THE ASSESSMENT OF ATTRIBUTIONAL STYLES OF DEPRESSIVES AND NON-DEPRESSIVES THROUGH AN INDIGENOUSLY DEVELOPED DEPRESSION SCALE

by

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To the Creator

Who keeps replenishing my soul

with determination after every

disillusionment

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Preface

Beyond the cultural and geographical barriers, depression remains a disorder with high prevalence and disturbing consequences. Reasons can be many. An increase in life-expectancy in many countries runs parallel to the increase in the risk of developing depression. The rapidly changing psycho-social environment of today's world often gives rise to situation of acute or prolonged environmental stresses which may precipitate depressive reactions. If not, they may predispose humans to depression through more enduring changes in their attitudes towards stress and coping. Though we are about to usher in to the 21st century- a promise of technological surpass for some and corresponding cultural lag for many- yet, too often we find ourselves standing at the crossroads. The dilemma is that a conquest of space is not paralleled by a linear progress in finding solutions of social and psychological problems. We are a witness to unprecedented sufferings of humanity from the unsettling effects of uprooting, family disintegration and social isolation both due to the natural disaster and unchecked political ambitions. All of these factors make the prevalence of depression more likely, which if not present primarily, then accompanies other organic problems. Therefore, it becomes imperative to increase the efforts in the realm of research, so that effective decision making can take place in treatment. Such efforts are often thwarted as ecological validity of researches is quite weak. The application of findings becomes questionable if these ignore the very specific cultural variables operating upon the individuals.

The present work is an attempt to understand the culture-specific aspects of depression in relation to attributional style. The present research is the first of its kind in the perspective of Pakistani culture. The central theme for the present work is "indigenous". It is my understanding that humans are made of such diverse forces that any science which claims to study and understand human behaviour can not ignore the subjective processes operant within an individual in the context of his/her culture. Therefore, an attempt is made in the present work to tap the peculiar cultural realities by keeping the design of the research comprehensive enough to provide a qualitative insight into the attributional framework pertaining to depression. This is the least I could do to empathize with those who are tormented by the recurrent episodes of depression.

The completion of this work is itself a proof of kindness and cooperation of a number of persons. For this ambition of mine, I left my home for the first time and came to Islamabad, which was a strange city then and has become a sanctuary now. Beside academic enlightenment, Islamabad has blessed me with wonderful friends and benefactors. The beauty of the environ has stimulated my personal growth and the academic atmosphere has illuminated my mind.

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S. S.

Abstract

The present research, which comprised of two studies, investigated the relationship of attributional style and depression. The first study purported to develop and validate a self-report scale to measure depression in both clinical and non-clinical populations. An initial item pool of 72 items was generated from the university students. The items were then judged for their relevance to depression by the psychiatrists and clinical psychologists. A 50% consensus among judges was taken as criteria to select the depression related items. Thirty-six items so obtained were split into two equivalent halves and tested on the clinical as well as non-clinical groups. The scale showed a split-half reliability of $r=0.79$ for clinical group and $r=0.80$ for non-clinical group. It showed an overall internal consistency of 0.91 for clinical and 0.89 for non-clinical group. The scale correlated significantly with the Zung's Depression scale, $r=0.55$ ($p < .001$) and psychiatrist's rating of depression, $r=0.40$ ($p < .05$). The scale showed a significant correlation of $r = 0.64$ ($p < .001$) with reported mood in the clinical group, as compared to a non significant correlation of $r = 0.14$ ($p =$ n.s.) in the non-clinical group . The percentiles and cut-off scores for the clinical as well as non-clinical groups have been determined. The scale was used in studying the attributional style concomitant with depression. Sixty-two subjects in the age range of 22 to 29 years, were asked to report six important events of their lives followed by a description of the cause for each event. They were then administered the depression scale developed for the study. The

subjects were then classified into depressed and non-depressed on the basis of their scores on the scale. The results showed that the depressed and non-depressed differed significantly on the dimensions of global and with regard to their attributions for unpleasant events, whereas, for pleasant events they differed significantly only with reference to external attributions. The results also showed that the attributional dimension of global-specific significantly differentiated between non-depressed, mildly-depressed and moderately-depressed for pleasant events, whereas, for unpleasant events the significant dimensions were global-specific and stable-variable. The content analysis of the verbatim of the subjects revealed further the various categories employed by them. Findings are discussed in the light of cultural variables and methodological issues. Areas of further research interest have also been indicated.

Chapter 1

HISTORICAL BACKGROUND

I- Introduction:

Attributional styles are the peculiar explanations an individual generally employs to understand the reason of events happening in one's social or physical environments. The need to know "why" of an event, is instrumental in acquiring such explanations which in turn are governed by the desire to exert control on one's environment. We learn to attribute or assign cause to an agent in the environment at a very young age. We learn to understand how things happen by linking events in causal connections (for instance, we learned it when we were very young that it rains when there are heavy dark clouds). This learning pervades other areas of our interactions as well and often determines our reaction to an event. Psychologists have shown particular interest in this respect and from Heider (1958) to Seligman (1975) many theorists have forwarded important formulations regarding the acquisition and maintenance of attributions. Though the concept of attribution is popular both in social and clinical psychology, the majority of the work in clinical psychology relates to its relationship with depression. Seligman (1975) presented a helplessness model of depression and later, in collaboration with his associates, expanded it to entail the differential attributional style of depressed and non-depressed. The attributional model of depression formulated by Seligman and his associates became popular in clinical psychology and several studies

were carried out to test the validity of its postulates. The basic postulate of the reformulated attributional model forwarded by Abramson, Seligman and Teasdale (1978) is that depressed and non-depressed individuals differ in their attributional style. Depression is associated with a consistent tendency to attribute negative (unpleasant) events to internal, stable and global causes and positive (pleasant) events to external, variable and specific causes. Thus, according to reformulated attributional model depressed individual's view of causality is such that he or she accepts the blame for negative outcomes and refuses to take credit for positive outcomes. The formulations have been generally supported by empirical verifications and a moderate association exists between depression and a tendency to attribute negative events to oneself in a generalized and stable manner. However, few controversial findings have also questioned the very basis of these formulations. Coyne and Gotlib (1983) summarised the research findings in this respect by pointing out that :

> Overall, then, studies of attributions for negative hypothetical events have produced at best equivocal support for hypotheses derived from the learned-helplessness model of depression. Even when expected group differences are found, investigators have expressed disappointment concerning their magnitude. The learned-helplessness model receives greater support from attributions for positive hypothetical events than was the case laboratory successes, but here, too, results are generally weak and inconsistent. Finally, studies examining the causal relationship of attributions to depression have yielded mixed results, and this issue

remains unresolved (pp. 493) .

These findings advocate the need to further study the attributional approach to depression. Moreover, as most of the attributional work has taken place in the United States, it is necessary that a cross-cultural validity of the attributional formulation is determined in cultures representing a contrast in terms of normative and value structure. Therefore, the present study attempts to explore the relationship of attributional style and depression with reference to Pakistan. It is the contention of present researcher that this work will provide a cross-cultural validity of the attributional formulations. Most of the cross-cultural studies suffer from the 'imposed etic approach' (Berry, cited in Favazza & Oman, 1984), as they adopt without reservations the structure identified outside the culture and language in question. This realization runs central to the present work. It is this realization which lead the researcher to not only opt for the content analysis of verbatim expressions to explore the peculiar attributional style, it also argued for developing an indigenous measure of depression. The researcher is guided by the belief that emic or culture-specific is a particularly powerful and straight way to verify cultural universals (Church & Katigbak, 1989). The culture-relevant dimensions of depression were allowed to emerge independently to arrive at the indigenous expression of depressive symptoms. The relevance of instruments measuring depression, used in this research, helps draw more confident conclusions with regard to the relationship of depression with attributional style.

In the pages to follow, the phenomenon of depression has been reviewed with reference to its nature, symptom-pattern and assessment approaches, followed by

a critical overview of the various theoretical approaches to depression. The following sections entail a perusal of the attributional theories from the perspective of clinical psychology and a review of empirical literature with regard to the relationship of depression with attributional style. Chapter 2 outlines the objectives and methods of the research. As the present work consists of two studies, study I (pertaining to the development of indigenous depression scale) and study II (exploration of attribution style of depressed and non-depressed), the Method section describes the steps involved separately. For a logical flow of expression and grasp of findings, study I and study II have been discussed separately along with description of their respective findings. Chapter 3 gives a comprehensive understanding of the present work, by providing an integrative analysis of study I and study II. The implications of present findings and areas of further research have also been indicated.

II- Depression: A Review of the Phenomenon

"Lying awake, calculating the future,
Trying to unweave, unwind, unravel,
And piece together the past and the future,
Between midnight and dawn, when the past is all deception
The future futureless....."

T. S. , Eliot

Depression being the common cold of psychopathology (Seligman, 1973) has been viewed from varied perspectives giving rise to diverse explanation of the phenomenon. The diversity also pertains to the symptom patterns and a description of the features of depression. It appears paradoxical sometimes, that a phenomenon so commonly experienced has such changing and varied shades of explanation. The psychological concept of depression has been variously described as "having the blues"; feeling sad, guilty, hopeless, helpless, and melancholy; or reacting to the grief of losing some loved objects. It is also described as a feeling state or symptom, a syndrome or reaction, a character or life style, and/or an illness (Schuyler, 1974). A number of authors have addressed some of the major issues related to depression (e.g. Beck 1970; Cammer 1972; Depue and Monroe, 1978; ; Frank, 1975; Freud, 1959; Huesman, 1978; Kolb, 1977; Lowen, 1972; Rakoff, Stancer & Kedward 1977 ; Lewinsohn 1974 ; Schoolar, 1977; Schuyler, 1974; Seligman, 1975; White, 1964; Woody, 1978 & Zung, 1977). Specifically, consideration has been given to its mild, moderate or severe intensity as well as its acute, recurrent, or chronic duration (Cammer, 1972). It has also been viewed as developing in stages (White, 1977). Attention has also been focused on the

various socio-economic, gender-specific, and age related groups it encompasses, as well as the strong relationship which seems to exist between depression and suicide (Gaitz, 1977, Kane, 1977; Kaplan, 1977 & White, 1977).

Inspite of the diversity of explanation and the fact that depression may manifest differently across culture, there is a general agreement on the most common signs and symptoms of depression (Robins & Guze, 1970; DSM III-R, 1987). They are:

1. Sad and depressed mood.
2. Poor appetite and weight loss or increased appetite and weight gain.
3. Difficulties in sleeping (insomnia); not falling asleep initially, not returning to sleep after awakening in the middle of the night, and early morning awakenings, or (in some depressed patients) a desire to sleep a great deal of the time.
4. Shift in activity level, becoming either lethargic (psychomotor retardation) or agitated.
5. Loss of interest and pleasure in usual activities.
6. Loss of energy, great fatigue.
7. Negative self-concept; self-reproach and self-blame, feelings of worthlessness and guilt.
8. Complaints or evidence of difficulty in concentrating, such as slowed thinking and indecisiveness.
9. Recurrent thoughts of death or suicide.

A heuristic definition of depression with concomitant disturbances of the whole organism has been proposed by Zung (1977). He states that depression is a syndrome of general withdrawal of the functions of life. In the psychic aspect, there is a general disturbance of behaviour. The patient's ability to think, feel, experience and express emotions is disrupted. In the physiological sphere, disturbances in the patient's growth, metabolism, and reproductive processes occur. There is a decrease in appetite and food intake. There may be weight loss, impaired sleep, dysautonomias (familial defect characterized by defective lacrimation, skin blotching, emotional instability, lack of motion coordination and hyporeflexia) and decreases in energy and libidinal levels. Psychomotor movement is disturbed as expressed by agitation, restlessness, and aimless wandering or by retardation, inhibitions, and a slowing down of body movements. In the psychological sphere, general disturbances in responsiveness and adaptation take place. There is a loss of a sense of well-being, or there may be confusion, irritability, and indecisiveness. Suicide may become an option or may be viewed as a way out of feeling miserable (Zung, 1977).

Attempts have also been made to identify specific types of depression. These efforts have led to various dichotomous ways of categorizing this psychological construct. Some depressions are considered a normal reaction to the situations being experienced; for instance, pre and post menstrual depressions are differentiated from pathological depressions. Moreover, it is accepted if a person appears grief-stricken when a significant other is lost, either through a temporary or permanent separation or through death. With particular reference to Pakistan where dependency on significant others is

generally accepted if not encouraged, this observation assumes more significance. Children , here, remain dependent on their parents' social, economic and emotional support even when they become adult. The extended family system is instrumental in inculcating this interdependency among family members.In such an atmosphere a loss of significant other appears colossal, therefore, intense depressive reaction ensues. In most of the psychiatric departments here, such cases are frequently brought, where psychotic depression ensued following an apparently normal grief reaction after some significant loss of relationship or person. As the prolonged grief reaction is generally tolerated, the family takes time to realize that the reaction has gone out of proportion. In terms of classification, a normal depressive reaction becomes neurotic when the person shifts his attention from the significant other to self . These reactive depressions are usually precipitated by some event, e.g. , either through some loss (money, job, death), separation (school, move, divorce) or responsibility (new home, loans, job), which are generally regarded as some of the precipitating events. The vegetative or physical symptoms typically associated with psychotic depression, are, however, absent in neurotic depression. The reactive depression may become psychotic if the individual stops attending to the reality outside and tends to perceive most external references as pertaining only to him. This personalized interpretation of external happenings not only exaggerates the depressive reaction, it deprives the individual an opportunity to develop a realistic appraisal of the situation as well.

Coming towards the formal classification of the phenomenon, the second edition of Diagnostic and Statistical Manual(DSM II) listed depression in three major

diagnostic categories - major affective disorders, psychotic depressive reaction, and depressive neurosis, whereas, it's third revised edition (DSM III-R) divides mood disorder into bipolar disorders and depressive disorders. The essential feature of bipolar disorders is the presence of one or more manic or hypomanic episodes (usually with a history of major depressive episodes). The essential feature of depressive disorders is one or more periods of depression without a history of either manic or hypomanic episodes. Bipolar disorders are further divided: bipolar disorder, in which there is one or more manic episodes (usually with one or more major depressive episodes); and cyclothymic, in which there are numerous hypomanic episodes and numerous periods with depressive symptoms. Disorders with hypomanic and full major depressive episodes, sometimes referred to as "Bipolar II," are included in the residual category of bipolar disorder NOS (Not otherwise specified). Depressive disorders are also divided into two: major depression, in which there is one or more major depressive episodes; and Dysthymia, "in which there is a history of a depressed mood for most of the day for at least two years and in which, during the first two years of disturbance, the condition did not meet the criteria for a major depressive episodes" (DSM III-R, pp. 232). In many cases of dysthymia, there are superimposed major depressions. If the criteria for a major depressive or manic episode are currently met, the episode is sub-classified as either; mild, moderate, severe without psychotic features, or with psychotic features. If the criteria are not currently met, it is indicated whether the disorder is partial or in full remission. In addition to these, the DSM III-R also classifies current major depressive episode as: "melancholic type - a typically severe form of a major depressive episode that

is believed to be particularly responsive to somatic therapy; or chronic - when the current episode has lasted to two consecutive years without a period of two months or longer in which there have been no depressive symptoms" (pp. 214).

Beside Diagnostic and Statistical Manual there are other traditional as well as more recent measures for diagnosis and assessment. Paper and pencil tests as well as projective techniques have been frequently employed for the diagnosis of depression. Among projective methods Rorschach and Thematic Apperception tests are more familiar. The Rorschach protocols of depressed patients show diminished responsiveness, particularly to colour and movement. Whether the patient has a psychotic or a neurotic depression can be judged by the degree to which psychoticism (alienation from reality) is reflected in responses of poor form. Depressive neurosis is characterized by a greater percentage of animal responses and a low incidence of originality. On the Thematic Apperception Test, depression is manifested by a lack of responsiveness, gloomy stories and a number of wishful fantasies about love, kindness, joy and happiness (Rapaport, Gill, & Schafer, 1968). Stereotyped phrases about morality and aim are expressed, especially as part of the delusional system of the depressive psychotic.

Minnesota Multiphasic Personality Inventory (MMPI) includes two scales related to the concept of depression; one is a Depression scale (measuring symptomatic depression) and a Hypomania scale (designed to measure manic excitement, which typically accompanies manic-depression). The majority of the items of scale were selected directly by comparison of the psychiatric groups and normals. Harris and Lingoes (1977) propose that the depression scale is representative of subjective

depression (general dysphoria), psychomotor retardation, physical malfunctioning, mental dullness (lack of energy to cope, concentrate, remember) and brooding.

The Institute of Personality and Ability Testing (IPAT) has developed a Sixteen Personality Factors Questionnaire (16 PF) (Cattell, Eber, & Tatsuoka, 1970), the Clinical Analysis Questionnaire (CAQ) (Delhees & Cattell, 1975), the Depression Scale (Krug & Laughlin, 1976) and the Eight State Questionnaire (Institute for Personality and Ability Testing, 1976). All these inventories measure depression to a certain extent. The Eight State Questionnaire measures, mainly the state of depression; the others mostly measure the trait of depression. The 16 PF was developed primarily to measure the normal personality. The mean profile for a depressive reaction (Cattell, et al. 1970) is characterized by apprehension, suspiciousness, tender-mindedness, imagination, soberness and the extent that feelings are affected. Karson and O'Dell (1976) claim that the 'O' scale, which measures apprehension, is the key scale which is concerned with depression. The CAQ presents five scales specifically associated with depression, as well as other contributing scales. Specifically, measures of Suicidal Depression, Agitated Depression, Anxious Depression, Low-Energy Depression, and Bored Depression can be obtained. The Guilt and Resentment scale can also contribute in understanding a depressed person. The IPAT Depression Scale, a 40-item inventory, measures a dimension of depression that is highly related to anxiety. Norms are presented for men and women which regard the higher sten score as indicative of greater probability of depression.

Several other short measures of depression also exist. The Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock & Erbaugh, 1961), a 21-

item self-report inventory, has been demonstrated to have moderate validity coefficients and appears to discriminate well between anxiety and depression. The Zung (1965) Self Rating Depression Scale is a 20-items inventory with an even amount of positive and negative statements. Zung's attempt was to quantify the symptoms of depression by using the diagnostic criteria of the presence of a pervasive depressed affect, and its physiological and psychological concomitants as test items. Hamilton (1967) also developed a rating scale for primary depressive illness. Beside these, Research Diagnostic Criteria (RDC) (Spitzer, Endicott, & Robins, 1978) and scale developed by the centre for Epidemiologic Studies Depression Scale (CES-D) (Radloff, 1977) are also in current use for the assessment of depression.

The 'Pleasant Events Schedule'(PES) measures pleasure, activity level, and reinforcer potential of varied activities (Mac Phillamy & Lewinsohn, 1974). There are three forms of PES measuring some 320 events and activities that the respondent is asked to rate in terms of pleasantness. The PES has been used by Lewinsohn and his co-workers to measure depression in their studies. Studies have indicated that depressed patients engage in fewer pleasant events than non-depressed psychiatric patients and normals (Lewinsohn & Libet, 1972).

These varied approaches to the assessment of depression have limited generalizability because of varied definitions of depression employed by different researchers and their reliance on convenient sampling. Even where the study was extended to other segments of population, it remained valid within the parameters of the culture in which the study took place. Assuming the universality of psychological

disorders, such as depression, one may use these instruments outside the culture where it was conceptualized and developed, however, the errors in the assessment as a result of the disregard for local values and norms can not be ignored. One way of taking care of such errors is to adapt and standardize the instrument before using it in cultures other than where it was developed, even though these attempts are not free from limitations. Rating scales or assessment techniques are infact an attempt to subject clinical observations and judgements to objective measure, therefore, adaptation or mere translation of an instrument developed in other culture entails an implicit assumption that the clinical observation are similar across cultures. This appears in serious violation of observable cultural peculiarities. Do we assume that, for instance, if we adapt a scale developed in United States, the socio-economic conditions, cultural norms and life-stresses are the same across the two countries, which even geographically are at a great distance? Moreover, cultures differ not only with respect to their norms and values but also in terms of their lexical categories of emotions (Russell, 1991). Emotional experiences and their expressions are determined to a great extent by the words available in a particular language. The basic categories of emotion may be pan-cultural but the expression varies with the degree of permissiveness present in a culture alongwith the available distinct lexical categories. As emotion is regarded the basic component of depression , these observation stand relevant and assume critical significance. Cross-cultural research has yet to emphasize the peculiarity as well as complexity of the cultural meanings associated with psychological disorders by lay persons. There appears an overwhelming concern to adapt western models of psychological disorders while

disregarding the more local nuances of emotional and other experiences. Such an outlook poses both methodological as well as validity problems due to the difficulties in linguistic and conceptual translation in representing illness episodes as meaningful social events. Therefore, to make the analyses and conceptualization of a disorder more universal, credence must be given to the conceptual organization of cultural knowledge of that disorder. That is, to discover how a lay person talks about his illness in social as well as personal context. This emphasis becomes critical with reference to the assessment of depression. Despite it's universality depression may be reported differently across various cultures as expression of emotion is determined both by the language and the conceptual organization of the disorder. For instance, psychological and mental symptoms are reported to be less prominent (and/or less differentiated) in certain non-western societies than somatic features (Marsella & White, 1984). Not only this, a difference in value orientation may as well determine specific predictors of depression (Aldwin & Greenberger, 1987). A difference in intrinsic cultural values resulted in higher scores of Japanese students on self-report of depression as compared to their U.S. counterpart (Baron & Matsuyama, 1987). Such differences in value structure across cultures and the documentation of culture- specific contents of emotion have highlighted the need to develop indigenous norms and culture-relevant operational definition of psychopathology.

The present work is an attempt to respond to these considerations with reference to assessment of depression in Pakistan. The researcher during her clinical experience frequently observed that a patient who is giving a depressive outlook and who later even responds to anti-depressants, if assessed on any of those depression scale

developed in the West would not appear as depressed as he seems to be. The reason lies in the nature of content of the items of the scale being administered. If the scale, for instance, asks a question regarding decreased interest in sex -one of the frequently assumed index of depression- the patient usually hesitate to respond in affirmation. Moreover, as leisure activities are not the norm of middle and lower middle class, the items assessing a decreased behavioural involvement will lose their relevance for a great number of depressives. The translation and adaptation of scales developed elsewhere misses out the assessment of peculiar complaints so frequently encountered in the psychiatric wards. Therefore, any study which intends to explore the concomitant variables of depression, must first attempt to measure depression with it's indigenous expression. In its absence the question of concomitance will appear elusive and the phenomenon would still remain an elephant being measured by people devoid of sight.

III- A Theoretical Analysis of Depression

"I wish he would explain his explanation"

Lord Byron.

