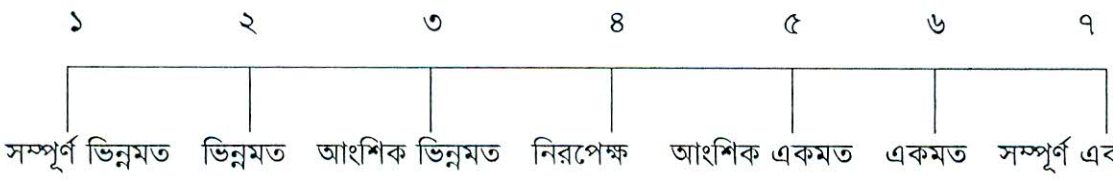
১। ঘনিষ্ঠজনের সমর্থন ছাড়া আমি অসহায় অনুভব করি।



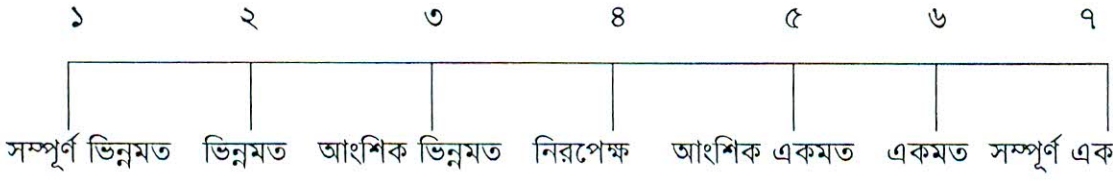
২। আমার প্রায় মনে হয় যে, আমি আমার আদর্শের মান অনুসারে জীবন যাপন করি না।



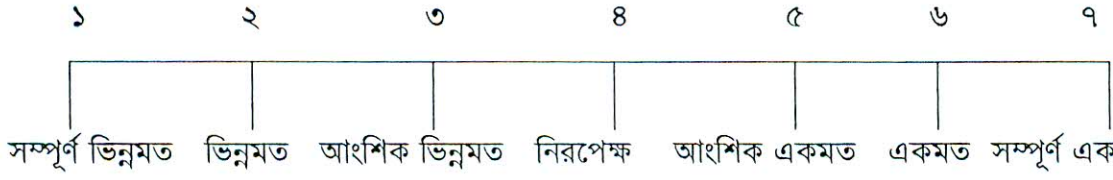
৩। প্রত্যাশা অনুযায়ী জীবন যাপনে ব্যর্থ হলে আমি নিজেকে অপদার্থ মনে করি ।



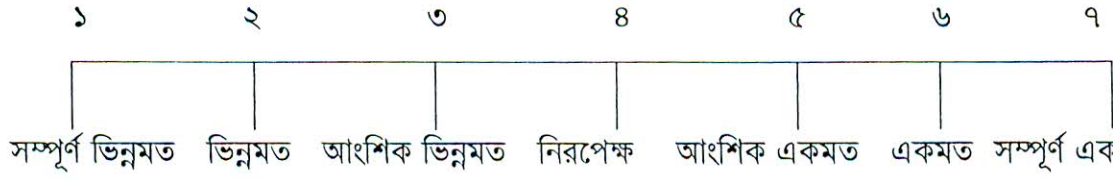
৪। আমি যা হতে চেয়েছিলাম এবং বর্তমানে যা হয়েছি তার মধ্যে অনেক পার্থক্য রয়েছে।



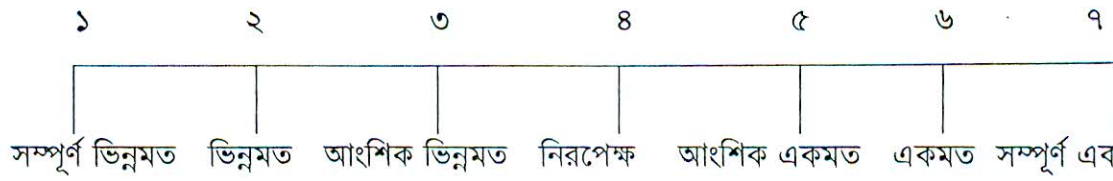
৫। এমন অনেক সময় আসে যখন আমি নিজের মধ্যে শূন্যতা বোধ করি।