Depression is perhaps the only psychological disorder which is experienced by almost all the human beings somewhere in their life span. And with the changes taking place across the globe, the resultant economic and political pressures are being felt by an individual as well, making researcher delve more vigorously into the study of the phenomenon. In one of the earliest accounts of depression, the Bible describes the grief and agonized feelings of men and women who seem to have lost faith in themselves and God as well as any hope for future. Saul -the first king of Israel (11th c. B.C) is noted to have developed recurrent depression, great suspiciousness, and irritability. He eventually committed suicide. In the second century A.D., Plutarch wrote about the helpless feelings of the depressed fighting against the gods. The Greek physician Aretaeus of Cappadocia associated melancholia with mania (cited by Page, 1971). He indicated that not everyone has the same form: some are suspicious of others, some flee to desert, whereas others hate life. Hippocrates (cited by Page, 1971), the father of modern medicine, provided a rational classification of mental illness and formulated a theory of the etiology of madness based on the interaction of four bodily humours - blood, black bile, phlegm, and yellow bile - which he thought were created by a combination of the four basic qualities in nature - heat, cold, moisture, and dryness. With

him came the first classification of mental disorders; they were: manias, melancholias and phrenitis.

With the passage of time the understanding of mental disorders progressed, so did the notions regarding the etiology of melancholia. In the middle ages, melancholia was regarded as a spell cast on the individual by some wicked or evil spirits. During the eighteenth century, the medical nature of mood disturbances were studied in established institutions and hospitals for mental disorders; and in the early nineteenth century the French physician Pinel (1801) wrote about the gloomy withdrawal of depressed patients. Around the same time, Falret (cited by Page, 1971), described an episodic depression, with remissions and attacks of increasing duration, which seemed to occur more frequently in women than in men. He also indicated that this phenomenon may be associated with a precipitating event. Steeped in the medical tradition of his time, Kraepelin (cited by Kolb, 1977) conceptualized mental illnesses as medical illness with definite symptoms and hereditary patterns, etiologies, and prognoses. He separated functional psychoses into two groups: dementia praecox and manic - depressive psychosis. He proposed that dementia praecox is chronic and unremitting indicating a poor prognosis, whereas manic - depression does not end in chronic invalidism. He also maintained that manic depression covers all abnormalities of mood and is innate (endogenous) rather than the result of social and psychological forces. In contrast, Meyer (1908) indicated that depression is a reaction to life's events; a hypothesis of current interest for many researchers.

In his work "Mourning and Melancholia", published in 1917, Freud

proposed that depression is the process of mourning the loss of a loved object. He believed that melancholia is the expression of hostile feelings formerly associated with the lost object and currently directed inward. He distinguished mental features of melancholia as profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, inhibition of all activity, and a lowering of the self-regarding feelings to a degree that finds utterance in self-reproaches and self-revilings and culminates in a delusional expectation of punishment. Differentiating mourning from melancholia, Freud suggests that melancholia is in some way related to an object-loss which is withdrawn from consciousness whereas in mourning the loss remains at the conscious level. Freud's work was actually an elaboration of Abraham's (1911) theorizing who saw self-centredness as differentiating depression from normal grief. Explaining depression in terms of psychodynamic positions, Freud explained depression as a resultant of fixation at oral stage. For him, the depressed introjects the loss and tends to identify with the lost one, as a result depression ensues. Because of the gaps in theorizing and circularity in expression, psychodynamic approach has provoked many criticisms (for instance, Beck 1967; Weisman, Klerman & Paykel 1971). Yet, many of its concepts like 'narcissistic identification' with lost object giving rise to irrational self-statements, has inspired many theorist in formulating their theories (see, Beck, 1964 ; Ellis, 1977). Several theories of depression (e.g., Beck, 1967; Bibring, 1953; Blatt, 1974; Fenichel, 1945 & Jacobson, cited by Snyder & Forsyth, (1991) identify the lowering of self-esteem as a core feature of this disorder. With the exception of Bibring (1953), the above mentioned theorists see this decrement in self-esteem as determined or

influenced by one's failure to live up to introjected standards of behaviour. For example, Fenichel (1945) sees the pre-depressive as having introjected unrealistically high standards into a rigid and uncompromising superego. When the pre-depressive fails to meet these standards, the hostility of the superego is directed against the ego and the individual experiences feelings of inferiority, guilt, and a loss of self-esteem. In a similar vein, Jacobson (cited by Snyder & Forsyth, 1991) considers depression as resulting from anger directed toward the self when a person is unable to meet the extreme demands of the superego. These demands are seen to be determined by the introjection of unrealistic and uncorrected parental images. Depression results from this internalized anger and is characterized primarily by loss of self-esteem. Blatt (1974) differentiates between anaclitic and introjective depression and suggests that ambivalent, hostile, demanding, and critical parental attitudes are central to the development of introjective depression.

Behavioural theorists broke the mould of the then prevalent explanation and took the stance of functional analysis of behaviour. A behavioural approach is useful for communicating, clarifying and making objective knowledge of human behaviour that has been discovered clinically or experimentally (Ferster, 1973). Inspired by the Skinner's (1957) functional analysis of behaviour, Ferster observed depression to be an especially appropriate field for the behavioural psychologist because of the missing items of behaviour that are so prominent. The behavioural stance of analysis emphasizes the frequency of behaviour as the primary datums, while the particular categories of behaviour whose frequency is to be accounted for are sought from the clinical literature or from common experience (Ferster, 1973).

Among Behaviourists' formulation of depression, Lewinsohn's (1974) work has been more influential. According to Lewinsohn, a low rate of response contingent positive reinforcement has consequences in terms of the respondent behaviour of the individual (elicits crying, dysphoric mood, etc.) and is itself sufficient explanation for reduced behavioural output in depression. In the early stages of depressive breakdown, symptoms may be maintained by reinforcement from others (sympathy), the secondary gain phenomenon, but later on close family and friends are more likely to swing away from rewarding any behaviour and try to avoid the depressed person altogether, thus further reducing frequency of rewards available in the environment (Lewinsohn, Weinstein & Alper, 1970). Ferster (1966, 1973) explained depression in terms of the reduction of reinforcible behaviour in the repertoire (for any reason). Such reduction in behaviour characteristically follows large and/or sudden environmental changes, changing the stimulus conditions which normally control behaviour, but may also result from reinforcible behaviour being squeezed out of the repertoire by aversively motivated behaviours (escape or avoidance of stress) or by suppressed anger which reduces social reinforcement. Costello (1972) talked of loss of reinforcer effectiveness i.e. sufficient reinforcers may be available in the environment and the individual might still be capable of procuring them, but for some reason they have lost their potency as reinforcers. According to Costello, the loss may result from endogenous changes in the biochemical mechanisms known to underlie consummatory motivation, or it may result from the disruption of a behavioural chain by the loss of a single reinforcer in that chain. Costello's position is different from Lewinsohn and Ferster who imply that only an

increase in the total amount of rewarding events or acquisition of necessary skills to procure such rewards can ultimately be effective in alleviating depression. His formulation seems particularly useful in accounting for depressions which do not seem to follow any loss event and also seems to account for the finding of depressives that their discomfort and dysphoria is increased when they attempt to do things which they formerly found pleasurable.

Behavioural formulations entail many methodological weaknesses and therefore have been the focus of much criticism. As most of the experiments, from which formulations were derived, were conducted in laboratory, the issue of generalizability becomes pertinent. Moreover, most of the studies are essentially correlational in nature, since independent variables like levels of depression are not always manipulated. The direction of causality between pleasant events and depression, therefore, remains unclear from these correlational analyses. Behavioural formulations appear too simple and straight-forward to explain the complexity of depressive reactions where there is a myriad of interaction between cognitive and interpersonal factors within the person and those operant in the external environment. Depression could result from a reduction in response-contingent positive reinforcement, but the opposite hypothesis is equally plausible (Sweeney, Shaeffer, & Golin, 1982). In addition to these, other contradictory findings have also been reported. Hammen and Glass (1975) found that increase in positive activity did not alleviate depressed mood, but in fact was correlated positively with depressed mood. Rehm (1978) too, failed to support the causal link suggested by Lewinsohn between drop in pleasurable activity and drop in mood. This gives rise to the

argument that depressive symptoms are not a reaction to environmental events only and a theory that relates depression to the frequency of positive or negative events without taking into account the kinds of cognitions a person has about such events, or the reciprocal effects of mood on cognitions, is incomplete (Sweeney et al., 1982).

A disappointment with behavioural formulations of depression led to the adoption of more wider perspective, where cognitive aspects could also be studied. It was Beck's cognitive theory of depression which helped cognitive approach achieve an ascendancy over alternative psychological conceptualizations of the disorder. Beck's cognitive model of depression evolved from systematic clinical observations and experimental testing (Beck, 1964, 1967, 1970). This interplay of a clinical and experimental approach has allowed for a progressive development of the model and of the psychotherapy derived from it (Beck, 1976). According to Beck the most salient symptom of depression is the profoundly altered thinking. The cognitive model postulates three specific concepts to explain the psychological substrate of depression (1) the cognitive triad, (2) schemata, and (3) cognitive errors (faulty information processing). The cognitive triad consists of three major cognitive patterns that induce the patient to regard himself, his future and his experiences in an idiosyncratic but predominantly negative manner. The cognitive model views the other signs and symptoms of the depressive syndrome as consequences of the activation of the negative patterns. Increased dependency and the motivational symptoms (for example, paralysis of the will, escape and avoidance wishes, etc.) can also be explained as consequences of negative cognition. A second major ingredient in the cognitive model consists of the concept of schemata

which refer to relatively stable cognitive patterns leading to the regularity of interpretations of a particular set of situations. The presence of negative schemata explains why a depressed patient maintains his pain-inducing and self-defeating attitudes despite objective evidence of positive factors in life. The schemata activated in a specific situation directly determine how the person responds. In psychopathological states such as depression, patients' conceptualizations of specific situation are distorted to fit the prepotent dysfunctional schemata. In milder depressions the patient is generally able to view his negative thoughts with some objectivity. In the more severe states of depression, the patient's thinking may become completely dominated by the idiosyncratic schema. In such states the depressive cognitive organization may become so independent of external stimulation that the individual is unresponsive to changes in his immediate environment (Beck, Shaw,Rush & Emery, 1979). Finally, depressed person commit systematic errors in thinking to maintain their belief in the validity of their negative concepts despite the presence of contradictory evidence. These error committed in processing of external stimuli are: selective abstraction, arbitrary inference, overgeneralization, personalization, magnification and minimization (Beck, 1967).

Though Beck's formulation of depression has achieved ascendancy over all other approaches to depression, many questions have been raised regarding its basic postulates. The fact that all the studies are correlational in nature invalidates the assumed causative role of faulty or erroneous cognition. Evidence is lacking for the role of cognitive errors and idiosyncratic schemata in depression because the investigators have been severely hampered by a lack of adequately validated measuring instrument.

Moreover, as the investigators have generally used college students as their subjects, the ecological validity of the findings become critical, especially, because clinically depressed are reported to go through a different kind of life events and stresses which do not exist for students (Brown & Harris, 1978). Nevertheless, Beck's formulation provided useful information about the cognitive outlook of the patient which in turn led to the development of effective therapeutic techniques of depression.

Beck held that the negative cognitive set is the central component of depression which biases depressives to believe that their actions are doomed to failure. Seligman (1975) extended the argument by formulating a theory of depression central to this perspective. Emphasizing the similarities between helplessness produced in the laboratory subjects (both animals and humans) exposed to aversive uncontrollable events and the major symptoms of human depression, Seligman (1975) proposed an explicit statement of a theory of depression. The underlying assumption of this model are that helplessness is a major feature of the syndrome of depression that many, though, perhaps not all, of the symptoms of depression result when a person come to believe that their responses will not control the important outcomes in their lives. The learned helplessness theory uses the concept of an expectancy for uncontrollability to explain negative effects of experiences with non-contingency. According to Seligman, an organism that is exposed to uncontrollability can develop the expectancy that it will not be able to control future events (uncontrollability expectancy). This cognitive anticipation is supposed to lead to the helplessness deficits. He suggests that although anxiety is the initial response to a stressful situation, it is replaced by depression if the person comes to believe that

control is unattainable. Seligman realizes that a laboratory model does not have the open-endedness of the clinical phenomenon as it clips the clinical concept off at the edges by imposing necessary features on it (Seligman, 1975). He observes that the label "depression" applies to passive individuals who believe they cannot do anything to relieve their suffering, who become depressed when they lose an important source of nurture - the perfect case for learned helplessness to model- but it also applies to agitated patients who make many active responses, and who become depressed with no obvious external cause. Therefore, learned helplessness need not characterize the whole spectrum of depressions, but primarily, only those in which the individual is slow to initiate responses, believes himself to be powerless and hopeless and sees his future as bleak which began as a reaction to having lost his control over gratification and relief from suffering.

Building on the behavioural and physiological parallels, Seligman examined the possible commonalities in the causes of helplessness and depression. The symptoms of learned helplessness are: lowered initiation of voluntary responses, negative cognitive set, lowered aggression, loss of appetite and physiological changes each of them having parallels in depression (Seligman, 1975). The helplessness model, however, failed to mark boundary conditions, especially, when human subjects were involved. For instance, it could not account for the opposite effects of inescapable noise and unsolvable anagrams when they made the subjects increase their activity and attempt at mastery instead of making them feel helpless (Roth, 1980). In addition, the original theory could not explain why depressed individual often blame themselves for bad events, especially

when those events are clearly out of their contingency. Finally, the original theory could not account for generality and chronicity of depressive symptoms i.e. why some individual experience transient and specific affective reactions to a negative event, whereas, other slide into a major depressive episode when confronted with the same type of event. A revision of the model was, therefore, proposed by Abramson, Seligman and Teasdale (1978); the essence of which lies in the concept of attriubtion. According to this revision, "the boundary conditions of depression following bad events are determined by causal attributions about the events. The central prediction of the reformulation is that " individuals who have an explanatory style that invokes internal, stable, and global causes for bad events tend to become depressed when bad events occur" (Peterson & Seligman 1984, pp. 347). To explain it further; when people experience an aversive event, they often ask why the event occured. The reason they provide for bad events can then be analyzed along three theoretically orthogonal dimensions: 'internal-external', 'global-specific' and 'stable-variable'. The model predicts that individuals who characteristically produce internal, global and stable explanations for bad events are more likely to become depressed in response to a bad event than individuals who make external, specific and variable explanations.

The model assigns a particular role to each attributional dimension in producing depression and helplessness deficits. First, if individuals believe that something about them caused a bad event (an internal explanation), they will experience self-esteem deficits in response to bad events. Second, an explanation involving causes that persist over time (a stable explanation) may be responsible for the chronicity of depressive

deficits. Finally, if individuals believe that the cause will affect many aspects of their lives (a global explanation), helplessness deficits may become generalized. Individuals who characteristically make internal, global and stable explanations about negative events can be said to have a pessimistic explanatory style and according to Abramson et al.'s (1978) model, will be at risk for development of the cognitive, motivational and affective deficits that are characteristics of a depressive episode whenever they confront an important negative event. In contrast, individual who make external, specific and variable explanations about bad events are less likely to experience loss of self-esteem and more likely to respond with a transient and circumscribed affective reaction to that event. Thus, the revised model distinguished an enduring attitude to attribute bad outcomes to personal, global, stable faults of one's self as "depressive attributional style" having a relationship with proneness to depression.

Like Lewinsohn, Seligman's model is also based on behavioural paradigm but unlike him, Seligman does not propose depression to be a result of a reduced frequency of reinforcement. Instead he emphasizes the individual's idiosyncratic cognitive style which intervene between characteristic of environment and his reaction (i.e., depression). Seligman's model though draws parallel between the behavioural formulations and cognitive model by taking into account both the actual experience of negative event and ensuing explanatory style, it is weakened by it's over-emphasis on one of it's premise and a disregard for the rest. Most of the interest has focused on the maladaptive attributional style which predisposes one to depression, and other premises of theory which pertain to present and past non-contingency of act and outcome have

been kept at periphery. It seems pertinent that interest is focused on central premises of the helplessness model, for instance, studying the cognitive processes which lead to expectation of non-contingency as well as examining those cognitive mediations which, specifically, lead to a particular attributional style. Moreover, the theoretical framework in which attributions are studied sometimes only succeed in measuring the reactive explanation of the subjects to the instructions given. That is, instead of exploring the idiosyncratic attributional style, they tend to adhere to the response required by the format of the questionnaire forcing them to rate their attributions or explanations without any understanding of the dimensions on which rating is required. What is needed is that the researcher should not forsake the essence of the investigation at the altar of methodological constraints, but rather attempt to study the phenomenon close to its actual occurrence. These attentions are in order, if helplessness model intends to maintain its status of being a cognitive model.

Related to both Beck's and Lewinsohn's formulations is the self-control theory of depression posited by Rehm (1977) which attempts to combine elements of the behavioural and cognitive formulations. Rehm developed Kanfer's (1970) self-regulation model which divided the control that an individual has over his own behaviour into three stages: self-monitoring, self-evaluation and self-reinforcement. Experiments asking subjects to monitor and evaluate their performance and reward their own-selves, have shown that self-evaluation and reinforcement do not necessarily correlate with actual accuracy (Bellack & Schwartz, 1976). Moreover, non-depressed appear to systematically underestimate their true accuracy. This is taken to be analogous to selective biases in

depression. Such experiments demonstrate that self-monitoring involves more than the passive registration of stimuli in the environment (Rehm, 1977). It is more an active scanning in which non-depressed individuals perceive and encode appropriately, whereas, depressed individuals are hypothesized to selectively attend to negative aspects of themselves and their world. Self-evaluation is performed on the basis of criteria that are set too high to achieve, so that overt and covert self-rewards are rarely dispersed. Thus the basis for normal rates of behaviour (self-regulation) in the relative absence of external control is diminished, and the depressed individuals behavioural repertoire is disrupted.

In contrast to above formulations, some researchers have attempted to take into account the social aspects of the stressful events which lead to depression. Brown and Harris (1978) examined the social origins of depression in women in terms of provoking agents such as severe life events, chronic difficulties and vulnerability factors including having three or more children at home, being unemployed, and lacking a confidant. Brown and Harris's (1978) main result was that an onset of depression at the individual level usually occurs following a 'provoking agent', in the presence of one or more 'vulnerability factors'. Provoking agents detected by the 'Life Events and Difficulties Schedules' (LEDS) are defined as events or difficulties posing a threat that lasts longer than one week, directly affects the subject, and is rated as severe, whereas, vulnerability factors are circumstances, such as lack of social support, that are not themselves threatening. Oately and Bolton (1985) extended Brown and Harris's formulation and postulated that the onset of depressive symptoms depends on the relation between a person's role expectations and the fulfilment of those expectations by others

who take part with her or him in role relationships. They propose that provoking agents increase the risk of depression by posing threats to selfhood, where the sense of self is realized in a role (or roles). For them a provoking agent is either (a) the loss of(one or more) others who enable one to exact an important role that fulfils self-definition goals, or (b) a situation making it impossible to sustain the performance of a central role in a way that is convincing to oneself. Oatley & Bolton's social cognitive theory (1985) classifies the symptoms of depression into three main categories. They are: (a) aspects of loss of the sense of self, (b) a set of emotions, and (c) a set of strategies for interaction with others. They also propose that an episode of full reactive depression includes symptoms in all three categories. One function of the cognitive role schema is that it helps explain these sets of symptoms. Other types of symptoms also occur clinically, although more rarely, and seem less directly related to immediate events or relationship in a person's life. Thus, the major tenet of their theory is that the depressive reaction arises neither for purely mental nor for purely environmental reasons, rather it is the result of an interaction between individual's own mental processes and the societal forces. The distress is the disruption of a working relation between a social schema and the immediate community (Oatley and Bolton 1985). Such a deduction increases the importance of studying culture-relevant variables interacting and determining the individual's response to stress.

The diathesis-stress theories have strong implication for depressive disorders too, necessitating the study of interactive forces with regard to socio-environmental circumstances that precede depression (Monroe & Simons, 1991).

Metalsky Abramson, Seligman, Semmel and Peterson, (1982) argued that the logic of the attributional reformulation suggests that in the presence of positive life events or in the absence of negative life events , people exhibiting the hypothesized depressogenic attributional styles should be no more likely to develop depressive reactions than people not displaying these attributional styles. Thus, it appears that the current theoretical position attempts to balance itself against the interactive forces of culture and the individual.

The analysis of theoretical formulations regarding depression reveals that contrary to oft-cited claims the causal roles of cognitive or behavioural variables in evoking depression is yet to be established. Coyne and Gotlib (1983) reviewing the gaps in the causality hypothesis comment that investigations have demonstrated little success in identifying a significant cognitive vulnerability to depression or depressive behaviour in people who are not already in a depressed state. A plausible defense from cognitive theorists against this assault would be that schemata -a latent cognitive structure- are reactivated when the patient is confronted with certain internal or external stimuli (Kovacs & Beck, 1978), though it remains difficult to subject it to empirical verification. Coyne and Gotlib (1983) further question that the other sense in which cognitions have been postulated to be causal in depression involves viewing cognitions as the cause of other concurrent features of depression. The supporting studies for such causal role attempt to manipulate thought contents in a negative fashion producing negative mood or improving the mood by decreasing negative thought contents. These studies though establish the link between manipulation of cognition resulting in mood changes, they do

not address the issue of the fundamental causal priority of cognitions over affects; (e.g. Isen, Shaiken, Clark & Karp, 1978). Lewinsohn, Steinmetz, Larson and Franklin (1981) carried out a large scale prospective study to resolve the direction of causality and concluded that depressive cognitions are consequent of depression, rather than antecedents. However, as Lewinsohn's study lacks adequate control- the environmental and other factors were not controlled during the interval of the study- the finding is suggestive and not conclusive. Golin, Sweeney and Shaeffer (1981) used a cross-lagged panel correlational analysis to examine the causality of attributions in depression and found that the degree of correlation of attributional vulnerability at time 1 with depression level at time 2 (one month later) significantly exceeded the level of correlation at time 1 with attributional vulnerability at time 2. That is, people who were more depressed at time 2 had shown greater attributional vulnerability one month before, but people who showed this vulnerability on second testing had not been more depressed one month before. Golin et al. , (1981) argued for causal link but with reservations, as they were aware of the fact that the statistical method used , acts more as indicative of temporal precedence rather than positive proof of causation. Like Lewinsohn's study Golin and his co-workers had no record of the intervening events between time intervals, therefore, Golin et al. , (1981) established the temporal sequence of attributions, whereas, its causal status still remain in doubts. Metalsky et. al. , (1982) came up with more encouraging results in this respect. In a prospective study they measured attributional vulnerability of undergraduate students prior to their mid-term examination. Findings showed that students who obtained grades lower than their desired ones,

provided significant correlation between their tendency to make internal and global attributions for bad outcomes and their subsequent mood disturbance. In contrast, student who obtained grades at or above with which they were happy, their subsequent mood disturbance was not significantly correlated with attributional style, though, attributing bad outcomes to stable causes tended to correlate with upset mood even in these successful students. Metalsky et al. , (1982) have established that ' in the absence of negative life-events people exhibiting depressogenic attributional styles will be no more likely to develop depressive reaction than people not displaying these attributional styles.

There are a number of other researchers who have studied the causal link between causal explanation and depression (e.g. Campbell, 1982; Tiggenmann, Winefield, Winefield, & Goldney, 1991) , however, the evidence with regard to the causal role of cognitive factors is still lacking, probably because stringent test of causal hypotheses with adequate methodologies have yet to come about. The cognitive outlook of depressed and non-depressed requires further attention. A common assumption in this regard is that depressives are negatively biased towards themselves and others, whereas, little attention is given to the generalized positive bias of the non-depressives .It is yet to be established that to what extent it is possible that non-depressives are demonstrating a positive bias and the depressives are merely reacting to the circumstances in which they find themselves (Brown & Harris, 1978). To answer the question of causal link between cognition and depression possible mediating variables are to be operationalized and explored. Moreover, environmental antecedents and consequents are to be taken into account which may be instrumental in precipitating and maintaining a depressive reaction.

The diathesis-stress model ,therefore, appears pertinent to clarify the ambiguities in the causal link. In the absence of such an attention, however, the present theories of depression provide only a correlational relationship with the variables of interest.

IV- Attribution Theories: A Review from the Perspective of Clinical Psychology

> *"There is occasions and causes, why and wherefore in all things."*
>
> *Shakespeare*

Humans have always been intrigued by the causes of events. They seem to have an inherent need for knowing the motives, intent or cause behind an action. This pursuit of 'why' not only plays a pivotal role in interpersonal relationship, but it has also been an inspirational force for all scientific and technological achievements. It is this pursuit which is known as 'attribution' among psychologists, and which appears to be natural to human beings. As Heider (1976) has rightly put...."attribution is part of our cognition of the environment. Whenever you cognize your environment you will find attribution occurring" (cited in Hewstone, 1989). However, the question remains as to what is the nature of the need behind this pursuit. Weiner (1986) comes up with two propositions. First, we might just want to know, to understand the environment, to penetrate ourselves and our surroundings. This interpretation, familiar to personality and motivational psychologists, is known as the principle of mastery (White, 1959). Second, it is clearly functional to know why an event has occurred. As Kelly (1971) stated, "the attributor is not simply an attributor, a seeker after knowledge; his latent goal in attaining knowledge is that of effective management of himself and his environment" (pp. 22). The desire for mastery and functional search have remained basic goals for humans beyond the limits of time and space. It is because of this that study of attribution assumes significance. This requires an understanding of the attributional process itself.

Harvey and Weary (1985), identify the following statements as basic tenets of attributional processes:

1. As a phenomenal state, attribution is a pervasive activity. It may occur spontaneously, as one cognizes the environment (Heider, 1976) or it may involve deliberate inferential or deductive activities (Kelly, 1967). Further, the fact that people may not be able to report (or are not willing to report) attributional activity does not necessarily mean that it is not occurring. It may occur subtly or quickly without conscious recognition, or people may not readily have the words or constructions with which to report the process. Also, attributional processes may be posited as a hypothetical construct without necessary reference to people's actual cognitive activity.

2. Because of the complexity of many real world events, attributions often will not be completely accurate. In recent years, there has been "much ado" regarding the so-called "fundamental attribution error" (Ross, 1977) that refers to people's tendency to over-attribute events and behaviour to others' personalities (Reeder, 1982; Harvey & McGlynn, 1982). At present, the idea that any one attributional bias is any more prevalent than other such biases is far from established empirically or logically. Not only does the complexity of events always mitigate against perfectly accurate attributions, but also attributors often attempt to meet conflicting goals (e.g., self-esteem protection, self-presentation concerns, desire to be

honest and sincere).

3. As Jones (1984) suggests, people, by and large, behave according to their perceptions and their understandings. This view probably represents as fundamental a position as could be entertained by attribution theorists. If true, it means that people usually do not become "lost in thought" with little or no relationship developing between their attributions about people or events and some action vis-a-vis those people (including self) or events (Yarkin, Harvey & Bloxom, 1981).

4. Another quite basic tenet of attributional activity is that it often serves the needs of human adaptation. In this sense, attribution may involve a relatively unbiased search for the causal sequence in some phenomenon (e.g., who and/what was responsible for an air plane crash). Or it may be highly biased for instance, the type of inquiry frequently conducted by persons for whom close relationships have recently ended, (Harvey, Wells, & Alvarez, 1978). Even in the latter case, biased interpretations may be adaptive because of their tranquillizing function (Weiss, 1975). As Jones (1984) suggests, the social order typically produces its own predictability whether or not participants' attributions are accurate. Further as has been shown in an intriguing fashion, people sometimes seek out attributional ambiguity (Snyder & Wicklund, 1981), presumably in the interest of preserving a sense of personal control. In general, then, and as a classic premise in attribution work, attributional processes are

assumed to facilitate people's feelings of control (pp. 2-3).

The analysis of these attributional processes has a long tradition in many fields of psychology as well as in different philosophical systems. Försterling (1988) gives an account of the contributions of philosophers like Hume and Mill, who were specifically interested in determining how individuals come to judge one event as a cause for another's occurrence. The classic approach is that of Hume who gave a number of definitions of cause. Hewstone (1989) quotes him as follows:

> " A cause is said to be an object followed by another, and where all the objects similar to the first are followed by objects similar to the second, where, if the first object had not been, the second had not existed (pp.76-77)" .

Hume postulated that there are some basic prerequisites that have to be met before we consider one event as the cause of another: first, the causal candidate must precede the event in time and secondly, there has to be a spatial closeness between the cause and the event. Most characteristic for Hume's position, however, is that the two events must occur repeatedly before one event could be identified as the cause for the other. Hume's ideas were elaborated and specified by Mill (1872) whose own conception of causation has in turn significantly influenced attribution theory via Kelly's (1967) formulations. Mill points to the fact that we also tend to perceive the non-existence of an event as a cause. Mill introduced the 'Method of Difference' as an explanation of

how causal judgments are performed. Försterling (1988) quotes Mill as follows: "

> if an instance in which the phenomenon under investigation occurs, and an instance in which it does not occur, have every circumstance in common save one, that one occurring only in the former; the circumstances in which alone the two instances differ, is the effect, or the cause, or an indispensable part of the phenomenon (pp. 452).

Mill argued that what people ordinarily call the cause is *one* of those arbitrarily selected conditions, which is inaccurately labelled as 'the' cause. Both Hume and Mill contend that causality itself is not a directly perceivable characteristic event, but it is a judgement that individuals need to infer from multiple observations. More specifically, Hume and Mill would argue that there are no 'causal ties between events that we could 'directly perceive', and that we would not be able to identify the fact that it snows as a cause for the road getting slippery if we had not observed these phenomena before' (Försterling, 1988).

It was Heider's (1958) formulation which influenced and guided the later work on attribution. He emphasized the importance of 'naive psychology', especially, with reference to the dynamics of interpersonal relationship. Heider was mainly concerned with the antecedent conditions of attributions of intention or motive or, in other words, the precondition by which a person attributes the behaviour of another

individual to his intention or motives. To explain the intentions with reference to causality, Heider talks of 'multifinality' and 'equifinality'. From the point of view of personal causality which is more relevant to the discussion of interpersonal dynamics, multifinality refers to a situation when different conditions or variables lead to different effects. In other words a stable relationship between antecedent and consequent conditions cannot be established, whereas, equifinality refers to a situation where several different actions or conditions consequent upon one specific effect. In such a case personal causality for an effect can be determined and intentions are attributed. Heider holds intention as the central factor in personal causality. He observes that people are held responsible for their intentions and exertions but not so strictly for their abilities. Moreover, personal responsibility varies with the relative contribution of environmental factors to the action outcome, in general: the more they (environmental factors) are felt to influence the action, the less the person is held responsible (Heider, 1958). Heider outlined the successive stages in which attribution to the person decreases and attribution to the environment increases. At the most primitive level the concept is more global one and the person is held responsible for each effect that is in any way connected with him or that seems in any way to belong to him. At the next level impersonal causality rather than personal causality characterizes the judegment of responsibility and anything that is caused by the person is ascribed to him irrespective of his intentions. Then, a person is considered responsible, directly or indirectly, for any after-effect that he might have foreseen even though it was not a part of his own goal and, therefore, still not a part of the framework of personal causality. Next is the stage where a person is held

responsible for having intended something. Finally, the stage where even person's own motives are not entirely ascribed to him but are seen as having their source in the environment. It is this determination of personal or environmental responsibility which lead to attribution of action, the fulcrum of which remains the lay analysis of intentions. Heider also talked of attribution to fate which refers to the desire of absolving oneself from the responsibility of action outcome, finding an ally in fate.

Kelly (1967) forwarded Heider's formulation and presented the influential model of 'covariation principle' which essentially holds a condition or variable as possible cause of an effect when it is observed to covary. Kelly differentiates between attribution to person, entities and circumstances with reference to inherent constancy of factors leading to a particular effect. According to covariation principle, whether an effect is traced back to one of these three causal classes depends on which of these causes the effect covaries with. Kelly further elaborates his covariation principle by introducing the concepts of 'consensus', 'distinctiveness' and 'consistency'. Consensus refers to information on the joint occurrence of effects and persons (e.g. it gets noisy in the neighbourhood, when Aslam comes to visit his uncle), informations on the joint occurrence of an effect and one or more entities is labelled distinctiveness (e.g. Aslam can play almost all of the musical instruments), and consistency stands for the circumstances under which an effect occurs (e.g. Aslam can perform with ease in all kind of situation). For him, the processing of covariation information does not only lead to causal attributions but, in addition, determines our certainty about the correctness of the causal attribution. Kelly's model helped stimulate a great deal of discussion and research

on the question of whether individuals do evaluate the available information rationally and systematically in their every day life as the model suggests. Contrary evidence is also being provided that under certain conditions distortion of information does occur resulting in faulty causal attribution. Nevertheless, Kelly's model did provide a systematic method of studying the attribution employed by layman.

Rotter (1966) from the perspective of social learning theory introduced the concept of internal versus external control which led to the logical analysis of causal structure. Though Rotter theorized with particular reference to perceived contingencies of reinforcement, his classification of individuals into internals and externals became a dominant focus in psychology. A number of subsequent distinctions were guided by the contrast between a perception of internal versus external control (cf. DeCharms, 1968; Lefcourt, 1982). Weiner et al., (1971) held Rotter's single dimension of causal analysis as inadequate and attempted to clarify the confusion by providing a more extensive model. Weiner's attributional analysis of achievement behaviour is the most comprehensive theoretical model that deals with the influence of attributions on behaviour, affect, and cognitive processes (Weiner, 1983, 1985, 1986 & Weiner et al., 1971). Though Weiner's theorizing revolved more around achievement motivation, it guided the theoretical analysis and empirical investigation of other motive systems and additional psychological phenomena within an attributional framework. Weiner systematically applied Heider and Kelly's formulation of attribution principles to issues of achievement motivation research in the 1950s and 1960s, which were then being explained in terms of value framework and expectancy (e.g., Rotter, 1966). The

attributional analysis of achievement oriented behaviour assumes that the perception, processing and interpretation of one's own behaviour is guided by the same mechanisms as the cognitive processing of the behaviour of others. For Weiner and his coworkers the answers to 'why question' following success or failure determine achievement oriented thinking. The past experiences of achievements and the attributions related to success and failure give rise to generalized expectancies. Unlike Rotter (1966), Weiner maintained that the attributional position is that the stability of a cause, rather than its locus, determines expectancy shifts. Thus, Weiner introduced the dimension of 'stability' to explain the development of expectancies. After an empirical determination of stability-expectancy linkage, Weiner proposed a general principle to account for goal anticipations. In Weiner's (1986) words: "Changes in expectancy of success following an outcome are influenced by the perceived stability of the cause of the event". (p. 114). He further elaborates his principle by stating the three corollaries:

> **Corollary 1:** If the outcome of an event is ascribed to a stable cause, then that outcome will be anticipated with certainty, or with an increased expectancy in the future.
>
> **Corollary 2:** If the outcome of an event is ascribed to an unstable cause, then the certainty or expectancy of that outcome may be unchanged, or the future will be anticipated to be different from past.
>
> **Corollary 3:** Outcomes ascribed to stable causes will be anticipated to be repeated in the future with a greater

> degree of certainty than outcomes ascribed to unstable causes. (Weiner, 1986, pp. 115).

Weiner has not only explained the manner in which expectancies are built, he has also provided insight into the cognition-emotion linkages. He advanced an attributional framework assuming a sequence in which cognitions of increasing complexity enter into the emotional process to further refine and differentiate experience. He refers to resultant emotion after an event as "outcome dependent - attribution independent", for they are determined by the "attainment or non-attainment of a desired goal, and not by the cause of that outcome" (Weiner, 1986, pp. 121). A causal ascription then follows the appraisal of the outcome depending on the nature of it. The chosen attribution determines the nature of emotion to be experienced as well. Moreover, the attributed causal dimension also gives rise to a particular set of feeling. For example, success and failure perceived as due to internal causes such as personality or effort respectively raise or lower self-esteem or self-worth. That is, feelings related to self-esteem are influenced by causal properties (dimensions) rather than by a specific cause.

Weiner's attributional analysis of emotional reactions, originally undertaken within the achievement context, helped evolve a general attribution-based model of emotion. Weiner and coworkers have suggested that, in addition to reaction to one's own outcomes in achievement contexts, attributions (about the outcomes of others) also influence how an individual feels towards others in achievement as well as

in non-achievement-related situations. Weiner's contribution in attribution is paramount and influential due to his sound theoretical formulation and methodological insight into the phenomenon. He deftly separated the entangled issues of causal structure and provided clarity and understanding.

Weiner studied the attribution-emotion linkages and Seligman analyzed them with particular reference to one emotional disorder i.e. depression. Seligman's learned helplessness model of depression underwent a radical change of emphasis to account for the inherent inconsistencies (explicated in detail in earlier section). Instead of viewing helplessness a product of expectation of non-contingency, Abramson, Seligman and Teasdale (1978) proposed that it was individual's understanding of the cause of current or past non-contingency that determined expectations of future non-contingency and ultimately led to helplessness. They suggested that causal attributions for events could be graded along a number of dimensions, and that each dimension was linked to particular kinds of consequences for the nature of the helplessness experienced. The reformulated model made distinction between personal and universal helplessness, as an explanation of the inconsistency in original formulations regarding actual non-contingency. Accordingly,' personal helplessness' refers to the situation in which subjects believe they cannot solve solvable problems, whereas, situations in which subjects believe that neither they nor relevant others can solve the problems are instances of 'universal helplessness'. Moreover, the reformulation regards the locus of control and helplessness as orthogonal: one can be either internally or externally helpless. The revised formulations contend that universally helpless individuals tend to make external

attributions for failures, whereas, personally helpless individuals make internal attributions.

Seligman and his associates define the self-other dichotomy as the criterion of internality. In this respect their formulation resembles other attributional framework. For instance, Heider (1958) made distinction between factors within the person and factors in the environment. Rotter (1966) delineated the perception of outcomes which are causally related to subject's response and those perceived as being caused by external force such as fate. Therefore, as in other formulations , in Seligman's formulations too, determinant of internality is a result of social comparison between the person and the outside social agent. The more the person finds an external agent lacking in the external environment, the more he perceives causal factors to be located in his own self.

In addition to the dimensions of locus of control (Rotter, 1966) and stability (Weiner, 1986), Abramson et al., (1978) introduced the bipolar dimension of generality with the poles labelled 'global' and 'specific'. If non-contingency is explained by a global factor, characterized by the perception that it does not just influence the original situation but also a wider range of other situations, the helplessness will consequently spread to a much larger area of life (global helplessness). In contrast, if the failure is attributed to a special psychomotor skill, then according to reformulated model, there should be no negative effects due to noncontingency in other areas of life or with regard to other tasks (specific helplessness). Preferring 'explanation' to 'attribution' in describing causal characteristics, Peterson and Seligman (1984) identified two influences on the particular explanation chosen. The first is the reality of the bad events themselves and second is

the habitual tendency of the individual to choose certain kinds of explanations for bad versus good events. They identified individual patterns in the selection of causes over a variety of events as 'explanatory style' and especially the depressive explanatory style, in which one tends to give internal, stable and global explanation for bad events. For Peterson and Seligman (1984), the explanation influenced by the internal, global and stable explanation is sufficient to produce symptoms of helplessness. They contend that because there is usually similarity between explanation and expectation of consequences, knowing an individual's explanation and explanatory style will usually predict helplessness deficits. However, in case of dissimilarity, an individual's causal explanation and explanatory style will not cause the deficits. Therefore, these variables (i.e., internality, globality and stability) can be taken as risk factors for helplessness and depression.

Unlike Heider (1958) who regards attributions as the stated beliefs that compose an individual's naive psychology, Peterson and Seligman (1984) regard an attribution "as a hypothetical construct, a way for the theorist to explain observable behaviours" (Peterson & Seligman, 1984, pp. 351). As they consider attribution a hypothetical construct, it leads to various convergent ways to infer the presence of causal explanation, the most significant of which is in relation to depression.

V. Attributional Style and Depression

> *"When some affliction visits a man, he cries out unto Us; when We confer on him a blessing from Us, he says, "I have been given (all) this by virtue of (my own) wisdom"."*
>
> *Al Quran, 39:49.*

Attributional style appears to be the dominant cognitive variable in the study of both concurring and causal factors in depression. The attributional theory of learned helplessness has stimulated a large number of studies designed to test its assumption (Benassi, Sweeney & Dufour, 1988; Brewin, 1985; Coyne & Gotlib, 1983; Peterson & Seligman, 1984). Although the attributional model formulated by Seligman and his coworkers, regards the 'expectancy of future uncontrollability' to be the most direct determinant of helplessness, the majority of the relevant research has been concerned with attributional style rather than the expectancies of depressives. The focus in the studies was to see whether depressives tend more than non-depressives to trace failures back to internal, stable and global factors and successes back to external, variable, and specific factors. Peterson and Seligman (1984) justify the fact that most of the relevant research has concentrated on the analysis of the attributional style of depressives. They maintain that thus far there are no suitable instruments for assessing expectancies, whereas, attributional research has already provided methods for reliably recording causal attributions.

As a direct test of attributional model would involve unethical

manipulations, empirical research depends typically on measuring the attribution of depressives and non-depressives during laboratory tasks for hypothetical events and in reference to critical life events (Coyne & Gotlib, 1983). Among the diverse methods, which researchers have employed , two most commonly used methods are : Attributional Style Questionnaire (ASQ) (Peterson , Semmel, von Baeyer, Abramson, Metalsky & Seligman, 1982) and Content Analysis of Verbatim Explanations (CAVE) (Peterson, Luborsky & Seligman, 1983). The ASQ describe positive and negative events taken from both social and achievement contexts. The respondents are asked to place themselves in each of the given situations and write down the main cause that could have led to the particular result. Afterwards, they are requested to rate on scales, ranging from 1 to 7, to what extent the given cause lies within or outside their person (internal-external), whether it is stable or variable (stable-variable) , and whether it is global or specific (global-specific). Subject's score on each dimension for good and bad events can then be summed in order to yeild a composite measure of attributional style for negative and positive events. Reliabilities for the composite scores on the ASQ have proven to be modest but usually adequate: in the range of .30 to .70. In addition, Peterson and Villanova (1988) have developed an expanded version of ASQ that utilizes only negative events and for which reliabilities have proved quite satisfactory: in the range of .66 to .88. A similar instrument, the Children's Attributional Questionnaire (CASQ) (Seligman, Peterson, Kaslow, Tanenbaum, Alloy & Abramson, 1984) has been developed to study explanatory style in children. The CASQ is a forced choice version of the ASQ and yeilds scores on the same three dimensions of the ASQ, as well as, composite scores for

negative and positive events. Reliabilities of composite scores on the CASQ tend to be modest: in the range of .50 to .73. The technique of Content Analysis of Verbatim Explanation (CAVE) (Peterson et al., 1983) uses independent trained judges to rate verbatim causal statements extracted from spoken or written statements on a scale 1 to 7 for the same three dimensions described for ASQ. The CAVE technique has demonstrated high internal reliability, adequate intra-subject consistency (Burns & Seligman, 1989; Peterson,et al. ,1983). Ratings derived from the CAVE also correlate significantly with ratings on the ASQ (Peterson, Bettes & Seligman, 1985), although these correlations tend to be modest: in the range of .30 (Peterson & Seligman, 1984; Peterson & Villanova, 1988).

The majority of the investigations are correlational studies that relate scores from depression inventories or psychiatric diagnoses to samples of 'attributional' thinking. Therefore, limiting to allow conclusions as to whether attributions are causes or consequences of depression or helplessness (Brewin, 1985).

Coyne and Gotlib (1983) point out that the first studies that analyzed the relationship between depression and causal attributions refer to Rotter's social learning theory and the Weiner's model, and that they were conducted before the publication of (attributional) learned helplessness model. These studies generally show that depressives make more internal attributions for failure in laboratory tasks than non-depressives. Studies that are directly concerned with the attributional model of helplessness record causal attributions of persons with varying intensities of depression in a multitude of hypothetical situations and not just for induced failure as in the early laboratory studies

(Peterson & Seligman, 1984). These studies make use of various questionnaires that were designed for measuring attributional style (Peterson, Semmel, von Baeyer, Abramson, Metalski, & Seligman, 1982; Seligman, Abramson, Semmel & von Baeyer, 1979).

In the first investigation, Seligman et.al., (1979) administered the Attributional Style Questionnaire (ASQ; Peterson et al., 1982) to college students along with the short form of the Beck Depression Inventory (BDI) (Beck & Beck, 1972) and found that "depressive symptoms among undergraduates correlate with internal stable and global explanations for bad events" (pp. 355). Later, studies demonstrated the 'depressive attributional style' in children, lower-class women, and depressed inpatients (Coyne & Gotlib, 1983; Peterson & Seligman, 1984).

Peterson and Seligman (1984) contend that attribution style of a person (or explanatory style) may have its antecedents in parents' attributional style, criticism levelled by teacher and in the reality of one's first traumatic loss , the extent to which it is actually internally, stably and globally caused. They take explanatory style as trait-like, though not necessarily invariant. The plasticity lies in the argument that although explanatory style affects depression, depression may also affect explanatory style. They quote Castellon, Ollove, and Seligman, (1982), Hamilton and Abramson (1983) and Persons and Rao's work (1981), who found that explanatory style changed for the better among patients as their depression lifted.

There has remained a growing concern to study the cognitive vulnerability to depression though it is fraught with theoretical and methodological problems. A major

theoretical issue is whether cognitive predisposition represents an enduring characteristic that is always evident, or a latent characteristics that is only evident under certain circumstances. Kovacs and Beck (1978) suggested that depressogenic schemata may be relatively specific to particular individuals and may only be activated in situations that resemble those in which the schemata were originally developed. If so, it explains the failure of the relatively generalized questionnaires administered on recovered depressives in non-threatening situations, to produce evidence of cognitive vulnerability to depressions (Teasdale & Dent, 1987). Teasdale and Dent (1987) studied recovered depressives in situations where the relevant cognitive structures and processes are likely to be active. Their findings supported the two prevalent hypotheses concerning the cognitive vulnerability to depression. They found that there are persistent individual differences in cognitive processing related to neuroticism which predispose one to depression and individuals in whom depressogenic processes are activated by mildly depressed mood are particularly vulnerable to becoming more seriously depressed. Peterson intended to study explanatory style as a risk factor; as individuals with internal stable and global explanations are contended to be more at risk for depression, demoralization, passivity, failure, and other helplessness deficits (Peterson & Seligman, 1984). Later, he was able to predict subsequent health and illness event with a questionnaire and found support for the hypothesis that a belief in stable and global factors causing bad events is a risk factor for illness (Peterson, 1988). Mikulincer (1988) also found that exposure to unsolvable problems worsened subsequent performance only for those subjects who attributed failure to stable causes, whereas, an

attribution of failure to unstable causes prevented the detrimental effect of unsolvable problems on performance. Assessing further the effects of individual's proneness to cognitive interference on performance following failure, Mikulincer (1989) concluded that the habitual tendency to turn attention inward makes people more susceptible to the debilitating effects of unsolvable problems. Providing support for the depressive attributional style, Bout, Cohen, Groen and Kramer (1987) maintained that the self-reports of extent of concern with the cause of a negative event and of concern with the avoidability of a negative event were positively associated with an index of extent of depression. They also found that the greater the dysphoria or depression, the greater the investment of energies in cognition relating to the causes of negative events. Pelster (1989) demonstrated that experimentally induced failure led to a deterioration in mood when it was attributed to internal-stable-global causes, but not when it was attributed to external unstable-specific causes. Finding an absence of effect of attribution on mood preceding induction of success or failure, Pelster was tempted to conclude that 'attribution is a cause and not a consequence of depressive mood reactions', but considering the interpretative ambiguities involved, maintained that negative life events that are of great importance are singly sufficient to generate even long-lasting depressive reactions. In such a case, an internal-stable-global attributional style will fulfil a reinforcing or maintaining function. Negative life events of only minor or moderate importance may cause no depressive mood reactions by themselves but could cause depression in interaction with an internal-stable-global attributional style (Pelster, 1989).