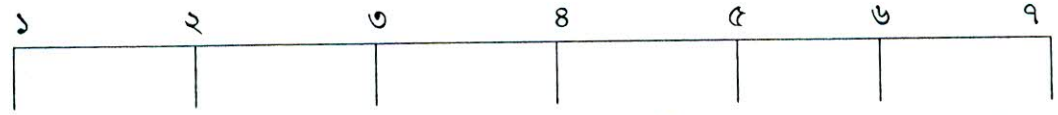
৬। আমার যা আছে তা নিয়ে সন্তুষ্ট না থাকার একটি প্রবণতা আমার আছে।



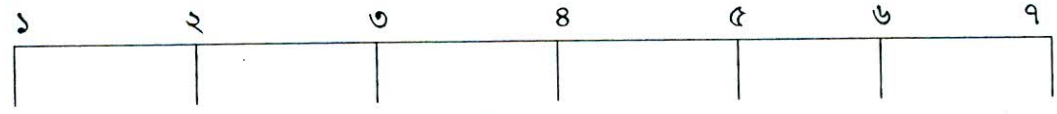
৭। অন্য লোকের প্রত্যাশা অনুযায়ী জীবন যাপন করছি কি না তা নিয়ে আমার কোন মাথা ব্যাথা নেই।



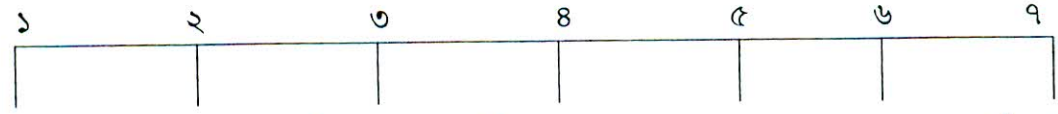
৮। নিজেকে একা বোধ করলেই আমি শঙ্কিত হয়ে উঠি।



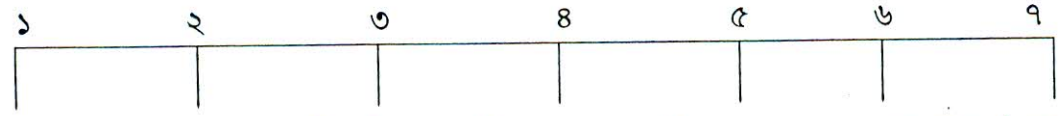
৯। একজন ঘনিষ্ঠ বন্ধুকে হারালে আমার মনে হয় যেন আমি আমার দেহের একটি গুরুত্বপূর্ণ অংশকে হারালাম।



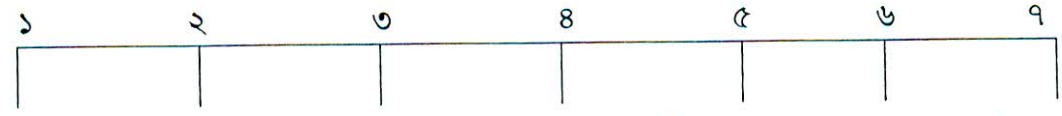
১০। আমার ঘনিষ্ঠ কোন জনকে হারানোর বিপদ সম্পর্কে আমি প্রায় চিন্তা করি।



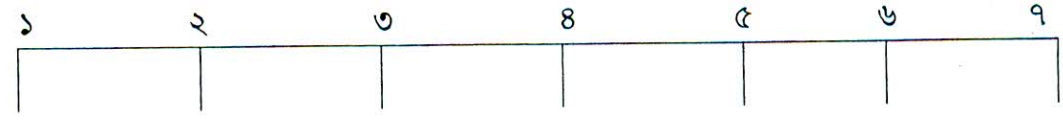
১১। অন্য লোকেরা আমার প্রতি কিরূপ প্রতিক্রিয়া করবে সে বিষয়ে আমি বেশী উদ্বিগ্ন নই।



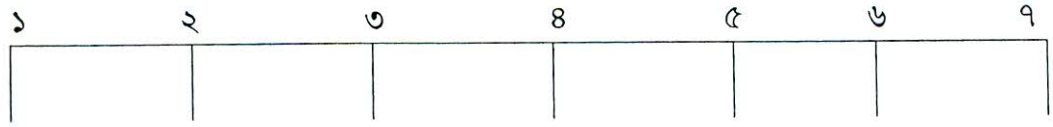
১২। দু'জন লোকের মধ্যে যতই ঘনিষ্ঠ সম্পর্ক থাকুক না কেন সেখানে সব সময়ই যথেষ্ট পরিমাণে সংশয় ও দ্বন্দ্ব বিরাজ করে।