Blatt, Quinlan, Chevron, McDonald and Zuroff (1982) attempted to study

the differential variables which cause individual to experience dysphoric affect and found consistent differences in patients on two foci of depression, namely dependency and self-criticism. Carrying the argument further, Brewin and Furnham (1987) investigated whether one or both foci are associated with a depressive attributional style. They found that internal and global attributions for hypothetical negative outcomes were found to be associated with both dependency and self-criticism, but neither of these aspects of depression was related to attributions for positive outcomes.

One of the criticism levelled at original helplessness model was that it did not account for the mediational variable for loss of self-esteem resulting in differential attribution for success and failure (Peterson & Seligman, 1984). Later, investigators found the variable of self-esteem of interest and studied its role in depressive attributional style. Tennen, Herzberger and Nelson (1987) demonstrated strong relationship of self-esteem with attributional style as well as depression. McCauley, Mitchell, Burke and Moss (1988) studied children and found that the depressed children endorsed significantly lower self-esteem, more hopelessness, a more externalized locus of control, and a more depressive attributional style than the resolved depressives or the nondepressed children. Stoltz and Galassi (1989), examining Janoff-Bulman's formulations (1979), concluded that depressed subjects with low self-esteem made more internal characterological attributions for bad events than the non-depressed who in contrast made more internal behavioural attributions. Cohen, Bout, Vliet and Kramer (1989) maintaining that both depressives and non-depressives characterize self-serving bias, investigated the relationship of dysphoria and self-esteem with attributional style. They found that low

dysphoria individuals and high self-esteem individuals exhibited positive attributional bias (i.e. tendency to attribute positive outcomes to relatively internal, stable and global aspects and negative outcomes to relatively external, unstable and specific aspects), whereas, high dysphoria individuals and low self-esteem individuals exhibited negative attributional bias (i.e. tendency to attribute negative outcomes to internal, stable and global aspects and positive outcomes to external, unstable and specific aspects). They maintained that most of the variance that dysphoria has in common with attributional bias can be accounted for by self-esteem. They further explained that self-esteem and dysphoria are constructs which overlap to a considerable degree and this area of overlap may offer a clue towards understanding the association with attributional bias. These findings lend support to the mediational role of self-esteem determining attributional style. However, a contrary evidence comes from Pillow, West and Reich (1991), necessitating continued research in the area.

Certain personality correlates have also been investigated for their role in attributional style (Rhodewalt, Strube, Hill & Sansone, 1988). Such insight into detrimental factors not only clarifies more the concept of attributional style but also has implication in psychotherapy as well. Attributions are focused to alleviate the symptoms of depression and foster an improved outlook (Cozens & Brewin, 1988). Recently the concept of 'attributional complexity' has been introduced to study the attributional style in a more differential manner. Flett, Pliner and Blankstein (1989) examined the relationship of increased attributional complexity with depression and found a potentially important correlation between them. In contrast, McClure, Lalljee and Jaspers (1991)

suggested that people respond to some extreme events by increasing the magnitude of a single cause rather than the number of causes.

The present review on attributional style with relation to depression does not in any way suggest that the theoretical formulation has successfully established an empirical verification of its postulates. There are contrary evidences too (see, Rothwell & William, 1983; and Hargreaves, 1985), which posit for more sound instruments of measurements and methodology. Though a particular pattern of attribution has been shown to be related with depression the link is yet to be demonstrated with more confidence. Moreover, if attributions are more enduring characteristic acquired by individuals through parental modelling and their own interaction with environment, then it would be interesting to study the phenomenon in cultures differing in value system. For instance, it would be interesting to study the peculiar attributional style in Pakistan, where , as reasoned earlier, interpersonal inter-dependency is the norm. It is possible that in such an atmosphere it is more characteristic of people that they externalize the responsibility of an event in contrast to holding themselves responsible. The attributional style then will have to be understood in the broader perspective of culture and its interactive forces. The framework of attributional style was forwarded in a different cultural set-up than that of Pakistan. Therefore, unless the basic concept is assessed in the light of cultural parameters an understanding of the theory across the culture would not develop. Though, attributional hypotheses have been tested out in other cultures too, but these more frequently took place in far eastern countries which do not represent the strongest possible cultural contrast with the United States as there exists less disparity

between religious dictates and forces of westernization. However, the realization is there that the focus should be on the culture which is more eastern in terms of its value system (Crittenden & Lamug, 1988). It appears relevant, therefore, to explore the peculiar dimensions of attributions in other Asian countries to provide more powerful tests of cross-cultural validity. The present research ,thus, attempts to achieve this aim by examining the validity of the attributional formulations in a culture where religious dictates are still stronger than personal values. It is a common observation that in Pakistan people tend to attribute the good or bad happenings to the will of the God, a sign of being a believer. It is not generally approved if someone regards his or her own effort or ability leading to a desired outcome, instead attributing it to God's will is taken as a sign of being humble; a trait much appreciated. It is a general assumption that in a culture where religion dominates the personal value system, individuals tend to adopt a more fatalistic outlook.They would attribute the cause of an event more to luck (*Kismat)* and fate (*Taqdeer*) than to their own ability and effort. These assumptions need to be tested out to understand the extent to which the proposed attributional style is valid across cultures.

In addition to these religious factors, there are many political and socio-economic factors which may be instrumental in tailoring a particular attributional style. Unlike England and USA , where most of the theory has been formulated , in Pakistan individual's freedom and sense of control is curtailed by a generalized feeling of powerlessness. It is a general perception that people here do not have much faith in their efforts and a sense of helplessness pervades their lives. This discourages them to think

that they can change their lot with their effort in case of any bad happenings (the general belief, instead is that there are always short-cuts to long routes if you have right connections). The political instability further weakens the faith in one's effort. Frequent conflicts between various ethnic groups create a sense of insecurity and uncertainity, making an individual find some solace by leaving everything on God's will.

Therefore, in such a cultural context where religion and socio-political forces are exerting pressures on individual, it appears relevant to study the prevalent peculiar attributional style. Furthermore, it would be pertinent to explore that in such a setting which particular attributional style will help significantly differentiate between depressed and non-depressed . Keeping these issues in perspective, the present research attempts to study the attributional style of depressed and non-depressed for pleasant and unpleasant events. This could be studied by content analyzing the causal ascriptions of the subjects. Attribution for pleasant and unpleasant events need to be analyzed separately as findings suggests that attributional style for pleasant and unpleasant events may contribute to depression separately, and in opposite directions (see, Crittenden & Lamug, 1988; Hull & Mendolia, 1991). More specifically, depressed tend to have an external, variable and specific attributions for pleasant events, in contrast to having an internal, global and stable attributional style for unpleasant events. For the assessment of depression, one separate study (Study I) is to be undertaken to develop an indigenous measure of depression. The rationale for such an effort has been explicated earlier, stressing both methodological and cultural aspect of assessment and diagnosis.

Chapter 2.

OBJECTIVES AND METHOD

I- Purpose of the Research

The present research purported to investigate the nature of attributional style and its relationship with depression. As reasoned earlier, the absence of any valid psychological measure renders the task of assessment difficult. It has also been reasoned that efforts at adaptation and standardization of any depression scale developed in the West, do not necessarily fill the lacunae, rather they only sacrifice the crispness of the findings in the end. The argument followed, that if a differential attributional style among depressives and non-depressives is to be explored, it becomes pertinent that we develop a measure of depression which differentiates depressives from non-depressives in a valid manner. Therefore, the work undertaken comprised of two specific domains i.e., development of an indigenous depression scale (Study I) and the study of attributional style in relation to depression (Study II).

The study I was carried over three phases with independent samples. The items for the scale were generated from student samples which were then judged for their relevance and intensity with clinical manifestations of depression. This was be followed by the determination of validity and reliability of the scale for both depressed and non-depressed. The scale was validated against the reported mood of the respondents, psychiatrist's rating of depression as well as one existing depression scale i.e., Zung's depression scale. Zung's scale was preferred as it was designed for use with a general population, is brief, and can be self administered. Moreover, it covers affective,

psychological and somatic symptoms; and it has been used extensively in cross-cultural research (Marsella, 1980). For reliability estimate of the scale, split-half reliability and internal consistency of the scale are to be determined. A normative analysis of scores obtained by both depressives and non-depressives will provide a classifying index to be used in study II.

The following hypotheses have been formulated for the study of attributional styles of depressives and non-depressives.

1. The individuals with high depression scores will identify more unpleasant events than individuals with low depression scores.
2. The individuals with high depression scores will more frequently attribute the causes of unpleasant events to internal factors than individuals with low depression scores.
3. The individuals with high depression scores will more frequently attribute the causes of unpleasant events to global factors than individuals with low depression scores.
4. The individuals with high depression scores will more frequently attribute the causes of unpleasant events to stable factors than individuals with low depression scores.
5. The individuals with high depression scores will more frequently attribute the causes of pleasant events, to external factors than individuals with low depression scores.
6. The individuals with high depression scores will more frequently attribute

the causes of pleasant events to specific factors than individuals with low depression scores.

7. The individuals with high depression scores will more frequently attribute the causes of pleasant events to variable factors than individuals with low depression scores.

II- Research Design

Study 1:

Study I aimed at the development and validation of an indigenous depression scale. It was carried out in three phases.

Phase: I — Generation of items for the depression scale.

Phase: II — Assessment of the intensity of items regarding their manifestation in the clinical group (known depressives).

Phase: III — Determination of reliability and validity of the scale and cut-off points for the intensity of depression.

Study 2:

The second study intended to investigate the relationship between attributional style and depression . The design was a 3 X 3 factorial with three bipolar attributional dimensions (internal-external, global-specific and stable-variable) and the severity of depression (no depression, mild depression and moderate depression).

Attributional Style

		Internal/ External	Global/ Specific	Stable/ Variable
Degree of Depression	Not depressed			
	Mildly depressed			
	Moderately depressed			

III- Method

Study I

The development of an indigenous depression scale was carried over three phases, comprising of generation of items for the scale, assessment of the intensity of items and determination of its reliability and validity.

Three different samples were taken for each phase according to the specific purpose entailed.

Phase I — The purpose of the first phase was to generate the items for the depression scale.

Sample

Sample consisted of 80 males and female students from the University of Punjab, Lahore, and Quaid-i-Azam University, Islamabad. Their ages ranged from 20-25 years and they were all studying at the post-graduate level. The sample can be regarded as representative of Pakistani university students, as the subjects, who participated in the study, belonged to geographically different parts of the country.

Procedure

The subjects were given a semi-structured questionnaire which consisted of three steps (see Annexure 1)

(i) Subjects were given instructions to recall and enlist those situations when

they felt depressed.

(ii) When the subjects completed the listing of situations they were given various examples to explain how the cognitions, feelings and behaviours can occur in a depressing situation.

(iii) They were then asked to write their cognitions, feelings and behaviours in the situations listed earlier.

The subjects were also given a questionnaire to obtain some personal information (Annexure II)

The items were written after analyzing the cognitions, feelings and behaviours experienced by the subjects during a depressive phase.

Phase II

In the second phase items generated in phase I were assessed for the intensity with regard to their relevance for clinically depressed group.

Sample

Forty-two clinical psychologists and psychiatrists were taken as judges to help assess the intensity of the items. These judges had the practical clinical experience and were working in different psychiatric settings of the hospitals and other institutions.

Procedure

Judges were asked to rate the items in the light of their clinical experience,

keeping in mind the actual occurrence of these feelings, cognitions and behaviours in depressives. They were given a list containing 72 items (extracted from phase I), along with a 3-point scale denoting '1' to normal sadness, '2' to mild depression and '3' to severe depression (Annexure III). If an item appeared more characteristic of normal sadness, the judges rated it as '1', if it was found to be reported more frequently by mildly depressed persons, the item was given a rating of '2', and if the item was considered a characteristic of severely depressed patients, the rating assigned was '3'. In this manner relevance and intensity of the items to the varying degree of depression were determined.

Phase III

The consensus among judges for the categorization of an item according to it's intensity helped select 36 items for the third phase of study I. In this phase of the study the validity and reliability of the scale was determined for the clinical and non-clinical groups and the cut-off points were determined for varying intensities of depression.

Sample

Two different groups were taken for this phase, which were: non-clinical (i.e., normals) and clinical (i.e., known depressives). The non-clinical sample comprised of 206 male and female university students from the five universities of major cities of the country. These included, Quaid-i-Azam university, Islamabad; university of Punjab,

Lahore; university of Karachi, Karachi; university of Peshawar, Peshawar; and university of Baluchistan, Quetta. An attempt was made to ensure a country wide representation of non-clinical group. The subjects were students at post-graduate level and their ages ranged from 22 to 28 years.

The clinical sample was selected from the two major hospitals of Rawalpindi and Islamabad. They were mostly taken from the psychiatric out-patient departments of the hospitals, few of them, however, were included from the psychiatric wards as well. Their ages ranged from 18 - 44 years.

Instrument:

The two groups were assessed on the same instrument with the exception of one measure. The non-clinical group was given the following measures (see annexure IV to VII) :

(a) A self-rating scale for the assessment of current mood on a 7-point scale.

(b) The 36 items obtained from phase II which related to various degrees of depression.

(c) Zung's Self-Report Depression Scale(SDS).

(d) A questionnaire about some personal information.

The clinical group was also assessed on above mentioned instruments, with the exception of Zung's depression scale as it was in English and its administration on patients was not feasible. Instead, psychiatrists making the referral of the patient for the

study, were asked to evaluate the clinically depressed on an assessment form based on ICD-10 (See annexure VIII). There were 30 such patients from the total sample of 60 who were diagnosed by the psychiatrists before being assessed on the 36 item depression scale.

Procedure

The non-clinical group was studied in small groups. They were instructed prior to the application of each instrument, whereas, the clinical group was studied individually in a one-to-one situation. Patients diagnosed by psychiatrists as depressed and who could communicate as well, were selected for the study.

Results

The section describes the findings of the Study I carried out to develop an indigenous depression scale (all statistical analysis were carried out with the help of computer package of 'SPSS' (Statistical Package for Social Sciences).

Table 1 **Frequencies and percentages of item-wise concurrence between the Judges.**

Items	Normal Sadness		Mild Depression		Severe Depression	
	f	%	*f*	%	*f*	%
1	16	38.1	18	42.9	8	19.0
2	15	35.7	21	50.0	6	14.3
3	8	19.0	20	47.6	14	33.3
4	6	14.3	29	69.0	7	16.7
5	19	45.2*	16	38.1	7	16.7
6	3	7.1	5	11.9	34	81.0*
7	7	16.7	26	61.9	9	21.4
8	3	7.1	3	7.1	36	85.7*
9	4	9.5	16	38.1	22	52.4*
10	19	45.2*	17	40.5	6	14.3
11	14	33.3	23	54.8*	5	11.9
12	18	42.9	22	52.4	2	4.8
13	10	23.8	25	59.5*	7	16.7
14	19	45.2*	17	40.5	5	11.9

Continued.....

Items	Normal Sadness		Mild Depression		Severe Depression	
	f	%	*f*	%	*f*	%
15	4	9.5	18	42.9	20	47.6*
16	18	42.9	19	45.2	5	11.9
17	33	78.6*	7	16.7	2	4.8
18	10	23.8	21	50.0	10	23.8
19	22	52.4*	20	47.6	-	--
20	24	57.1*	16	38.1	2	4.8
21	24	57.1*	13	31.0	5	11.9
22	17	40.5	19	45.2	6	14.3
23	8	19.0	19	45.2	15	35.7
24	4	9.5	10	23.8	28	66.7*
25	1	2.4	12	28.6	29	69.0*
26	1	2.4	3	7.1	38	90.5*
27	13	31.0	22	52.4	7	16.7
28	8	19.0	8	19.0	25	59.5
29	12	28.6	25	59.5*	4	9.5
30	17	40.5	22	52.4	2	4.8
31	3	7.1	11	26.2	28	66.7*
32	5	11.9	21	50.0	16	38.1
33	24	57.1*	15	35.7	3	7.1
34	22	52.4*	17	40.5	2	4.8
35	20	47.6*	19	45.2	2	4.8
36	10	23.8	22	52.4	10	23.8
37	13	31.0	22	52.4	7	16.7
38	--	--	13	31.0	29	69.0*
39	2	4.8	11	26.2	29	69.0*
40	11	26.2	28	66.7	3	7.1
41	11	26.2	26	61.9*	5	11.9
42	14	33.3	13	31.0	15	35.7
43	12	28.6	19	45.2	10	23.8
44	1	2.4	5	11.9	36	85.7
45	1	2.4	2	4.8	39	92.9*

Continued.....

Items	Normal Sadness		Mild Depression		Severe Depression	
	f	%	*f*	%	*f*	%
46	7	16.7	28	66.7*	7	16.7
47	13	31.0	26	61.9	3	7.1
48	-	--	23	54.8*	19	45.2
49	9	21.4	30	71.4*	3	7.1
50	10	23.8	22	52.4	10	23.8
51	21	50.0*	17	40.5	4	9.5
52	19	45.2	19	45.2	4	9.5
53	13	31.0	26	61.9	3	7.1
54	24	57.1*	17	40.5	1	2.4
55	13	31.0	23	54.8	5	11.9
56	16	38.1	23	54.8	3	7.1
57	15	35.7	26	61.9*	1	2.4
58	8	19.0	24	57.1	10	23.8
59	5	11.9	23	54.8	14	33.3
60	7	16.7	26	61.9	9	21.4
61	9	21.4	26	61.9*	7	16.7
62	4	9.5	18	42.9	20	47.6*
63	7	16.7	15	35.7	20	47.6
64	11	26.2	24	57.1*	7	16.7
65	14	33.3	20	47.6	8	19.0
66	16	38.1	21	50.0	5	11.9
67	11	26.2	22	52.4	8	19.0
68	5	11.9	28	66.7*	9	21.4
69	3	7.1	19	45.2	20	47.6
70	7	16.7	23	54.8	12	28.6
71	15	35.7	23	54.8*	4	9.5
72	15	35.7	19	45.2	6	14.3

Table 1 indicates the frequencies and percentages of item-wise concurrence

between the judges, assigning each item into one of the three categories (i.e., normal sadness, mild depression and severe depression). As regards the consensus of the judges, items assigned to one of the three categories with above 50% consensus were selected for the final scale. However, to reduce the redundancy of the content and to make it more representative of the domain (i.e., the specific category), few items having low concurrence were included , whereas, some with above 50% concurrence were left out. This resulted in a 36 item scale having 12 items from each category i.e., normal sadness, mild depression and severe depression. Table 1 indicates these selected items with the help of asterisk .

Table 2 Mean depression scores and standard deviations of clinical and non-clinical groups

Groups		Mean	S.D
Clinical	(N=60)	51.93	18.33
Non-clinical	(N=206)	27.07	12.70

Table 2 shows means of depression scores and their standard deviations for the clinical and non-clinical groups. As the scale measures the frequency of the indicators of depression, subject's score is determined by the category of endorsement of his responses. The categories of endorsement are inherently a 4-point scale, where 'none of the time' is given a value of zero, 'some of the times', a value of '1', 'most of

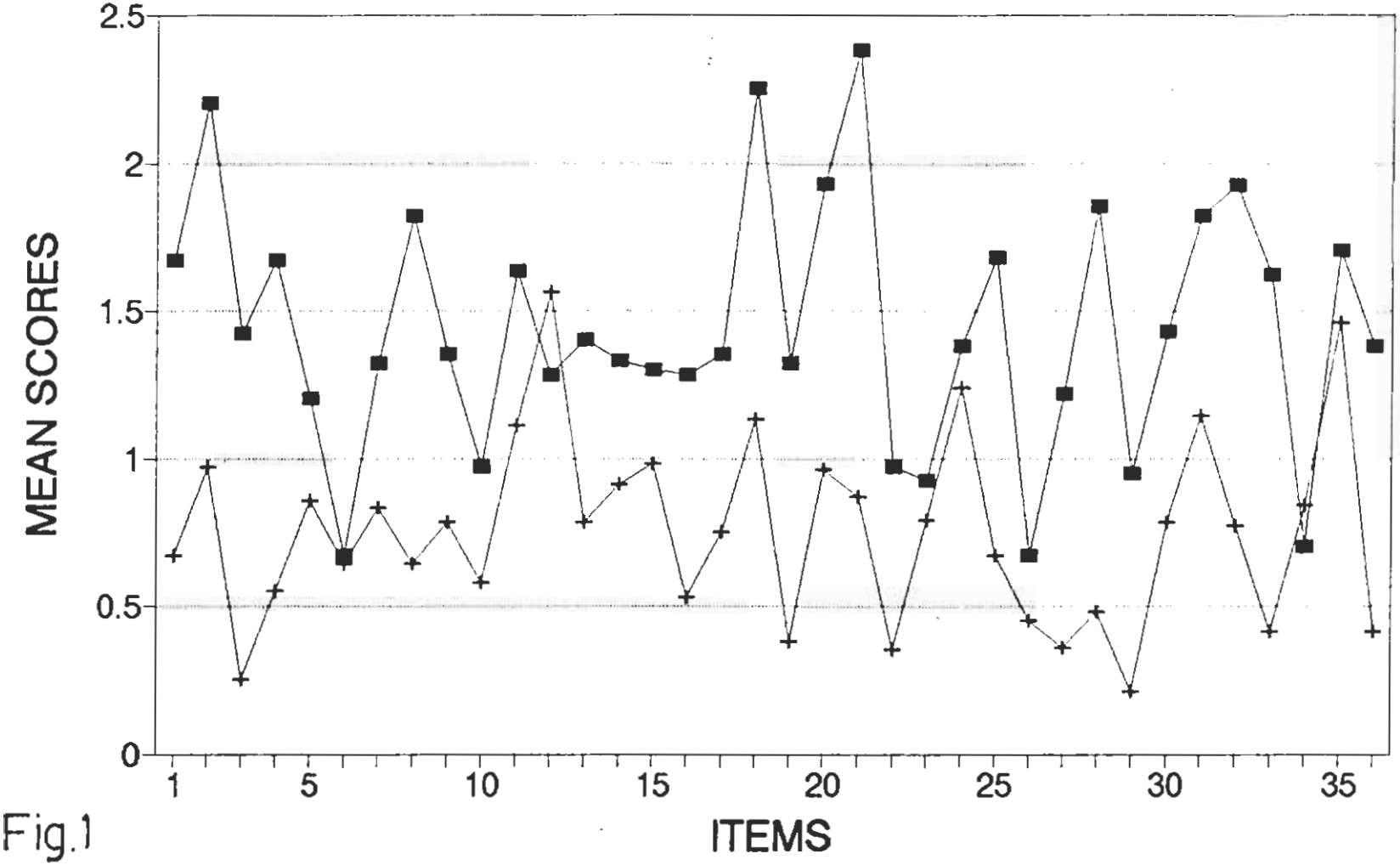

MEAN DISPERSION SCORES OF CLINICAL &
NON-CLINICAL GROUPS ON ITEMS OF SSDS
MEAN SCORES
2.5
2
1.5
1
0.5
0
1
5
10
15
20
25
30
35
ITEMS

Fig.1

the time', a value of '2', and 'all of the times' a value of '3'. The score of the subject is an aggregate of the categories checked on various items. The minimum score is zero and the maximum can be '108' (36 X 3). The clinical group has a higher mean (51.93) than non-clinical group (27.93). An item-wise differentiation between the mean dispersion scores of clinical and non-clinical group has been demonstrated in Figure 1.

Table 3 **Correlation coefficients for split-half reliability and Spearman-Brown correction of the scale for clinical and non-clinical groups**

Groups	Split-half Correlation	Spearman Brown Correction	*p*
Clinical	0.78	0.84	0.001
Non-clinical	0.80	0.89	0.001

Table 3 and 4 indicate the reliabilities of the scale. As the items of the scale were ordered in such a manner that it comprised of two equal halves , each containing equal number of items pertaining to the varying intensity of depression, split-half reliability could easily be calculated. Table 3 shows highly significant split-half reliability ($p < .001$), for both clinical group ($r = .79$) and non-clinical group ($r = .81$), along with Spearman-Brown correction for the full scale for both clinical ($r = 0.84$) and non-clinical group ($r = 0.89$).

Table 4 indicates a highly significant internal consistency for both the groups i.e., an alpha coefficient of 0.92 ($p < .001$) for clinical group and 0.89 ($p < .001$) for non-clinical group.

Table 4 Internal consistency of the scale for clinical and non-clinical groups

Groups	Alpha - co-efficient	*p*
Clinical	0.91	0.001
Non-clinical	0.89	0.001

Table 5 shows concurrent validities of indigenous depression scale. The correlation between Zung's depression scale and our scale is r = 0.55 ($p < .001$) for non-clinical group. It has a significant correlation r = 0.64 ($p < .001$) with reported

Table 5 Construct and concurrent validity of indigenous depression scale

Tests	Correlation	*p*
Correlation between the scores on items of indigenous depression scale and Zung depression scale (non-clinical group $N = 206$)	0.55	.001
Correlation between current mood and items of indigenous depression scale (non-clinical group $N = 206$)	0.14	n.s.
Correlation between current mood and items of indigenous depression scale (clinical group $N = 60$)	0.64	.001
Correlation between items of indigenous depression scale and psychiatric rating for depth of depression (clinical group $N = 30$)	0.40	.05

mood for clinical group, in contrast to a non significant r= 0.14 (p= n.s.) obtained from non-clinical group. The scale has a non-significant correlation 0.40 (p< .05) with the psychiatric rating.

Table 6 **Mean and S.D. of depression scores of males and females in clinical group**

	Mean	S.D
Males (N = 23)	58.43	16.72
Females (N = 37)	7.89	18.34

t = 2.24 , df = 58, p < .03

Table 6 and 7 indicate mean depression scores and the standard deviations for females and males in the clinical and non-clinical groups.

Table 7 **Mean and S.D.of depression scores of males and females in non-clinical group**

Mean		S.D.
Males (N = 95)	27.63	12.93
Females (N = 111)	26.59	12.54

t = 0.58 , df = 204 , p =n.s.

Males in clinical group show a greater mean depression score than the females, t= 2.24, df= 58, p< .03, whereas, the difference in the mean depression score of males and females is negligible in the non-clinical group, t= 0.58, df= 204, p = n.s.

Table 8 shows the item-total correlation for the selected items in both clinical and non-clinical groups. All 36 items correlate significantly high with the total score, indicating a high internal consistency of the scale.

Table 8 Item-total score correlations for indigenous depression scale

Items	Non-clinical (N = 206)	Clinical (N = 60)
1	.5427**	.6580**
2	.5746**	.5570**
3	.4463**	.6308**
4	.2236**	.3122*
5	.3006**	.5235**
6	.3907**	.3232*
7	.4651**	.3784*
8	.4546**	.4318**
9	.3996**	.3930**
10	.4333**	.3354*
11	.4480**	.4295**
12	.3695**	.4369**
13	.5307**	.4959**
14	.5417**	.5821**
15	.5847**	.5475**
16	.6170**	.6530**
17	.4860**	.4182**
18	.4864**	.4409**

Continued...

Items	Non-clinical (N = 206)	Clinical (N = 60)
19	.6076**	.5919**
20	.5686**	.4341**
21	.4626**	.3461*
22	.4093**	.7167**
23	.3711**	.5763**
24	.5420**	.4742**
25	.5702**	.5854**
26	.4018**	.6468**
27	.6024**	.6491**
28	.5856**	.6217**
29	.3484**	.6744**
30	.4023**	.6135**
31	.4714**	.4802**
32	.3678**	.4485**
33	.5768**	.5478**
34	.5468**	.4414**
35	.2776**	.4802**
36	.5310**	.4702**

TABLE 9 **Factor loadings of items of indigenous depression scale on four factors**

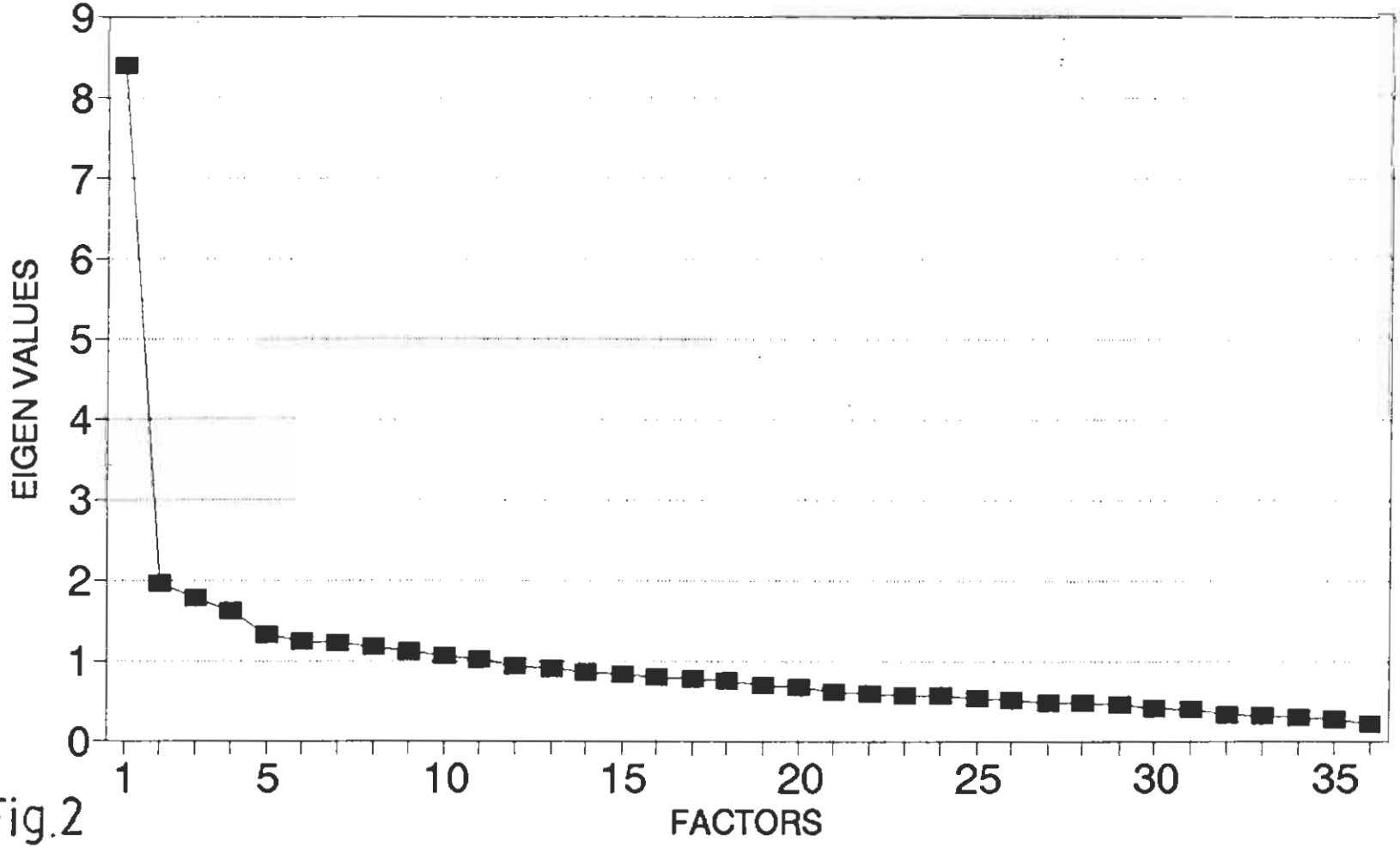
Item No.	*F*.1	*F*.2	*F*.3	*F*.4
1	.56	-.26	.06	-.21
2	.59	.05	.03	-.13
3	.47	-.46	-.01	-.20
4	.19	-.36	.33	.18
5	.28	-.27	.02	.00
6	.39	-.33	.12	-.12
7	.47	.29	.02	-.11

Continued.....

Item No.	*F*.1	*F*.2	*F*.3	*F*.4
8	.45	.12	.26	.09
9	.37	.34	.05	.30
10	.40	.14	.13	.44
11	.43	-.12	.15	.40
12	.32	.19	.25	-.02
13	.50	.10	-.03	.56
14	.53	.01	.08	.13
15	.59	.25	-.10	-.18
16	.63	.11	-.38	.10
17	.47	.33	-.14	.27
18	.46	.31	.11	-.27
19	.62	-.37	.09	.22
20	.57	.01	.15	-.00
21	.45	.32	.16	-.34
22	.42	-.11	-.12	-.00
23	.35	.25	-.05	-.10
24	.53	.11	.33	-.25
25	.58	.09	-.25	-.00
26	.41	.29	-.45	-.11
27	.62	.05	-.20	-.19
28	.61	-.26	.11	-.23
29	.36	-.22	-.52	.11
30	.38	-.01	-.07	-.03
31	.44	.06	.28	.08
32	.35	.00	.19	.13
33	.59	-.26	-.26	-.06
34	.55	-.18	-.11	-.11
35	.23	.07	.47	-.07
36	.53	-.24	.17	.11

Principal component analysis was run to determine the factor structure of the scale.

Table 9 shows the factor loadings of the items. The majority of the items except item 4, 5, 12, and 35 have factor loadings of .35 and above on Factor I. Table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FACTORS
EIGEN VALUES

Fig.2

10 demonstrates that the Factor I has an eigenvalue of 8.4 and explains 23.3% of the total variance. All the items are positively loaded on factor I. (Figure 2 shows eigenvalue diagrams).

Table 10 Eigenvalues and percentages of variance explained by the extracted factors

Factor	Eigenvalue	Pct of Var	Cum Pct
1	8.39801	23.3	23.3
2	1.94145	5.4	28.7
3	1.76956	4.9	33.6
4	1.60113	4.4	38.1
5	1.31419	3.7	41.7
6	1.22751	3.4	45.1
7	1.21081	3.4	48.5
8	1.16808	3.2	51.8
9	1.11418	3.1	54.8
10	1.05994	2.9	57.8
11	1.01177	2.8	60.6

Table 11 shows the frequencies and cumulative percentages of depression scores in the non-clinical group. The minimum depression score obtained is zero, whereas, the maximum is '86'. At a cumulative percentage of 26.9 % (23+ 29), the corresponding depression score is '18.5', at 50% the score is '25' and '75.5' % the depression score is '32' .

Table 11 **Frequencies and cumulative percentages of depression scores for non-clinical group**

Depression scores	Frequency	Cum Percent
.00	1	.5
7.00	2	1.5
10.00	6	4.4
11.00	4	6.3
12.00	3	7.8
13.00	5	10.2
14.00	4	12.1
15.00	3	13.6
16.00	5	16.0
17.00	10	20.9
18.00	6	23.8
19.00	11	29.1
20.00	9	33.5
21.00	2	34.5
22.00	6	37.4
23.00	15	44.7
24.00	5	47.1
25.00	8	51.0
26.00	8	54.9
27.00	11	60.2
28.00	9	64.6
29.00	6	67.5
30.00	7	70.9
31.00	5	73.3
32.00	5	75.7
33.00	4	77.7
34.00	1	78.2
35.00	4	80.1
36.00	6	83.0
37.00	2	84.0
38.00	6	86.9
39.00	4	88.8
40.00	1	89.3

Continued....

Depression scores	Frequency	Cum Percent
41.00	1	89.8
42.00	2	90.8
43.00	1	91.3
45.00	1	91.7
46.00	1	92.2
47.00	2	93.2
49.00	1	93.7
52.00	2	94.7
53.00	2	95.6
55.00	2	96.6
57.00	1	97.1
59.00	2	98.1
62.00	1	98.5
71.00	1	99.0
79.00	1	99.5
86.00	1	100.0

Table 12 **Frequencies and cumulative percentages of depression scores for clinical group**

Depression score	Frequency	Cum Percent
18.00	1	1.7
19.00	1	3.3
26.00	1	5.0
27.00	1	6.7
29.00	3	11.7
30.00	2	15.0
31.00	1	16.7
33.00	3	21.7
36.00	1	23.3

Continued....

Depression score	Frequency	Cum Percent
40.00	1	25.0
41.00	3	30.0
42.00	1	31.7
43.00	3	36.7
44.00	2	40.0
46.00	2	43.3
48.00	2	46.7
49.00	1	48.3
50.00	1	50.0
51.00	1	51.7
52.00	1	53.3
53.00	3	58.3
54.00	1	60.0
57.00	1	61.7
58.00	4	68.3
60.00	1	70.0
62.00	1	71.7
63.00	2	75.0
64.00	1	76.7
66.00	1	78.3
67.00	2	81.7
68.00	1	83.3
72.00	1	85.0
76.00	2	88.3
83.00	4	95.0
86.00	2	98.3
91.00	1	100.0

Table 12 shows the frequencies and cumulative percentages of depression scores in the clinical group. The minimum depression score obtained is '18', whereas the maximum is '91'. At a cumulative percentage of 25 % the corresponding depression score is '40', at 50% the score is also'50' and at 75 % the depression score is '63'. A comparative look at table 11 and 12 shows that the two groups demonstrate marked

difference in terms of the frequency distribution of depression scores.

Table 13 shows the frequency distribution of depression scores of males in the non-clinical group on the indigenous scale. The minimum depression score is zero and the maximum is '71'.

Table 13 **Frequency and cumulative percentages of depression scores for male subjects in non-clinical group (N = 95)**

Depression Score	Frequency	Percent	Cum. Percent
0.00	1	1.1	1.1
10.00	4	4.2	5.3
11.00	3	3.2	8.4
13.00	3	3.2	11.6
14.00	3	3.2	14.7
15.00	2	2.1	16.8
17.00	8	8.4	25.3
18.00	3	3.2	28.4
19.00	2	2.1	30.5
20.00	4	4.2	34.7
21.00	1	1.1	35.8
22.00	2	2.1	37.9
23.00	2	2.1	40.0
24.00	1	1.1	41.1
25.00	4	4.2	45.3
26.00	1	1.1	46.3
27.00	7	7.4	53.7
28.00	6	6.3	60.0
29.00	4	4.2	64.2
30.00	3	3.2	67.4
31.00	1	1.1	68.4
32.00	1	1.1	69.5

Continued.....

Depression Score	Frequency	Percent	Cum. Percent
33.00	2	2.1	71.6
35.00	3	3.2	74.7
36.00	4	4.2	78.9
37.00	2	2.1	81.1
38.00	3	3.2	84.2
39.00	3	3.2	87.4
41.00	1	1.1	88.4
42.00	1	1.1	89.5
43.00	1	1.1	90.5
45.00	1	1.1	91.6
46.00	1	1.1	92.6
52.00	1	1.1	93.7
53.00	1	1.1	94.7
55.00	1	1.1	95.8
57.00	1	1.1	96.8
59.00	1	1.1	97.9
62.00	1	1.1	98.9
71.00	1	1.1	100.00

Table 14 **Frequencies and cumulative percentages of depression scores for female subjects in non-clinical group($N=111$)**

Score	Frequency	Percent	Cum. Percent
7.00	2	1.8	1.8
10.00	2	1.8	3.6
11.00	1	0.9	4.5
12.00	3	2.7	7.2
13.00	2	1.8	9.0
14.00	1	0.9	9.9

Continued.....

Score	Frequency	Percent	Cum. Percent
15.00	1	0.9	10.8
16.00	5	4.5	15.3
17.00	2	1.8	17.1
18.00	3	2.7	19.8
19.00	9	8.1	27.9
20.00	5	4.5	32.4
21.00	1	0.9	33.3
22.00	4	3.6	36.9
23.00	13	11.7	48.6
24.00	4	3.6	52.3
25.00	4	3.6	55.9
26.00	7	6.3	62.2
27.00	4	3.6	65.8
28.00	3	2.7	68.5
29.00	2	1.8	70.3
30.00	4	3.6	73.9
31.00	4	3.6	77.5
32.00	4	3.6	81.1
33.00	2	1.8	82.9
34.00	1	0.9	83.8
35.00	1	0.9	84.7
36.00	2	1.8	86.5
38.00	3	2.7	89.2
39.00	1	0.9	90.1
40.00	1	0.9	91.0
42.00	1	0.9	91.9
47.00	2	1.8	93.7
49.00	1	0.9	94.6
52.00	1	0.9	95.5
53.00	1	0.9	96.4
55.00	1	0.9	97.3
59.00	1	0.9	98.2
79.00	1	0.9	99.1
86.00	1	0.9	100.0

Table 14 shows the frequency distribution of depression scores of females in the

non-clinical group on the indigenous scale. The minimum depression score is '7' and the maximum is '86'.

Table 15 **Frequencies and cumulative percentages of depression scores of male subjects in clinical group (N = 23)**

Score	Frequency	Percent	Cum. Percent
33.00	1	4.3	4.3
40.00	1	4.3	8.7
41.00	2	8.7	17.4
42.00	1	4.3	21.7
43.00	1	4.3	26.1
44.00	1	4.3	30.4
46.00	1	4.3	34.8
49.00	1	4.3	39.1
51.00	1	4.3	43.5
52.00	1	4.3	47.8
53.00	1	4.3	52.2
58.00	1	4.3	56.5
63.00	2	8.7	65.2
66.00	1	4.3	69.6
72.00	1	4.3	73.9
76.00	2	8.7	82.6
83.00	3	13.0	95.7
86.00	1	4.3	100.00

Table 15 shows the frequency distribution of depression scores of males in the clinical group . The minimum depression score is '33' and the maximum is '86'.

Table 16 **Frequencies and cumulative percentages of depression scores for female subjects in clinical group (N = 37)**

Score	Frequency	Percent	Cum.Percent
18.00	1	2.7	2.7
19.00	1	2.7	5.4
26.00	1	2.7	8.1
27.00	1	2.7	10.8
29.00	3	8.1	18.9
30.00	2	5.4	24.3
31.00	1	2.7	27.0
33.00	2	5.4	32.4
36.00	1	2.7	35.1
41.00	1	2.7	37.8
43.00	2	5.4	43.2
44.00	1	2.7	45.9
46.00	1	2.7	48.6
48.00	2	5.4	54.1
50.00	1	2.7	56.8
53.00	2	5.4	62.2
54.00	1	2.7	64.9
57.00	1	2.7	67.6
58.00	3	8.1	75.7
60.00	1	2.7	78.4
62.00	1	2.7	81.1
64.00	1	2.7	83.8
67.00	2	5.4	89.2
68.00	1	2.7	91.9
83.00	1	2.7	94.6
86.00	1	2.7	97.3
91.00	1	2.7	100.0

Table 16 shows the frequency distribution of depression scores of females in the clinical group . The minimum depression score of '18' and the maximum is '91'.

The cut-off points for the scale can be determined through the cumulative frequency distribution of the scores of non-clinical and clinical groups. The two frequency distributions can be used to locate an optimal cutting score which would minimize the sum of false positives and false negatives. In our case a depression score of 26 specifies 54.9 % of the non-clinical sample as not depressed, whereas, the same score classifies 5% as non-cases in the clinical sample. Taking the score of 26 as the lowest score indicative of depression and the score of 36 as the upper range indicative of mild depression provides us the first range of clinical cutting scores. The frequency distribution of depression scores shows that 83% of the non-clinical sample has obtained a score of 36, whereas in the clinical group 23.3% of the sample has obtained the same score. At a score of 49, 93.7% cases of non-clinical sample are covered, whereas, in the clinical group this percentage is 48.3. This provides us another set of clinical cutting score raging from 37 to 49, interpretable as moderately depressed. A score of 50 or above can be considered as presence of severe depression.

A discriminant index for each cutting score (i.e., 26, 36 & 50) was obtained by dichotomizing the frequencies of false positives and false negatives around each cut-off scores. This resulted in three 2 X 2 contingency tables (Tables 17,18 & 19).

Table 17 shows that below the cutting score of '26', the frequency of non-cases in non-clinical sample is 113, whereas, 93 individuals of non-clinical group are being classified as false positive at this cut-off point. In comparison, only 3 cases of

Table 17 **Discriminant validity of the scale for the cutting score of, below and above, 26 for depressed and non-depressed groups.**

Depression Score	Non-Depressed	Depressed
26 and below	113	3
27 and above	93	57

Phi = 0.42, X^2 = 46.9, df = 1, p < .001.

clinical group are being missed out as non-cases and 57 are classified as depressives at the same cut-off score. The phi-coefficient demonstrates a significantly high discriminant validity for the cut-off score of 26, phi = 0.42, X^2 = 46.9, df= 1, p< .001.

Table 18 **Discriminant validity of the scale for the cutting score of, below and above, 36 for depressed and non-depressed groups.**

Depression Score	Non-Depressed	Depressed
36 and below	171	14
37 and above	35	46

Phi = 0.55, X^2 = 80.5, df = 1, p < .001

Table 18 shows that below the cutting score of '36', the frequency of non-cases in non-clinical sample is 171, whereas 35 individuals of non-clinical group are

being classified as false positive at this cut-off point. In comparison, 14 cases of clinical group are being missed out as non-cases and 46 are classified as depressives at the same cut-off score. The phi-coefficient demonstrates a significantly high discriminant validity for the cut-off score of 36, phi = 0.55, X^2 = 80.5, df= 1 p< .001.