১৩। প্রত্যাখ্যানের আভাস পেলেই আমি অন্যের প্রতি স্পর্শকাতর হয়ে পড়ি।

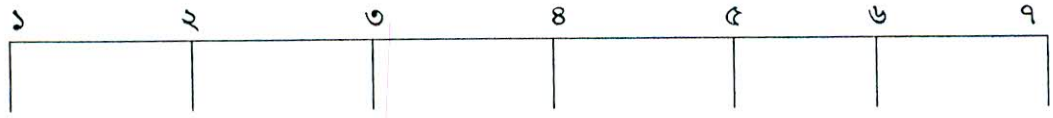


১৪। আমি প্রায় অনুভব করি যে, অন্যকে আমি হতাশ করেছি।



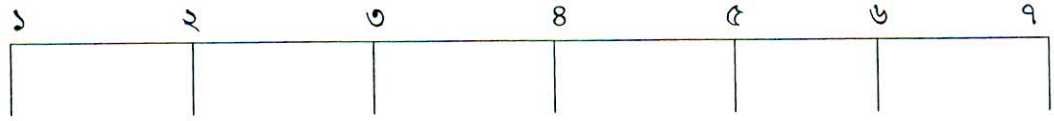
সম্পূর্ণ ভিন্নমত ভিন্নমত আংশিক ভিন্নমত নিরপেক্ষ আংশিক একমত একমত সম্পূর্ণ একমত

১৫। আমার ঘনিষ্ট ব্যাক্তিদের সন্তষ্ট বা সাহায্য করার জন্য আমি সর্বদা চেষ্টা করি এবং প্রায় আমি আমার গন্ডি বা সীমা অতিক্রম করি।



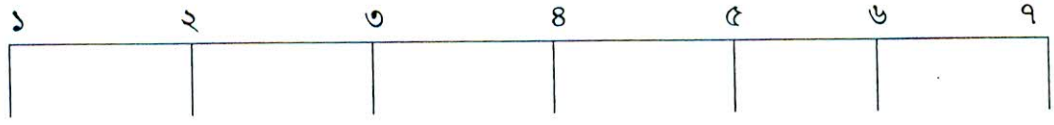
সম্পূর্ণ ভিন্নমত ভিন্নমত আংশিক ভিন্নমত নিরপেক্ষ আংশিক একমত একমত সম্পূর্ণ একমত

*১৬। আমার কৃতকর্ম ও আমাকে নিয়ে আমি অত্যন্ত সন্তুষ্ট।



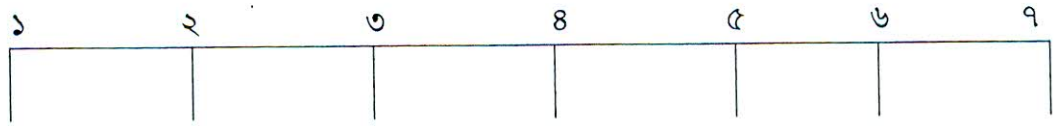
সম্পূর্ণ ভিন্নমত ভিন্নমত আংশিক ভিন্নমত নিরপেক্ষ আংশিক একমত একমত সম্পূর্ণ একমত

১৭। ঘনিষ্ট সম্পর্কের ক্ষেত্রে বাস্তবিকভাবে আমি কখনই নিজেকে নিরাপদ বোধ করি না।



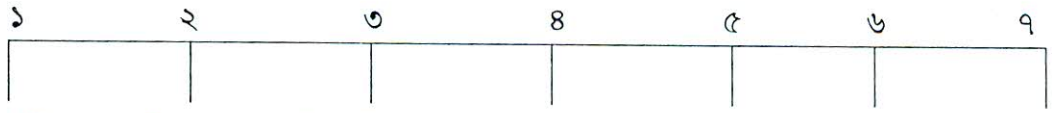
সম্পূর্ণ ভিন্নমত ভিন্নমত আংশিক ভিন্নমত নিরপেক্ষ আংশিক একমত একমত সম্পূর্ণ একমত

১৮। নিজের সম্পর্কে আমি যেভাবে চিন্তা করি তা ঘন ঘন পরিবর্তন হতে থাকে। কোন কোন সময় আমি নিজ সম্পর্কে অত্যন্ত ভাল বোধ করি। কিন্তু অন্য সময়ে আমি যখন নিজের মধ্যে শুধুমাত্র খারাপ বিষয়ে প্রত্যক্ষণ করি তখন মনে হয় আমি সম্পূর্ণ ব্যর্থ হয়েছি।