Table 19 **Discriminant validity of the scale for the cutting score of, below and above, 49 for depressed and non-depressed groups.**

Depression Score	Non-Depressed	Depressed
49 and below	193	29
50 and above	13	13

Phi = 0.50, X^2 = 66.5, df = 1, p < .001

Table 19 shows that below the cutting score of '49', the frequency of non-cases in non-clinical sample is 193, whereas 13 individuals of non-clinical group are being classified as false positive at this cut-off point. In comparison, 29 cases of clinical group are being missed out as non-cases and 31 are classified as depressives at the same cut-off score. The phi-coefficient demonstrates a significantly high discriminant validity for the cut-off score of 49, phi = .50, X^2 = 66.5, df = 1 p< .001.

Table 20 Percentiles scores for clinical and non-clinical groups

Percentiles	Clinical	Non-clinical
5	26.05	11.00
10	29.00	13.00
15	30.15	16.00
20	33.00	17.00
25	40.25	19.00
30	41.30	20.00
35	43.00	22.00
40	44.80	23.00
45	48.00	24.00
50	50.50	25.00
55	53.00	26.85
60	55.80	27.20
65	58.00	29.00
70	61.40	30.00
75	63.75	32.00
80	67.00	35.60
85	75.40	38.00
90	83.00	42.00
95	85.85	53.00

Table 20 shows percentile scores for the clinical and non-clinical group for comparative purposes.

Table 21 Percentile scores for males and females in non-clinical group.

Percentile	Male	Female
5.00	10.8	11.6
10.00	12.6	14.2
15.00	15.0	16.0
20.00	17.0	18.4
25.00	17.0	19.0
30.00	18.0	20.0
35.00	20.6	22.0
40.00	23.4	23.0
45.00	25.0	23.0
50.00	26.0	24.0
55.00	27.0	25.0
60.00	28.0	26.0
65.00	30.0	27.0
70.00	32.2	29.4
75.00	34.0	31.0
80.00	36.0	32.0
85.00	39.0	36.0
90.00	43.8	39.8
95.00	54.8	52.4

Table 21 depicts the percentile scores for the females and males in the non-clinical group. The variation in the pattern of percentile scores for the two sex in the non-clinical group shows that females are scoring relatively higher at lower ranks as compared to males , but the pattern reverses after the 45th percentile.

Table 22 Percentile scores for males and females in clinical group.

Percentile	Male	Female
5.00	34.4	18.9
10.00	40.4	26.8
15.00	41.0	29.0
20.00	41.8	29.6
25.00	43.0	30.5
30.00	44.4	33.0
35.00	47.2	37.5
40.00	50.2	43.0
45.00	51.8	44.2
50.00	53.0	48.0
55.00	59.0	49.8
60.00	63.0	53.0
65.00	64.8	56.1
70.00	70.8	58.0
75.00	76.0	59.0
80.00	77.4	62.8
85.00	83.0	67.0
90.00	83.0	71.0
95.00	85.4	86.5

Table 22 shows variation in percentile scores for the clinical group. In this group, except the 95th percentile, the percentile scores of females are lower than the males.

Discussion

The findings reported of the study I demonstrate that indigenously developed depression scale concurs well with other measures of depression and is significantly reliable and internally consistent.

The development of the scale has an indigenous base as no prevalent Western definition was borrowed to define the construct (i.e., depression). Instead, items were generated by instructing the subjects to give an account of situations when they felt depressed. The assumption behind this was that it would help procure items which are more relevant to culture-specific aspects of depression. As reasoned earlier, efforts at adaptation run the risk of following the same list of symptomatology and indices of a disorder which have been found to be reported in the West. This approach among other deficits, entails an inherent weakness that totally misses out the true manifestation of a disorder in a particular cultural context. The fact that no item pertaining to sex was obtained substantiates the assumption that due to restricted cultural permissiveness in this regard, such complaint would not come up as an index of depression. A perusal of the items of the scale gives the idea, that most of the items pertain to the hopelessness aspect of depression (Item No. 1, 3, 5, 9, 10, 16 & 25). This is consistent with the prevalent conceptualization of the depressive disorder which regards hopelessness as one of the chief component of depression. Interpersonal conflicts with friends, parents and other family members also constitute a significant component of depression (item No. 6, 7, 17, 24, 30 & 34) supporting our earlier argument that ,here, significant others influence the

life of an individual in a psychologically significant manner. The component of guilt manifests in terms of being punished for some deed (item No. 10) and prayers not being accepted (item No. 5). This is different from the expression of guilt as measured by depression scale developed in the West. The guilt here is more in connection with perceived transgression of religious laws than social mores. The expression the prayers are not accepted, also refers to the same where the person thinks that God has stopped listening to him. Thus, in contrast to other scales of depression, our scale explicitly relates the feelings of guilt to perceived or actual transgression of divine laws emphasizing the religious orientation of our people. The punishment also has a divine connotation. Feelings of personal worthlessness and incompetence, similar to the Western features of depression, are also reported (item No. 9, 15, 16, 22, 23 & 27). Somatic complaints also constitute a significant portion of the scale (item No. 4, 11, 21 & 32). It is generally accepted that depression has more somatic manifestations in non-western cultures as compared to western one (Marsella & White 1984). Death wish is also reported (item No. 13 & 36). This is in contrast to the suicidal wish generally measured in scales developed in West. This again may be a reflection of religious orientations of our people as in Islam suicide is forbidden. It is generally believed that in the hereafter those who commits suicide will not be blessed by God. Moreover, the one who commit suicide is believes to be going through a perpetual torture till the day of judgement. Therefore, instead of expressing or doing something to end their lives, the depressives here verbalize a passive wish for death to give them relief from their miseries. Such a content which is truly indigenous, would not have been known if any adaptation has been

opted for the present work.

The items of the scale were selected largely on the basis of consensus among the judges. The violation incurred in this respect were , however, deemed necessary as the purpose was to develop a scale which is sensitive to varying intensities of depression. If all the items having consensus of 50% and above were selected, the scale would have lost its representativeness, as it would have been dominated by items measuring the 'mild depression' only. Therefore, a rational decision was taken to select the items is such a manner that they are equally sensitive to the varying degree of depression. To achieve this aim, as many as 22 items pertaining to mild depression have to be dropped and few items having lower percentage of concurrence among judges were included in the category of 'normal sadness' and ' severe depression'. As the items were generated from a non-clinical sample, it is not surprising that most of the content of items generated in phase I were characteristic of 'mild depression'. However, this bias was taken care of in the final selection of the items. One can question the generation of items for the scale of depression from a non-clinical population, but the justification lies in the absence of properly managed files of the patients in the psychiatric wards and the fact that it would have required the researcher to spend a considerably greater amount of time -spread over years- to collect a representative content of reported symptoms. Therefore, the feasible method was to first generate the items in a non-clinical sample and then establish its relevance in a clinical sample. This is further substantiated by the fact that students have been reported to show similar clinical manifestation, though varying in degree, as reported in known depressives (Hammen 1980). The scale has

demonstrated its strength by providing significant split-half reliability and internal consistency among the items. Along with reliability, the validity of scale is the criterion for its robustness. The indigenous depression scale demonstrated significant relationship with Zung's depression scale. This significant correlation indicates that our scale is a valid measure of depression and does contain items pertaining to the features of depression.

The significant correlation of reported mood in clinical group establishes further the validity of the scale, whereas, a low correlation with non-clinical group points towards other pertinent variables. It is possible that the non-clinical group did not experience any significant unpleasant mood while filling out the scale but they were experientially familiar with the content of the item. The argument focuses upon the distinction of two components of depression i.e., mood and cognitions. The question arises whether it is possible to endorse cognitions pertaining to depressive state while feeling not as depressed. Moreover, does this imply that the scale is sensitive to both trait and state of depression? All these questions can be clarified only after specifically studying these aspects of depression.

Coming back towards the discussion of validities, the significant correlation of the scale with psychiatric rating indicates that the scale is sensitive to the clinical manifestation of depression. Such a finding encourages its use in clinical population for the assessment of depression.

A comparison of women and men's score revealed that there exists a significant difference in the clinical group in this respect. It appears that men, though less

in number, reported to be more depressed as compared to their counterparts. This could be due to two reasons. One reason could be that as men in our society, being the only bread-winner in majority of the household, are subject to many pressures both within and outside the home. The changing socio-economic structure, the increased index of prices, political and civic disturbances impinge more upon men who remain present in the environment where such forces are operative. As the sample is mostly representative of middle and the lower middle class, the high scores speak of the prevalent pressures of this class. The other possible reason , which though appears more nebulous, is that in Pakistani culture there exists a greater acceptance of a depressive outlook for a woman. It goes with the cultural stereotype of a women that she is submissive, weak-hearted and prone to crying even on small issues. It is a well-understood fact that a person reports as complaints only those features which he or she regards as ego-dystonic. Therefore, if a depressive outlook is in the order, then a woman takes it as a part of her self concept (ego- syntonic) and does not report it when experienced by her. However, both of these arguments remain speculative as they need to be tested for their credence.

The dominance of single factor has further strengthened the validity of the contents of items. Thus, it can be maintained that our depression scale successfully establishes it's internal validity.

The marked difference in the frequency distribution of depression scores between clinical and non-clinical groups reflects upon the fact that the two samples were representative of their respective population, therefore, any assessment based on the

frequency distribution of the two groups can be relied upon as classification index.

The frequency score distribution for women and men in clinical and non-clinical group depicts that women are scoring higher than men, however, the difference stands statistically significant only in clinical group (The difference with respect to means has already been discussed).

The three ranges of cut-off scores enable us to interpret the scores of the individual against the sample studied. The procedure of using frequency distribution to determine clinical cut-off scores has been used by other scale developers as well (Westhuis & Thyer, 1989). These cut-off scores have demonstrated significant discriminant validity as well. However, these cutting scores are not to be interpreted as a precise estimate of the true cutting score; especially a user should never interpret borderline scores (for instance, near 26) as definitive classification indicators. This is due to two reasons: one, that the sample used to develop this cutting scores is relatively small, reducing the stability of its estimate. Therefore, the possibility remains that as a result of future validation studies the cutting scores may be shifted. Secondly, the scale has been designed to assess the severity of respondent's self-reported depression and not as a definitive diagnostic instrument. The scale will help diagnose the undetected cases in a busy psychiatric out- patient departments of hospitals, however, to be treated as definitive diagnostic instruments, the scale has yet to go through the rigors of psychometric procedures. The assessment based on the cut-off scores have to be repeatedly validated in various clinical groups, differing in intensity and nature of depression to determine the sensitivity-specificity of the scale. The fact that the lowest

cut-off score of 26 results in only 5% of false negative is quite encouraging ,however, a 45% false positive at the same score calls for further empirical support. Though, one can argue that such a percentage is reflective of the presence of mild depression in the non-clinical sample, it would, however, require various cross-section of the population to be assessed by different researchers. Therefore, in the absence of such prerequisites, the corroborative data from other key sources would still be needed for a diagnostic or treatment decision.

The use of the scale for assessment purposes is further facilitated by the provision of percentile scores. Two separate percentile tables will facilitate the researcher to evaluate a score in a differential manner, thus determining the relative index of the severity of a score.

The development of an indigenous depression scale, henceforth, called Siddiqui-Shah Depression Scale (SSDS), will be useful both in clinical assessment and research. Being a measure of depression based on culture-relevant expression of depression may help assess the very features being missed out, thus facilitating the clinician in more accurate diagnosis. Moreover, as the scale does not need a trained interviewer, it can be used in psychiatric out-patient departments with much ease, as even the staff nurses can be easily trained for it's use. In this manner, it proves to be far more economical than routine psychiatric interview.

Finally, as the scale provides a numerical index of the degree of depression, it can be used for comparative purposes with other quantitative data both for the purpose of clinical assessment and in research as well.

The SSDS is in the primary stages of its development. The present researcher understands that many more validation studies are in order for it to attain a status of definitive diagnostic instrument. In any case, SSDS will not be able to provide standard diagnostic classification (e.g., as outlined in DSM III), as it was designed to measure varying intensities of depression along a continuum. The focus was more to keep the item relevant to the culture where it is being developed. Therefore, any equivalence of its classification with Western standard diagnostic categories calls for new series of research which may, nevertheless, entice some of the future researchers.

One major limitation of SSDS is that it's applicability is dependent on the respondent's cooperation as well as her/his ability to comprehend the content of items. This limitation is critical in the use of SSDS with reference to Pakistan, where the literacy rate is appallingly low. This limitation can be taken care to some extent, as expressed earlier, by employing staff nurses for it's administration. This in any case, seems unavoidable as the linguistic diversity in Pakistan limits the use of any paper-pencil test even in Urdu, the language spoken and understood by the majority, across many geographical region. In Pakistan, it is commonly said that here lingo changes after every 30 kilometres. However, Urdu, being the national language, remains the only medium to be relied in writing the items of the scale, and any difficulty of comprehension or barrier due to low level of literacy will have to be intervened by the person administering the scale. The minimum training required for this purpose must,

therefore, emphasize the conceptual understanding of the items by the staff, otherwise an interpretative or judgemental error may destroy the whole purpose of assessment.

Study II -- Depression and Attributional Style.

The focus of Study II is to explore the differential attributional styles of depressives and non-depressives. The SSDS will be used for the classification of depressives and non-depressives. This section, therefore, describes the second part of the present work which entails an empirical verification of the postulates of attributional framework.

Sample

The sample consisted of 24 male and 38 female students studying at post-graduate level. They were taken from male and female colleges of Rawalpindi and Islamabad. Their ages ranged from 20-31 years, the majority falling between 20-24 years.

Instruments

Attributional style were studied through the technique of Content Analysis of Verbatim Explanations (CAVE) (Peterson et al., 1983) by giving verbal instructions to the subjects (See annexure IX).

The following instruments were employed:

1. Siddiqui-Shah Depression Scale (SSDS).(Annexure X).
2. A questionnaire to obtain some personal information. (Annexure XI).

Procedure

The study was carried out in small groups. The researcher introduced herself and the relevance of the research briefly . An attempt was made to create a comfortable atmosphere so that subjects could be motivated to follow the instructions. Subjects were first asked to write six important events of their life, which could either be pleasant or unpleasant. After reporting the events, they were asked to state the nature of events as pleasant or unpleasant by assigning a positive (+) sign to pleasant event and negative (-) to unpleasant events. They were, then asked to give one main cause for each event. This was finally followed by administration of SSDS, to measure the degree of depression, and a questionnaire regarding certain personal information.

Scoring

Three judges, including the researcher herself, evaluated the causes described by the subjects for their dimensional properties of attribution. Each of the three judges independently rated each statement on three bipolar attributional dimension (i.e., internal-external, global-specific & stable-variable) in the light of theoretical framework of Abramson et al.(1978). There were 372 statements in total (62 x 6 = 372). The polarity of each statement on the attributional dimensions was decided on the basis of agreement between two judges. For example, if a statement is regarded to be pertaining to internal factor by two judges and external by the third one, the consensus of the two judge for the internality was taken as the attributional content of that statement. In other words a consensus of 66% was the criterion of acceptance for any

judged attributional dimension. In this manner, attributional dimension for each statement was determined for all the subjects. Following this, the subject's score for each statement on the ascertained attributional dimension was obtained by averaging the ratings given by each judge to the six statements. A subject obtained three separate scores on three attributional dimensions i.e., internal-external, global-specific and stable-variable. A subject's total score was, thus, an aggregate of scores for each cause on three attributional dimensions. Later, the researcher, treated the pleasant and unpleasant events separately, to study the differential attributional style. The scores of the subjects on SSDS were categorized according to the cut-off points of the scale.

Results

As the subjects in this study were administered Siddiqui-Shah Depression Scale (SSDS), for the assessment of depression, their score on SSDS helped classify them in three groups. They were: non-depressed, mildly-depressed and moderately-depressed. (No group of severely-depressed could be formed, as our sample of college students was not clinically depressed). Various statistical analyses were carried out to determine the relationship of attributional style with depression with the help of SPSS. Before analyzing the specific hypotheses of the study, analyses of the variance were computed for the main effect of attributional style for three groups of non-depressed, mildly depressed and moderately depressed. This was done to find out the extent of significance for each particular attributional dimension in differentiating between the varying degrees of depression.

Table 23 **One way analysis of variance on attributional scores for 'internal-external' dimension between non-depressed, mildly depressed and moderately depressed for pleasant events**

Sources of Variance	*SS*	*df*	*MS*	*F*	*p*
Groups	237.88	2	118.94	1.60	n.s
Residual	4375.442	59	74.16		
Total	4613.32	61	75.62		

Table 23 shows the result for the bipolar attributional dimension of 'internal-external' for pleasant events. The data show a non-significant main effect for the attributional dimension of 'internal-external', $F(2, 59) = 1.60$, p = n.s. This shows that the dimension of ' internal-external' is statistically non-significant in differentiating between the attributional style of non-depressed, mildly-depressed and moderately-depressed.

Table 24 **One way analysis of variance on attributional scores for 'global-specific' dimension between non-depressed, mildly depressed and moderately depressed for pleasant events**

Sources of Variance	*SS*	*df*	*MS*	*F*	*p*
Groups	36.17	2	18.08	3.48	$p < .04$
Residual	306.122	59	5.18		
Total	342.29	61	5.61		

Table 24 shows the result for the bipolar attributional dimension of ' global-specific' for pleasant events. The data show a significant main effect for the attributional dimension of 'global-specific', $F(2, 59) = 3.48$, $p < .04$. This shows that the dimension of global-specific is statistically significant in differentiating between the non-depressed, mildly-depressed and moderately-depressed.

Table 25 **One way analysis of variance on attributional scores for 'variable-stable' dimension between non-depressed, mildly depressed and moderately depressed for pleasant events**

Sources of Variance	*SS*	*df*	*MS*	*F*	*p*
Groups	3.20	2	1.60	0.309	n.s
Residual	306.54	59	5.19		
Total	309.74	61	5.07		

Table 25 shows the result for the bipolar dimension of 'variable-stable' for pleasant events. The data show a non-significant a main effect for the attributional dimension of ' variable-stable'. This shows that the dimension of variable-stable is statistically non-significant in differentiating between the non-depressed, mildly-depressed and moderately-depressed, $F(2, 59) = 0.30$, p = n.s.

Table 26 **One way analysis of variance on attributional scores for 'internal-external' dimension between non-depressed, mildly depressed and moderately depressed for unpleasant events**

Sources of Variance	*SS*	*df*	*MS*	*F*	*p*
Groups	74.35	2	37.17	1.87	n.s
Residual	1168.56	59	19.80		
Total	1242.92	61	20.37		

Table 26 shows the result for the bipolar attributional dimension of 'internal-external' for pleasant events. The data show a non significant main effect for the attributional dimension of 'internal-external', $F(2, 59) = 1.87$, p = n.s. This shows that the dimension of 'internal-external' is statistically non-significant in differentiating between the attributional style of non-depressed, mildly-depressed and moderately-depressed.

Table 27 **One way analysis of variance on attributional scores for 'global-specific' dimension between non-depressed, mildly depressed and moderately depressed for unpleasant events**

Sources of Variance	*SS*	*df*	*MS*	*F*	*p*
Groups	30.76	2	15.38	3.52	$p < .04$
Residual	257.49	59	4.36		
Total	288.25	61	4.72		

Table 27 shows the result for the bipolar attributional dimension of 'global-specific' for pleasant events. The data show a significant main effect for the attributional dimension of 'global-specific', $F(2, 59) = 3.52$, $p < .04$. This shows that the dimension of global-specific is statistically significant in differentiating between the non-depressed, mildly-depressed and moderately-depressed.

Table 28 **One way analysis of variance on attributional scores for 'variable-stable' dimension between non-depressed, mildly depressed and moderately depressed for unpleasant events**

Sources of Variance	*SS*	*df*	*MS*	*F*	*p*
Groups	54.01	2	27.0	6.42	$p < .003$
Residual	247.98	59	3.20		
Total	302.00	61	4.95		

Table 28 shows the result for the bipolar attributional dimension of ' global-specific' for pleasant events. The data show a significant main effect for the attributional dimension of 'global-specific', $F(2, 59) = 6.42$, $p < .003$. This shows that the dimension of global-specific is statistically significant in differentiating between the non-depressed, mildly-depressed and moderately-depressed.

The multiple analysis of variance (MANOVA) was computed in which the three groups i.e., depressed, mildly depressed, and moderately depressed were treated as independent and the three dimensions i.e., internal-external, variable stable, and global specific as dependent variables. The test of significance Pillias was preferred as it is more robust even in conditions where basic assumption of MANOVA are violated. The aim this analysis was to determine the level of significance with which the three attributional dimensions differentiate between non-depressed, mildly depressed and moderately depressed.

The analyses of variance alongwith multiple analyses of variance provided the results with regard to the main effects of attributional style between non-depressed, mildly depressed and moderately depressed for pleasant and unpleasant event. To further substantiate the results and tests our specific hypotheses of the study, t- test of significance of difference were computed.

Table 29 **Pillias multivariate test of significance for attributional style for pleasant events between non-depressed, mildly depressed and moderately depressed subjects on three attributional dimensions.**

Tests	Value	Hypoth. *df*	Error *df*	Approx. *F*	*p*
Pillias	0.196	6	116.00	2.10	n.s

Table 29 shows that all three dimensions of attribution are not significantly differential for non-depressed, mildly depressed and moderately depressed for pleasant events.

Table 30 **Pillias multivariate test of significance for unpleasant events between non-depressed, mildly depressed and moderately depressed subjects on three attributional dimensions**

Tests	Value	Hypoth. *df*	Error *df*	Approx. *F*	*p*
Pillias	0.209	6	116.00	2.26	0.042

Table 30 shows that all three dimension of attributions significantly differentiate between non-depressed, mildly depressed and moderately depressed for unpleasant events.

Table 31 Frequency of pleasant and unpleasant events described by depressed and non-depressed groups

Groups	Pleasant Events	Unpleasant Events	Total
Not-Depressed (N =34)	122	82	204
Depressed (N = 28)	97	71	163

X^2 = 0.16 df = 1 p = n.s.

The first hypothesis of the study stated that 'the individuals with high depression scores will identify more unpleasant events than individual with low depression scores'. A 2 X 2 chi-square test was computed for the nature of events and depressed and non-depressed subjects. Table 31 shows the frequency of pleasant and unpleasant events among depressed and non-depressed subjects. The findings do not confirm our hypothesis as chi-square value is non significant, $X^2 = 0.16$, df = 1, p = n.s.

Table 32 depicts the results for our second, third and fourth hypotheses. The second hypothesis stated that ' the individuals with high depression scores will attribute more frequently the causes of unpleasant events to internal factors than individuals with low depression scores'. Table 32 shows that results do not confirm our

second hypothesis, t = -1.66, df = 60, p = n.s.

Table 32 **Mean, standard deviations and t-values of depressed and non-depressed groups on attributional dimensions of internal-external (I/E), global-stable (G/S) and stable-variable (S/V) for unpleasant events**

	Not Depressed (N = 34)		Depressed (N = 28)				
	Mean	*SD*	*Mean*	*SD*	*t*	*df*	*p*
I/E	6.26	4.17	8.15	4.76	-1.66	60	n.s.
G/S	2.74	1.46	3.73	2.74	-1.82	60	0.07
S/V	2.59	1.31	4.06	2.80	-2.72	60	0.009

The results reported in Table 32 confirm our third hypothesis that ' the individuals with high depression scores will attribute more frequently the causes of unpleasant events to global factors than individuals with low depression scores', t = -1.82, df = 60, p < 0.07.

Table 32 also shows the difference between depressed and non-depressed for the attributional dimension of 'stable-stable'. The findings confirm our fourth hypothesis that 'the individuals with high depression scores will attribute more frequently the causes of unpleasant events to stable factors than individuals with low depression scores', t = -2.72, df = 60, p < 0.009.

Table 33 depicts the results for our fifth, sixth and seventh hypotheses. Table 33 shows the difference in attributional ascriptions for pleasant events between depressed and non-depressed groups. The findings support our fifth hypothesis that ' the

individuals with high depression scores will attribute more frequently the causes of pleasant events to external factors than individuals with low depression scores', t = 1.70, df = 60, p < 0.09.

Table 33 **Means, standard deviations and t-values of depressed and non-depressed on attributional dimensions of internal-external (I/E), global-specific (G/S) and stable-variable (S/V) for pleasant events**

	Not Depressed (N = 34)		Depressed (N = 28)				
	Mean	*SD*	*Mean*	*SD*	*t*	*df*	*p*
I/E	17.96	8.86	14.24	8.18	1.70	60	0.09
G/S	4.33	1.48	4.96	3.12	-1.03	60	n.s.
S/V	4.67	1.74	4.74	2.78	-0.13	60	n.s.

Table 33 shows the results for our sixth hypothesis. The findings do not support our hypothesis that ' the individuals with high depression scores will attribute more frequently the causes of pleasant events to specific factors than individuals with low depression scores', t = -1.03, df = 60, p = n.s.

Table 33 also shows the result for our seventh hypothesis. The findings do not support our hypothesis that ' the individuals with high depression scores will attribute more frequently the causes of pleasant events to variable factors than individuals with low depression scores', t = 0.13, df = 60, p = n.s.

The content analysis of complexity of attributional style.

The content analysis of verbatim of reported events of subjects was carried out by the researcher. The researcher, guided by the theoretical insight of attributional framework, analyzed each causal statement for its nature of content.

Table 34: The content analysis of frequency of different categories of attributions used by depressed and non-depressed persons for pleasant and unpleasant events

Categories	Non-depressed	Depressed
Internal evaluative attribution	54	41
External evaluative attribution	43	40
External descriptive statement	38	15
Associated and resultant effect	25	15
External descriptive attribution	17	28
Internal descriptive statement	14	09
Internal descriptive attribution	5	10
External evaluative statement	4	02
Associated reason	2	04
Internal evaluative statement	1	03
Amphibian attribution	--	02
Multiple attribution	29	25
Single attribution	174	137

Table 34 shows these categories along-with the frequency of statement in each one for depressed and non-depressed respectively. These categories were determined on the basis of the structure of sentence, describing the cause of an event, and the clarity of expression in indicating the causal agent. An attribution was considered to be that statement where causal agent was either clearly stated in words or it could be easily inferred through interpretative analysis of the structure of sentence, (e.g., 'I worked hard for it'). Instead, if the cause of an event appeared more like a description of an event (e.g. , 'it was a marvellous function'),it was regarded a 'statement', and not 'attribution'.

A cause was considered internal if on descriptive level personal pronouns was used to help clearly classify it such. Problem arose where only phrases were given without apparent clue of either internality or externality. A term was coined for such statements and they were regarded as' amphibian statement '. For an analysis of content in this category, the author had to indulge in interpretative analysis, however, dynamic interpretation of the content was avoided and focus remained on the structure of the sentence. For instance, one subject described 'breaking of engagement' as one of the event and gave the phrase,' educational problem', as the cause. Here, it is difficult to interpret that whether it is subject's educational problem or that of the fiance. As the phrase can be true either way, it was regarded as amphibian statement and was not categorized as either internal or external. In contrast, another subject described 'visit to an historical city' as one of the event of his life and gave as cause 'the increase in

knowledge'. This was not considered an amphibian statement as a little interpretative analysis of the structure of phrase with reference to the nature of event for the subject helped it classify as internal statement. In this case, the inference was possible and internality appeared more close to the structure of statement than externality. However, this was regarded a statement and was not categorized as an attribution because the given cause did not imply any causal agent.

Thus, in this manner a distinction was made between internal and external statement and attribution. Internal and external statements and attributions were further differentiated on the basis of the 'evaluative' (e.g. 'I made a mistake') or 'descriptive' content of the description. If a description entailed a value judgement it was classified as evaluative, whereas, if it simply stated the fact about causal agent, (e.g. it was a big gathering, in response to an event described as memorable) it was regarded as descriptive. Another category is that of 'associated and resultant affect' which comprises of those descriptions where the subject has given either the affect experienced during the event or afterwards (e.g. 'I felt very happy'). Another similar content area is that of 'associated reason' which entails only those descriptions where subject has described the reason related to the event only (e.g. in response to the event that 'I won prize in debating competition', the cause identified was; 'it was a successful function'). As no interpretation of the direction of causality could be determined from such descriptions, they were classified on the basis of reported affect or reason.

Table 33 shows that the first two categories for depressed and non-depressed subjects are similar in rank order. After that there is a variance in the order

of content area. The difference in frequency of each content area is not significant as there were more non-depressed subjects than depressed.

Discussion

The findings of study II explain the differential attributional style for depressed and non-depressed subjects. The hypotheses formulated for the study referred to theoretical framework of Abramson et al. (1978).

The results section of study II first shows the findings of analyses for the attributional style of non-depressed, mildly depressed and moderately depressed. A perusal of Table 23, 24, and 25 shows that for pleasant events the only attributional dimension significantly differentiating between non-depressed, mildly depressed and moderately depressed is that of 'global-specific'. In contrast, the results presented in Tables 26, 27, and 28 show that the two dimensions i.e. 'global-specific' and 'stable-variable' are statistically significant in differntiating between non-depressed, mildly depressed and moderately depressed. The Pillias multivariate test of significance - results showed in Table 29 and 30 - indicate the presence of a differential attributional style for pleasant and unpleasant events for three groups. The data presented in Table 29 indicate that the three attributional dimensions do not significantly differentiate between non-depressed, mildly depressed and moderately depressed for pleasent events. In contrast for unpleasent events-results showed in Table 30 - the three attributional dimensions stand statistically significant. These results obtained through analyses of variance and multivariate analyses demonstrate a differential attributional style for pleasant and unpleasant events. The significance of these findings will be deliberated upon, after

reviewing the results for our hypotheses to arrive at a comprehensive understanding of our findings.

Our first hypothesis is related to the difference in the nature of reported events between depressed and non-depressed subjects which stated 'that depressed individuals will identify more unpleasant events as compared to individuals with low depression'. The reason that no significant difference was observed in terms of the pleasantness or unpleasantness of the events reported could be due to the fact that the sample comprised of students, who though did vary in their depression scores , were not severely depressed. Though, the assumption for not having a restriction on stating the pleasant and unpleasant events was that it will allow the depressed to express their proneness towards the recall of unpleasant events, an absence of intense depression among the subjects might have resulted in failure to demonstrate any significant difference. It would be interesting to carry out a similar study on other segments of population which approximates more closely the features of clinical depression. Such an effort will enable us to know more confidently the differential bias of depressives for pleasant and unpleasant events.

It is generally assumed that the depressed attribute internally the cause of an unpleasant events, holding themselves responsible for bad outcomes. However, our findings do not suggest this for our subjects. A perusal of the content of the verbatim of the causes explains the reason that our second hypothesis stating that depressed will attribute the cause of unpleasant events to internal factors as compared to individuals with low depression scores, is not supported. This may be due to the fact that most of the

reported unpleasant events were not the events happened to the subjects, instead they were the events which occurred to their significant others. It is interesting to note that when the subjects are explicitly instructed to report important events of their own lives, which can either be pleasant or unpleasant they more often recall the events experienced by their significant others than their own-selves. This may be reflective of the peculiar interpersonal interactions characteristic of Pakistani culture, where life events assume importance with reference to their cumulative effect on the members of extended family. Therefore, events which had greater magnitude of pleasantness and unpleasantness across family or individuals, appear to be recalled more frequently by the subjects than some events which had impact only on their own-selves. This line of reasoning is supported by the fact that for a couple of subjects the explosion of ammunition camp near Faizabad (Rawalpindi) on April 10th 1988, was one of the important unpleasant event of their life. Such events, when reported, will not result in internal attribution as they are temporally and spatially distant from the subject's life.

The third hypothesis with regard to the global attribution for unpleasant events by depressed has been significantly supported, which means that subjects demonstrated an inclination to perceive the cause for an unpleasant event generalized across other areas of life as well. This appears to be consistent with the general outlook prevalent in this culture, where people tend to lose all hopes and get depressed if one bad thing happens to them, considering themselves good for nothing. Seldom, one would find a student, who if fails in a task or in examination will differentially reason out his ability for that particular task or examination. The general tendency is to generalize the result

to other areas of competence as well.

The fourth hypothesis was also supported by the data, demonstrating that depressed subjects tended to attribute the cause for an unpleasant event to stable factors. That is, if a causal agent is potent enough to be responsible for an unpleasant event, it will continue to be so in the future as well. This outlook is characteristic of pessimism of depressives who believe that if something unpleasant has happened to them, its effect will spread over time. This is regarded as hopelessness in Beck's cognitive theory (1976), whereas, Seligman (1975) interpreted it as 'lowered expectancy of contingency'.

The fifth hypothesis regarding the tendency of depressives to attribute the cause of pleasant events to external factors, has also been supported by our findings. This reflects upon the tendency of depressives that they do not consider themselves worthy or able enough to have worked for pleasant happenings. This is consistent with the suggested lowered self- esteems of depressives, commonly regarded to be the chief characteristic of depression (Tennen, Herzberger & Nelson, 1987).

The sixth hypothesis regarding the depressives' tendency to attribute the cause of pleasant events to specific factor is not supported by our findings. It is interesting to note that though a difference in this dimension of attributions was observed with respect to unpleasant events between depressed and non- depressed, it is not found in the case of attributions of pleasant events. This means that though non-depressed differ from depressed and attribute unpleasant events to specific factors, they, however, do not differ from depressed in their attribution of pleasant events. Does this imply that this attributional dimension is indicative of a general tendency to hold pleasant events

restricted to a point in time to a specific factor irrespective of the degree of depression? If so, then it would mean that people here generally, do not perceive that pleasant events will have pervasive effect, one pleasant event leading to another (a bias, reported to be characteristic of non-depressed). If it is more prevalent cultural characteristics then this dimension will fail to report any differences with regard to degree of depression. It would be of theoretical interest to establish this reasoning empirically, by taking a larger sample from the cross- section of population.

Our seventh hypothesis that depressed as compared to non-depressed will attribute the pleasant events to 'variable factors' is not supported by our findings. This means that our depressed and non-depressed subjects do not differ for their attribution of pleasant events in this respect, though they differed on the same dimension for unpleasant events. Future studies can attempt to further establish this differential attributional style of depressives for pleasant event.

The results reported in earlier section demonstrates that the dimension of internal-external does not significantly differentiates between the three groups of non depressed, mildly depressed and moderately depressed for their attributions for pleasant events. The only attributional dimension which significantly differentiates between the non-depressed, mildly depressed and moderately depressed for their attribution for pleasant events is the dimension of global-specific as the dimension of stable-variable, also appears non-significant in demonstrating a difference between the three groups for pleasant events.

It is interesting to review the results of analyses of variance between the three groups for their attributions for pleasant events which show only one dimension (global-specific) as significant , whereas an analysis of difference between the depressed and non-depressed for the hypotheses of the study demonstrates that for pleasant events the only significant attributional dimension is that of internal-external i.e. the depressed tend to attribute pleasant events more externally than non-depressed . The fact that the two different dimensions emerged as significant when sample was classified differently, signifies the importance of taking larger samples from other section of population to determine the consistency of attributional patterns across varying intensity of depression.

The analysis of variance computed for the unpleasant events between non-depressed, mildly-depressed and moderately depressed show that the dimension of global specific and variable stable is statistically significant, whereas, internal-external is non-significant in differentiating between the three groups. Substantiating our findings for the depressed and non-depressed for their attributional style for unpleasant events, this demonstrates that our findings suggest a differential attributional style for unpleasant events. The non-significance of internal external dimensional in both analyses strengthens our reasoning that this may be an artifact of the events described by the subjects ,a significant portion of which pertained to the events occurred in the lives of their significant others rather than being descriptive of their own experiences. This means that for unpleasant events the dimension of global- specific and variable-stable are significant in differentiating between individual with varying intensities of depression, whereas, the dimension of internal-external fails to provide similar differentiation. The over-all

findings demonstrate that the global-specific dimension of attributions is strongly significant in differentiating between attributional styles of individuals with varying intensities of depression. The dimension of stable-variable demonstrates a marginal significance in this respect. With respect to attribution for pleasant events, two different dimensions i.e. , internal- external and global-specific have emerged to be significantly differential between the attributional styles of individuals of varying intensities of depression. The findings are more consistent with regard to the attributions for unpleasant events. The dimension of global-specific and variable-stable significantly differentiates between the attributional styles of individuals with varying intensities of depression.

The fact that not all of our hypotheses found support is not peculiar to our study only, but one finds contradictory findings in this respect reported by other researchers as well. For instance, Hammen in one of her studies found significant difference among depressed and non depressed on only global attribution (Hammen, Krantz, & Cochran, 1981). Golin, Sweeney and Schaeffer (1981) found significant difference in the attributional styles of depressed and non-depressed on only stable and global attributions for negative events. Such results necessitate the efforts to carry out more methodologically sound researches to ascertain a more consistent and differential attributional style for individuals with varying intensities of depression. This is important to determine as it is postulated that an internal, global and stable attributional style is characteristic of depression. If one of the dimension fails to report differences consistently, then it calls for serious reformulation of the theory. However, such

conclusions can not be drawn under the present circumstances, as this requires further stringent proofs.

Our findings can be seen in broader perspective of culture and methodological issues. The over-all modest differential evidence and an absence of strong interactional effect of internal-external dimension in the present study could be explained in the larger context of cultural peculiarities. Religion dominates various spheres of our people's lives. It not only appears so in various religious rituals , it seems to be a strong part of cultural unconscious as well. It is a common observation, though not yet empirically studied, that people here tend to attribute the cause of an event to God. This tendency is a result of more prevalent religious instillations, which admonish one to ascribe the good or bad happenings to one's own actions or abilities. All happenings are considered a trial (Aazimaish) to test the faith and purity of a believer. The majority of our people find it a great consolation; the fact that they can attribute all the miseries and catastrophes of life to a greater power i.e. , God. Moreover, it is not appreciated in general, if a person holds his/her efforts or abilities responsible for his/her achievement. It is rather taken as being ungrateful to God, from whom come all the pleasures and satisfactions. People may not be religious in other apects of life, but their attributional style reflects a strong religious imbibing. It is interesting to note that people who in their frank conversation would often boast of their efforts and abilities, would more frequently refrain, if made conscious of their claim, to explicitly submit to the same.

With such religious instillations, it is more probable that a person would hold his fate or luck responsible for unpleasant and pleasant events of his life than his

own self. The verbatim of the subjects repeatedly contained the mention of fate, luck and God's will as cause of an event. It is, therefore, understandable that a consistent attributional style has not been demonstrated by the present study and the dimension of internal-external, remained non-significant for both pleasant and unpleasant events between non-depressed, mildly depressed and moderately depressed. These findings, which reflect the impact of religious orientation can be seen in another way as well. That is, to determine the extent to which the impact of religion is functioning as a shock absorber, a consolation, against the life's stresses. If so, it should contribute to a better adjustment and absence or lowered depression. This line of reasoning is supported by evidence demonstrating intrinsic religious orientations correlating positively with self control and better functioning (Bergin, Masters & Richards, 1987). It would be informative to look into this peculiar relationship of attributional style and depression.

The content analysis of verbatim of the subjects gives insight into the absence of significant difference for all dimensions. As the subjects tend to miss out the explicit description of causal agent, the given cause can not be judged as having the peculiar dimensional quality. Moreover, if a subject gives associated and resultant affects or reason instead of a cause, the task would again become difficult to ascertain the attributional quality of explanation. The fact that all such statements which lacked a mention of causal agent or were in effect relating the associated reason or affect were regarded as 'external' attribution as they could not be judged otherwise, might have contributed to our moderate findings. Future studies can opt for more structured instructions to take care of this shortcoming.

The multiple attributions, though few, do indicate the significance of reasoning that people do not tend to attribute in categorical sense, they instead appear to explain the cause taking the attributional dimensions as a continuum (Flett, et al. , 1989). They may attribute an event to both internal and external factors. This is supported in our case as well, a number of multiple attributions did in fact entail both internal and external explanations. For instance, a success in examination was attributed both to God's will (external attribution) and one's effort (internal attribution). Therefore, future studies may explore this aspect by treating each attributional dimension as a continuum, instead of having it as bipolar, more differential pattern of explanations may emerge.

Beside these culture-specific aspects, certain methodological considerations are pertinent with respect to study of attributional style, which may also have had implicative effect on our findings too. For instance, the temporal characteristic of stress is detrimental to its causal attribution (Monroe & Simons, 1991). The more the reported event is distant in temporal dimension, the more likely it is that the causal ascriptions are banal. As most of the events reported in the present study were temporally distant, it would be interesting to focus on the present stresses of individuals and study their attributions regarding them.

The fact that dimensional location of a cause is in itself not constant (Weiner, 1985) can also lead to undifferentiated results. For instance, individual can differ with regard to their perception of luck, or ability as stable or variable, internal or external, global or specific. Therefore, it is possible that a single cause is being

perceived as conveying different meanings in disparate context and, therefore, is suppressing any differential pattern.The findings should also be weighed in the light that causal attribution is itself a Western construct. The question as to how people attribute in their general lives, when not made cognizant of the very process, thus, becomes pertinent. A sizeable body of literature indicates that people do not readily make use of such notions in their daily lives (Nisbett & Ross, 1980 ; Tversky & Kahneman, 1974). However, it is difficult to deny the basic human tendency to know the 'why' of an event. The present researcher contends that people, in their every day life, may not readily attribute the cause of an event explicitly, they, nevertheless, try to analyze the cause in an implicit manner. Moreover, it is possible that this implicit causal analysis is determined by their lingual proficiency (Hoffman & Tchir, 1990), that is, possessing a rich content of interpersonal lexicon facilitates in the process of causal attribution. More indirect methods, therefore, can be adopted to explore the underlying attributions, for instance, asking subjects to maintain diaries of important events in their everyday lives. It would enable us to explore the dimensions people generally use to attribute the event in their lives. Such qualitative analysis will not only give a depth and relevance to our understanding of causal attributions, it will strengthen the validity of theoretical framework as well.

Chapter 3.

GENERAL DISCUSSION AND CONCLUSION

As reasoned earlier the absence of valid assessment instrument for the measure of depression made the task of the present work double-fold. It was realized during the conceptualization of present research design that an exploration into the attributional style will not assume relevance if the basic tool for classifying subjects with regard to their scores on depression remains dependent upon the norms advocated by a scale developed in the West. Findings based on any scale alien to the peculiar norms of a culture always end up being clouded. The researcher always seems shy of drawing conclusions as the arguments of culture and normative differences remain the dominant factor involved. The present researcher, therefore, considered it pertinent to arrive at culture-relevant index of depression by developing an indigenous scale. Though, SSDS requires many more validation studies to prove its robustness, it, however, stands relevant and sensitive to the cultural peculiarities of Pakistan.

The findings of the Study I and Study II can lead to many areas of investigations. For instance, the relationship of mood with attributional style can be studied. It has been discussed in the review of literature that mood has demonstrated significant relationship with attributional style. Moreover, if depression varies across sex, it would be interesting to study their particular attributions with regard to socio-cultural pressures assumed to lead to depression. A difference in terms of attributions for stresses may help us understand the peculiar depressogenic variables for women and men.

As the present work is first of its kind with reference to Pakistan,

therefore,many more studies are to be carried out to strengthen the findings of the study. This link of attributional styles and depression has to be further strengthened by employing larger samples from various cross-sections of the population. The specific attributional style with regard to political and economic forces can be explored to help understand the general outlook of people. An exploration into the general attributional pattern will help understand any exaggeration by the depressives. As internal-external dimension did not appear to differentiate consistently among depressives and non-depressives, it needs to be studied further to give credence to present findings. Those situations which lead to internal attributions in contrast to external ones, are to be focused to arrive at more confident findings.

The content analysis of attributions revealed that people generally miss out the causal agent and instead state the reason of an event. This insight can be further deepened by more in-depth qualitative analysis of verbatim. The possibility of other relevant attributional dimensions should not be excluded. It would be significant to find out if people generally refrain from attributing or verbalizing the attributions and instead restrict to reason them out, or there are certain specific situations in which they tend to withhold, whereas, in other they tend to attribute. In short, situation-specific attributions may be focused to explore a normative pattern of attributions.

The possibility that people may be different in their information processing style also appears plausible. Those who refrain from identifying a causal agent or ascribe the event to the will of the God may be reflecting something more than a fuzzy expression and religious instillation. Metalsky and Abramson (1980) suggest that people may employ two distinct attributional pattern which are belief based (tendency to make

particular causal inference on the basis of similar generalized beliefs or knowledge about oneself and others) or evidence-based (tendency to make particular causal inference on the basis of situational information) to resolve causal ambiguity. If such an argument holds truth then its empirical verification would give insight into the peoples' preference for particular explanations.

Nevertheless, the present research has contributed significantly by assessing the cross-cultural validity of attributional formulations . The findings may be statistically modest, however, these have provided a creative insight into the peculiar thought patterns of a culture which presents a significant contrast to the one where attributional theory was formulated. It has also been fruitful in indicating areas of empirical interest both from a methodological as well as cultural point of view. The researcher contends that the work on attributional style not only demands methodological soundness, it also asks for creative insight into the peculiar cultural thought patterns to conceive a research design which is sensitive to the realities, that are prevalent but subtle enough to be measured by just any method.

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Annexure 1 = Instruction for the Phase I (Study I)

یہ سوالنامہ میری ریسرچ کاایک حصہ ہے، جس کا مقصد ان مواقع کو شناخت کرناہے، جب ایک فرد Depression محسوس کرتا ہے۔ آپ سے درخواست ہے کہ ان مواقع کو ترتیب وار لکھیں۔ جب آپ نے Depression محسوس کیا ہو تو کوشش کریں کہ ایک سے زائد واقعات کے بارے میں لکھیں اور انگریزی یا اردو جس زبان میں اپنے آپ کو بہتر بیان کر سکتے ہوں، بیان کریں۔ اگر آپ اس صفحہ کو ناکافی سمجھیں تو مزید صفحات لے سکتے ہیں۔

یاد رہے کہ آپ کی فراہم کردہ اطلاعات مخفی رکھی جائیں گی!