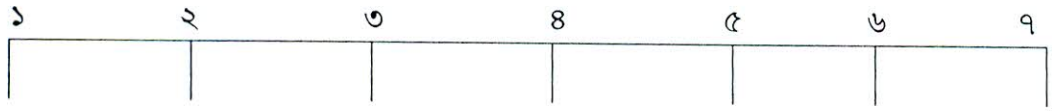
সম্পূর্ণ ভিন্নমত ভিন্নমত আংশিক ভিন্নমত নিরপেক্ষ আংশিক একমত একমত সম্পূর্ণ একমত

১৯। যে কোন পরিবর্তনই আমার কাছে হুমকি বলে মনে হয়।



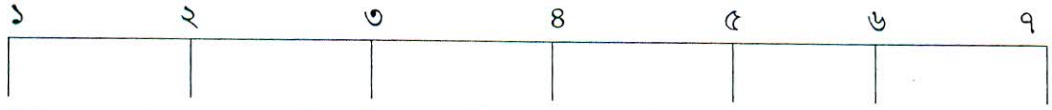
সম্পূর্ণ ভিন্নমত ভিন্নমত আংশিক ভিন্নমত নিরপেক্ষ আংশিক একমত একমত সম্পূর্ণ একমত

২০। অন্যের প্রতি আমার কৃতকর্ম বা বক্তব্যের জন্য আমি প্রায় নিজেকে দোষারোপ করি।



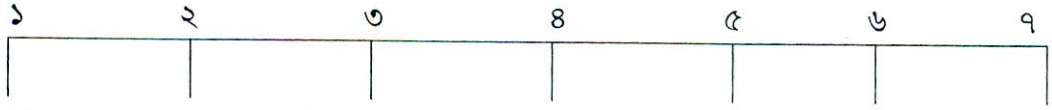
সম্পূর্ণ ভিন্নমত ভিন্নমত আংশিক ভিন্নমত নিরপেক্ষ আংশিক একমত একমত সম্পূর্ণ একমত

২১। আমি প্রায়ই নিজেকে অপরাধী মনে করি।



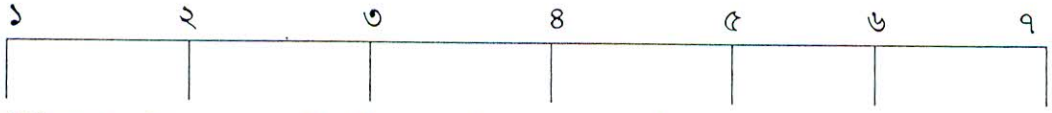
সম্পূর্ণ ভিন্নমত ভিন্নমত আংশিক ভিন্নমত নিরপেক্ষ আংশিক একমত একমত সম্পূর্ণ একমত

২২। ক্রোধ আমাকে ভীত করে।



সম্পূর্ণ ভিন্নমত ভিন্নমত আংশিক ভিন্নমত নিরপেক্ষ আংশিক একমত একমত সম্পূর্ণ একমত

২৩। যাকে আমি গুরুত্ব দিই এমন কোন ব্যাক্তি যদি আমার প্রতি রাগান্বিত হয়, তবে এই ভেবে আমি শঙ্কিত হই যে সে হয়ত আমাকে ছেড়ে চলে যাবে।



সম্পূর্ণ ভিন্নমত ভিন্নমত আংশিক ভিন্নমত নিরপেক্ষ আংশিক একমত একমত সম্পূর্ণ একমত

*২৪। আমার কৃতকর্ম ও আমাকে নিয়ে আমি অত্যন্ত সন্তুষ্ট।

সম্পূর্ণ ভিন্নমত ভিন্নমত আংশিক ভিন্নমত নিরপেক্ষ আংশিক একমত একমত সম্পূর্ণ একমত

বিঃদ্রঃ * উত্তরের সংগতি নিশ্চিত করার জন্য ১৬নং ও ২৪নং এ একই বিষয় বর্ণনা করা হয়েছে। যে সকল উত্তরদাতা ১৬নং ও ২৪নং এ ভিন্ন উত্তর দিবে, তাদের ফরম বাতিল বলে গণ্য হবে।