Contd

سوالنامے کے دوسرے حصے کا مقصد یہ جاننا ہے کہ پہلے بیان کی گئی صورت حال میں جب آپ نے (Depression) محسوس کیا تو آپ کی سوچ (Cognitions) احساسات (Feelings) اور کردار (Behavior) کیا تھے؟ آپ سے درخواست ہے کہ پہلے صفحے پر اپنے بیان کردہ مواقع کو ایک ایک کر کے منتخب کریں اور ان سے متعلق سوچ، احساسات اور کردار لکھیں۔ مثلاً اگر آپ نے اس وقت Depression محسوس کیا ہو، جب آپ فائنل امتحان میں فیل ہو گئے، تو ایسی صورت میں آپ کالم اس طرح بھریں گے:

	مواقع	سوچ	احساسات	کردار
۱۔	امتحان میں فیل ہونا	میں کسی قابل نہیں۔ میں کچھ نہیں کر سکتا۔ سب مجھے نالائق سمجھیں گے۔	مایوسی بددلی شرمندگی یا (Disheartened)	سماجی تعلقات میں کمی۔ لوگوں سے ملنے سے کترانا

۲۔ دوسری مثال: جب آپ کو شدید مالی نقصان اٹھانا پڑا:

مالی نقصان۔	یہ نقصان ناقابل تلافی ہے۔ (اب کچھ نہیں ہو سکتا)۔ یہ میرے ساتھ ہی کیوں ہوا؟	Depression Frustration	(Lethargy) Inactivity.

۳۔ کسی عزیز ترین ہستی سے آپ کے تعلقات منقطع ہو گئے۔

عزیز ترین ہستی سے تعلقات کا منقطع ہونا۔	میں محبت/توجہ کے لائق نہیں۔ میں بہت بدنصیب ہوں۔	Depression رنج، غصہ	گھر میں قید ہو جانا۔ کام/پڑھائی میں دل نہ لگنا۔

مواقع سوچ احساسات کردار

Annexure II - A questionnaire about some personal informations.

عُمر:

جنس:

تعلیم:

بہن بھائیوں کی تعداد:

بہن بھائیوں میں اپنا نمبر:

والدین کی ماہانہ آمدنی:

مُستقل رہائش:

Annexure III - The list of 72 items, extracted from Phase I (Study-I) judged by psychiatrists and clinical psychologists.

ذیل میں دیئے گئے بیانات ڈپریشن کی مختلف حالتوں سے تعلق رکھتے ہیں۔ بیانات شدت کے لحاظ سے مختلف درجوں سے تعلق رکھتے ہیں۔ کچھ معمولی شدت رکھتے ہیں، کچھ اس سے زیادہ اور کچھ بے حد شدید ہیں۔ کم شدت کے بیان ڈپریشن کی کم شدت سے متعلق ہو سکتے ہیں۔ اسی طرح زیادہ شدید بیانات، ڈپریشن کی شدید سطح سے تعلق رکھ سکتے ہیں۔

آپ سے درخواست ہے کہ ان بیانات کو مندرجہ ذیل سکیل کی مدد سے درجہ بند کریں:-

1	2	3
Normal Sadness	Mild Depression	Severe Depression

مثلاً جو بیان آپ کے خیال میں اداسی کی کیفیت سے زیادہ قریب معلوم ہوتا ہے، اس کے سامنے نمبر ایک تحریر کر دیں، پھر اسی طرح دوسرے بیانات کی درجہ بندی کریں: شکریہ!

۱۔ میرا دنیا میں کوئی مخلص دوست نہیں ہے۔
۲۔ کسی کو میری پرواہ نہیں ہے۔
۳۔ میں بے بس ہوں۔
۴۔ میں بہت اکیلا اور تنہا رہتا ہوں۔
۵۔ میں نالائق ہوں۔
۶۔ مجھے اپنی زندگی سے نفرت ہے۔
۷۔ میں توجہ کے لائق نہیں۔
۸۔ میں ایک قابل نفرت انسان ہوں۔
۹۔ میں ایک ناکارہ شخص ہوں۔
۱۰۔ میں کوئی کام ڈھنگ سے نہیں کر سکتا۔

۱۳۔ میں اوروں سے کم تر ہوں۔
۱۴۔ مجھ میں بہت سی خامیاں ہیں۔
۱۵۔ میں بہت بد نصیب ہوں۔
۱۶۔ محنت کا کبھی صحیح اجر نہیں ملتا۔
۱۷۔ کامیابی اور ناکامی قسمت کا کھیل ہے۔
۱۸۔ میں قابل اعتبار نہیں ہوں۔
۱۹۔ مجھ میں کسی چیز کی کمی ہے۔
۲۰۔ زیادہ تر لوگ بھروسے کے لائق نہیں ہوتے۔
۲۱۔ میں اپنے والدین کے مثالی بچے کے تصور پر پورا نہیں اترتا۔
۲۲۔ میں کسی کی مدد کرنے کا اہل نہیں ہوں۔
۲۳۔ میرے ساتھ ہمیشہ ناانصافی ہوتی ہے۔
۲۴۔ مجھے اپنے کئے کی سزا مل رہی ہے۔
۲۵۔ میں اپنے مستقبل سے بے حد مایوس ہوں۔
۲۶۔ میری زندگی ختم ہونے والی ہے۔
۲۷۔ میری رائے کی کوئی اہمیت نہیں ہے۔
۲۸۔ میں بہت برا ہوں۔
۲۹۔ میری دعائیں اکثر قبول نہیں ہوتیں۔
۳۰۔ میں اکثر اپنے کئے پر شرمندگی محسوس کرتا ہوں۔
۳۱۔ میرا زور زور سے رونے کو دل چاہتا ہے۔
۳۲۔ ایک احساس ناکامی مجھے اکثر گھیرے رہتا ہے۔
۳۳۔ میں بہت جلد پریشان ہو جاتا ہوں۔
۳۴۔ میں اکثر اپنے آپ کو الجھا ہوا محسوس کرتا ہوں۔
۳۵۔ میں بہت جلد حوصلہ ہار دیتا ہوں۔
۳۶۔ اکثر مجھے ایک دکھ کا احساس گھیرے رہتا ہے۔
۳۷۔ مجھ پر ہر وقت ایک بے قراری سی طاری رہتی ہے۔
۳۸۔ میرا دل اب بالکل اچاٹ ہو گیا ہے۔
۳۹۔ میں اپنے آپ کو بہت بے قیمت محسوس کرتا ہوں۔
۴۰۔ ایک بے یقینی کا احساس مجھے اکثر ستاتا رہتا ہے۔
۴۱۔ مجھے اکثر کچھ کھو دینے کا احساس دامن گیر رہتا ہے۔

۴۴۔ میں مر جاؤں، تو بہتر ہے۔
۴۵۔ میں شدت سے موت کی خواہش کرتا ہوں۔
۴۶۔ دوسرے لوگ ہمیشہ مجھ پر حاوی رہتے ہیں۔
۴۷۔ میں عموماً اداس رہتا ہوں۔
۴۸۔ میں بہت ناامید ہو گیا ہوں۔
۴۹۔ میں اکثر اپنے آپ کو تنہا محسوس کرتا ہوں۔
۵۰۔ مجھے ہر وقت احساس ندامت گھیرے رہتا ہے۔
۵۱۔ مجھے ماضی کی یاد اکثر اداس کر دیتی ہے۔
۵۲۔ لوگوں سے کسی قسم کی توقع رکھنا فضول ہے۔
۵۳۔ لوگ اکثر اوقات میری انا کو ٹھیس پہنچاتے ہیں۔
۵۴۔ میرا اپنے والدین سے اکثر اختلاف رہتا ہے۔
۵۵۔ مجھے اکثر یہ احساس ستاتا ہے کہ میں اپنی ذمہ داریاں پوری طرح نہیں نبھا رہا۔
۵۶۔ لوگ بڑے بے حس اور بے مروت ہیں۔
۵۷۔ میرے دوست مجھے خود غرض لگتے ہیں۔
۵۸۔ میری کوششیں اکثر ناکام رہتی ہیں۔
۵۹۔ ہمیشہ مجھے ہی نقصان اٹھانا پڑتا ہے۔
۶۰۔ مجھے اکثر اپنے کندھوں پر ایک بوجھ سا محسوس ہوتا ہے۔
۶۱۔ مجھے عموماً اپنا جسم تھکا تھکا سا لگتا ہے۔
۶۲۔ میری بھوک تقریباً ختم ہو چکی ہے۔
۶۳۔ کھانے کی خوشبو سے مجھے الٹی سی آنے لگتی ہے۔
۶۴۔ میرے دل کی دھڑکن یکدم تیز ہو جاتی ہے۔
۶۵۔ میرا معدہ اکثر خراب رہتا ہے۔
۶۶۔ مجھے اکثر گیس کی شکایات رہتی ہیں۔
۶۷۔ میرے ہاتھ پاؤں زیادہ تر ٹھنڈے رہتے ہیں۔
۶۸۔ مجھے اکثر ٹھیک سے نیند نہیں آتی۔
۶۹۔ زندگی سے اکثر بیزاری سی محسوس ہوتی ہے۔
۷۰۔ میری توقعات کبھی پوری نہیں ہوتیں۔
۷۱۔ دوست میرے احساسات کو سمجھ نہیں پاتے۔
۷۲۔ کوئی بھی میری خواہش کا احترام نہیں کرتا۔

Annexure IV - The 7-point rating scale for the assessment of current mood.

وقت اور حالات کے لحاظ سے انسان کے موڈ میں تبدیلی ہوتی رہتی ہے ۔ اس وقت ہم آپ کے موڈ کے بارے میں جاننا چاہتے ہیں ۔ آپ کی سہولت کے لئے ہم نے مندرجہ ذیل پیمانے (Scale) کا انتخاب کیا ہے ، جن کی مدد سے آپ اپنے اس وقت کے موڈ کا اظہار کر سکتے ہیں !

-3	-2	-1	+1	+2	+3
بہت زیادہ ناخوشگوار	زیادہ ناخوشگوار	ناخوشگوار	خوشگوار	زیادہ خوشگوار	بہت زیادہ خوشگوار

اگر اس وقت آپ کا موڈ بہت زیادہ خوشگوار ہے تو +3 پر نشان لگائیں اور اگر موڈ بہت زیادہ ناخوشگوار ہے تو -3 پر نشان لگائیں۔ اسی طرح آپ اسکیل کے درمیانی درجوں کو اپنے موڈ کی نوعیت کے اظہار کے لئے منتخب کر سکتے ہیں۔ اگر اس وقت آپ کا موڈ نہ تو خوشگوار ہے اور نہ ہی ناخوشگوار، تو صفر کے گرد نشان لگائیں۔

re V: - The 36-items obtained from Phase II (Study I)

یہ سوال ہر فرد کی مختلف سوچ اور احساسات کو بیان کرتا ہے۔ ہر بیان کے سامنے چار کالم دیئے گئے ہیں جو ان سوچ اور احساسات کے مختلف درجوں کو ظاہر کرتے ہیں۔ آپ سے درخواس
کو غور سے پڑھیں اور وہ جس حد تک آپ پر لاگو ہوتے ہیں ان کا اظہار دیئے گئے درجوں کی مدد سے کریں مثلاً اگر ایک بیان آپ پر "کبھی نہیں" لاگو ہوتا ہے تو
درست (س) کا نشان لگائیں اور اگر بیان "ہر وقت" صادق آتا ہے تو آخری کالم میں درست (س) کا نشان لگائیں۔ اسی طرح کالم نمبر ۲ اور ۳ کو استعمال ک

	کبھی نہیں	کبھی کبھار	اکثر اوقات	
۱۔ میں بہت ناامید ہو گیا ہوں / ہو گئی ہوں۔				۱
۲۔ میں اپنے آپ کو الجھا ہوا محسوس کرتا ہوں / کرتی ہوں۔				۲
۳۔ میں بہت بدنصیب ہوں۔				۳
۴۔ میری بھوک تقریباً ختم ہو چکی ہے۔				۴
۵۔ میری دعائیں قبول نہیں ہوتیں۔				۵
۶۔ میرا اپنے والدین سے اختلاف رہتا ہے۔				۶
۷۔ لوگ مجھ پر ہمیشہ تنقید کرتے ہیں۔				۷
۸۔ میرا زور زور سے رونے کو دل چاہتا ہے۔				۸
۹۔ میں کوئی کام ڈھنگ سے نہیں کر سکتا / کر سکتی۔				۹
۱۰۔ مجھے اپنے کئے کی سزا مل رہی ہے۔				۱۰
۱۱۔ میرے دل کی دھڑکن یکدم تیز ہو جاتی ہے۔				۱۱
۱۲۔ کامیابی اور ناکامی قسمت کا کھیل ہے۔				۱۲
۱۳۔ میری زندگی ختم ہونے والی ہے۔				۱۳
۱۴۔ مجھے کچھ کھو دینے کا احساس دامن گیر رہتا ہے۔				۱۴
۱۵۔ مجھ میں کسی چیز کی کمی ہے				۱۵
۱۶۔ میں اپنے آپ کو بہت بے قیمت محسوس کرتا ہوں / کرتی ہوں۔				۱۶
۱۷۔ دوسرے لوگ ہمیشہ مجھ پر حاوی رہتے ہیں۔				۱۷
۱۸۔ میں بہت جلد پریشان ہو جاتا ہوں / ہو جاتی ہوں۔				۱۸
۱۹۔ مجھے اپنی زندگی سے نفرت ہے۔				۱۹
۲۰۔ میں اپنے آپ کو تنہا محسوس کرتا ہوں / کرتی ہوں۔				۲۰
۲۱۔ مجھے اپنا جسم تھکا تھکا سا لگتا ہے۔				۲۱
۲۲۔ میں ایک ناکارہ شخص ہوں۔				۲۲
۲۳۔ مجھ میں بہت سی خامیاں ہیں۔				۲۳
۲۴ دوست میرے احساسات کو سمجھ نہیں پاتے۔				۲۴
۲۵۔ میں بہت جلد حوصلہ ہار دیتا ہوں / دیتی ہوں۔				۲۵
۲۶۔ میں نالائق ہوں۔				۲۶
۲۷۔ میں اوروں سے کم تر ہوں۔				۲۷
۲۸۔ میرا دل اب بالکل اچاٹ ہو گیا ہے۔				۲۸
۲۹۔ میں ایک قابلِ نفرت انسان ہوں۔				۲۹
۳۰۔ میرے دوست مجھے خود غرض لگتے ہیں۔				۳۰
۳۱۔ مجھے ماضی کی یاد اداس کر دیتی ہے۔				۳۱
۳۲۔ مجھے ٹھیک سے نیند نہیں آتی۔				۳۲
۳۳۔ میں اپنے مستقبل سے بے حد مایوس ہوں۔				۳۳
۳۴۔ میں اپنے والدین کے مثالی بچے کے تصور پہ پورا نہیں اترتا / اترتی۔				۳۴
۳۵۔ زیادہ تر لوگ بھروسے کے لائق نہیں ہوتے۔				۳۵

Annexure VI

This is a test of statement which describes how generally people feel about themselves. You are requested to respond to each statements as it applies to you now with the help of four columns given before each statements. If a statement does not apply to you or applies to you a little of the time you can indicate so by placing a check mark in the first column. If it applies to you all or most of the time, you can place the check mark in the last column. Similarly, you can use the middle columns to indicate the statements as they apply to you.

	None or a little of the time	Some of the time	Good part of the time	Most or all of the time
1.	I feel downhearted, blue, and sad.			
2.	Morning is when I feel the best.			
3.	I have crying spells or feel like it.			
4.	I have trouble sleeping through the night			
5.	I eat as much as I used to.			
6.	I enjoy looking at, talking to, and being with attractive women/men,			
7.	I notice that I am losing weight.			
8.	I have trouble with constipation.			
9.	My heart beats faster than usual.			
10.	I get tired for no reason.			
11.	My mind is as clear as it used to be.			
12.	I find it easy to do the things I used to.			
13.	I am restless and cannot sleep.			
14.	I feel hopeful about the future.			
15.	I am more irritable than usual.			
16.	I find it easy to make decisions.			
17.	I feel that I am useful and needed.			
18.	My life is pretty full.			
19.	I feel that others would be better off if I were dead.			
20.	I still enjoy the things I used to do.			

Annexure VII - A questionnaire about some personal informations.

عُمر:

جنس:

تعلیم:

بہن بھائیوں کی تعداد:

بہن بھائیوں میں اپنا نمبر:

والدین کی ماہانہ آمدنی:

مُستقل رہائش:

Annexure VIII

ASSESSMENT FORM

IDENTIFYING INFORMATION

Name:

Age:

Sex:

Date:

ASSESSMENT OF THE CASE

1. Appearance: _____

_____

2. GENERAL BEHAVIOUR

LASSITUDE _____

AGITATION _____

TALK _____

MOOD _____

PERCEPTION _____

THOUGHT _____

COGNITIVE FUNCTIONS _____

(Concentration _____

Memory _____

Recall _____

Judgment _____

Reality Testing) _____

3. INSIGHT: _____

_____

4. VEGETATIVE SIGNS

(Sleep _____

Appetite _____

Constipation) _____

_____

5. PSYCHO-SOCIAL INDICATORS

(Performance _____

Indecisive _____

Loss of interest _____

Fatigability) _____

_____

_____

6. Presence of other Psychiatric & Psychosomatic Symptoms

_____

_____

7. DEPTH OF DEPRESSION

1	2	3	4
None	Mild	Moderate	Severe

8. PROVISIONAL DIAGNOSIS

_____

9. REMARKS (if any)

_____

_____

_____

(SIGNATURE)

۱۔ انسانی زندگی میں بہت سے خوشگوار اور ناخوشگوار واقعات پیش آتے ہیں۔ ان میں سے کچھ ذہن پر گہرا اثر چھوڑ جاتے ہیں۔ آپ سے درخواست ہے کہ ایسے چھ واقعات بیان کریں جو آپ کے لئے اہم ہوں۔ یہ واقعات خوشگوار بھی ہو سکتے ہیں اور ناخوشگوار بھی! خیال رہے کہ یہ واقعات آپ کی اپنی ذات سے متعلق ہوں۔

۲۔ اب آپ بیان کئے گئے واقعات میں سے جو آپ کے کئے خوشگوار حیثیت رکھتے ہوں، ان کے سامنے مثبت (+) کا نشان لگا دیں اور جو ناخوشگوار ہوں، ان کے سامنے منفی (-) کا نشان لگا دیں۔

۳۔ اب آپ پہلے بیان کئے گئے واقعات کے اسباب بیان کریں۔ اسباب سے مراد وہ "وجوہات" ہیں جو آپ کے نزدیک ان واقعات کا باعث بنی۔ ہر واقعہ کے لئے آپ کو ایک سبب تحریر کرنا ہے جو آپ کے نزدیک اس واقعہ کی وجہ تھی۔

ure X - Siddiqui Shah Depression Scale (SSDS)

یہ سوال مرد کی مختلف سوچ اور احساسات کو بیان کرتا ہے۔ ہر بیان کے سامنے چار کالم دیئے گئے ہیں جو ان سوچ اور احساسات کے مختلف درجوں کو ظاہر کرتے ہیں۔ آپ سے درخواست
کو غور سے پڑھیں اور وہ جس حد تک آپ پر لاگو ہوتے ہیں ان کا اظہار دیئے گئے درجوں کی مدد سے کریں مثلاً اگر ایک بیان آپ پر "کبھی نہیں" لاگو ہوتا ہے تو یہ
درست (س) کا نشان لگائیں اور اگر بیان "ہر وقت" صادق آتا ہے تو آخری کالم میں درست (س) کا نشان لگائیں۔ اسی طرح کالم نمبر ۲ اور ۳ کو استعمال کریں

	کبھی نہیں	کبھی کبھار	اکثر اوقات	ہ
۱- میں بہت ناامید ہو گیا ہوں / ہو گئی ہوں۔	۱			
۲- میں اپنے آپ کو الجھا ہوا محسوس کرتا ہوں / کرتی ہوں۔	۲			
۳- میں بہت بدنصیب ہوں۔	۳			
۴- میری بھوک تقریباً ختم ہو چکی ہے۔	۴			
۵- میری دعائیں قبول نہیں ہوتیں۔	۵			
۶- میرا اپنے والدین سے اختلاف رہتا ہے۔	۶			
۷- لوگ مجھ پر ہمیشہ تنقید کرتے ہیں۔	۷			
۸- میرا زور زور سے رونے کو دل چاہتا ہے۔	۸			
۹- میں کوئی کام ڈھنگ سے نہیں کر سکتا / کر سکتی۔	۹			
۱۰- مجھے اپنے کئے کی سزا مل رہی ہے۔	۱۰			
۱۱- میرے دل کی دھڑکن یکدم تیز ہو جاتی ہے۔	۱۱			
۱۲- کامیابی اور ناکامی قسمت کا کھیل ہے۔	۱۲			
۱۳- میری زندگی ختم ہونے والی ہے۔	۱۳			
۱۴- مجھے کچھ کھو دینے کا احساس دامن گیر رہتا ہے۔	۱۴			
۱۵- مجھ میں کسی چیز کی کمی ہے	۱۵			
۱۶- میں اپنے آپ کو بہت بے قیمت محسوس کرتا ہوں / کرتی ہوں۔	۱۶			
۱۷- دوسرے لوگ ہمیشہ مجھ پر حاوی رہتے ہیں۔	۱۷			
۱۸- میں بہت جلد پریشان ہو جاتا ہوں / ہو جاتی ہوں۔	۱۸			
۱۹- مجھے اپنی زندگی سے نفرت ہے۔	۱۹			
۲۰- میں اپنے آپ کو تنہا محسوس کرتا ہوں / کرتی ہوں۔	۲۰			
۲۱- مجھے اپنا جسم تھکا تھکا سا لگتا ہے۔	۲۱			
۲۲- میں ایک ناکارہ شخص ہوں۔	۲۲			
۲۳- مجھ میں بہت سی خامیاں ہیں۔	۲۳			
۲۴- دوست میرے احساسات کو سمجھ نہیں پاتے۔	۲۴			
۲۵- میں بہت جلد حوصلہ ہار دیتا ہوں / دیتی ہوں۔	۲۵			
۲۶- میں نالائق ہوں۔	۲۶			
۲۷- میں اوروں سے کم تر ہوں۔	۲۷			
۲۸- میرا دل اب بالکل اچاٹ ہو گیا ہے۔	۲۸			
۲۹- میں ایک قابلِ نفرت انسان ہوں۔	۲۹			
۳۰- میرے دوست مجھے خود غرض لگتے ہیں۔	۳۰			
۳۱- مجھے ماضی کی یاد اداس کر دیتی ہے۔	۳۱			
۳۲- مجھے ٹھیک سے نیند نہیں آتی۔	۳۲			
۳۳- میں اپنے مستقبل سے بے حد مایوس ہوں۔	۳۳			
۳۴- میں اپنے والدین کے مثالی بچے کے تصور پر پورا نہیں اترتا / اترتی۔	۳۴			
۳۵- زیادہ تر لوگ بھروسے کے لائق نہیں ہوتے۔	۳۵			
۳۶- میں شدت سے موت کی خواہش کرتا ہوں / کرتی ہوں۔	۳۶			

Annexure XI - A questionnaire about some personal informations.

عُمر:

جنس:

تعلیم:

بہن بھائیوں کی تعداد:

بہن بھائیوں میں اپنا نمبر:

والدین کی ماہانہ آمدنی:

مُستقل رہائش: