

CHAPTER 09 DEPRESSION

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CHAPTER 09

DEPRESSION

Wayne McDuffie was a football coach with a solid record of achievement at several Southeastern universities. Football was McDuffie's life; on and off the field, he lived it and breathed it. As long as McDuffie was coaching, McDuffie was happy. But coaching in the world of sports is hardly a secure enterprise, and when McDuffie was fired from his position at the University of Georgia, he slipped into a dark depression. One afternoon, he learned he had been passed over for a coaching job with the Miami Dolphins. Later that day, McDuffie took his life, leaving three children and a wife behind.

Wayne McDuffie's story is extreme, but hardly unique. Approximately 15 percent of the population experiences a depressive episode at one time in their lives ([Secunda, Katz, & Friedman, 1973](#)), and most of these arise in response to significant life events ([Paykel, 1979](#)). Although these episodes tend to abate in six to nine months, approximately 20 percent of those who become clinically depressed remain depressed for at least two years ([Downey & Coyne, 1990](#)). Moreover, those who experience one bout of depression are at risk for future depression, perhaps experiencing as many as five or six depressive episodes in their lives ([Amenson & Lewinsohn, 1981](#)). Finally, depression is closely related to suicide. Approximately one in every 200 people with depression attempts suicide, and most people who attempt suicide have experienced a recent bout of depression ([Minkoff, Bergman, Beck, & Beck, 1973](#)).

Depression is not only a very prevalent and virulent disorder, it is also a very heterogeneous one. It is influenced by many factors, characterized by a variety of symptoms, and comprised of several subtypes. In this chapter we will focus on understanding the role self-relevant processes play in the onset and maintenance of depression. Our exclusive focus on self-relevant processes means that many other viable approaches to understanding depression, including ones that emphasize genetic, biochemical, and broad-scale environmental factors (e.g., poverty and violence) will not be considered. This inattention does not mean these factors are unimportant, only that they are less relevant to self-psychology.

Our review will focus on three related issues. First, we will examine the onset of depression. What causes depression, and what role do people's thoughts and feelings about themselves play in this matter? The second issue we will consider is the experience of depression itself. Self-referent thoughts and feelings are prominent features of a depressive episode, and people who are depressed process personal information differently than do people who are not depressed. The second part of this chapter will explore these tendencies. Finally, we will look at factors that influence the duration and severity of a depressive episode. Here our concern will be with understanding why some people are able to recover quickly from depression, while others are not.

I. Conceptual Overview

A. Diathesis-Stress Models of Depression

The model shown in Figure 9.1 will guide our discussion. This model, which is known as a *diathesis-stress* model (Monroe & Simons, 1991), identifies two general factors that influence the onset of depression. One of these factors is a negative life event (or source of stress). These events typically involve the loss of an important source of love, security, identity, or self-worth. The death of a loved one, the breakup of an important romantic relationship, or a significant personal failure are prototypic examples (Arieti & Bemporad, 1978).

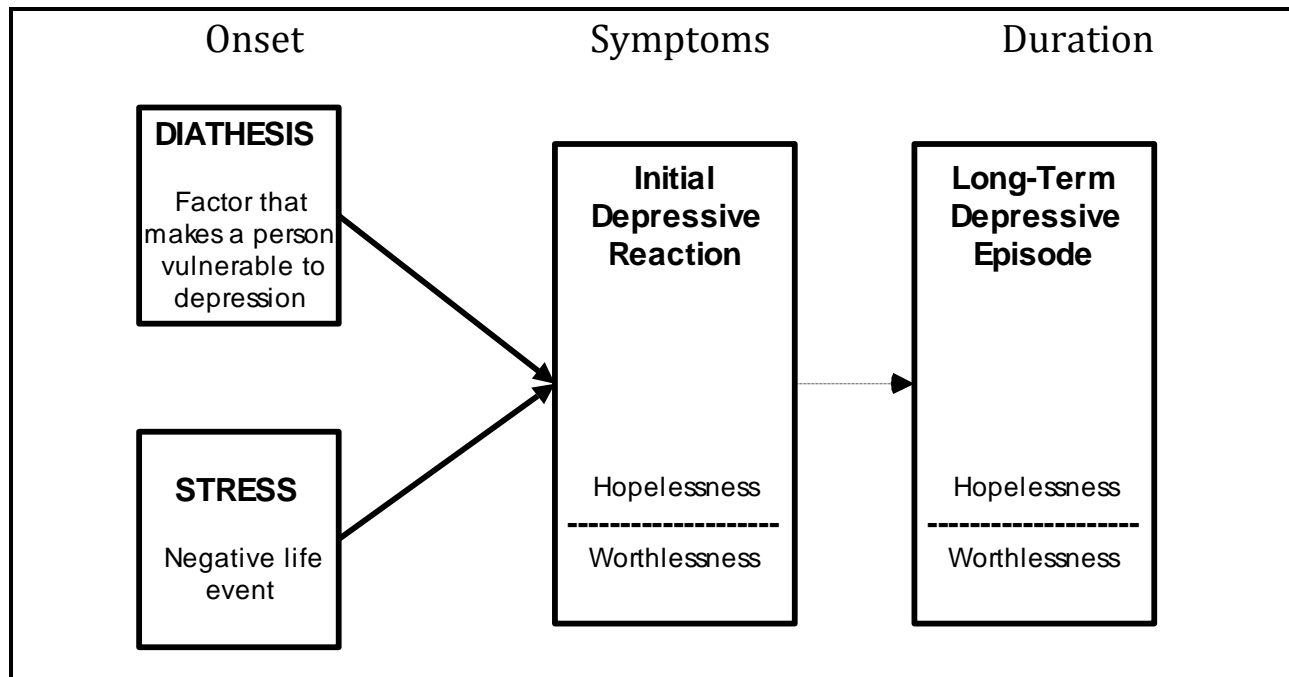


Figure 9.1. Schematic representation of a model of reactive depression. A depressive reaction occurs when a person vulnerable to depression experiences a negative life event. Among other things, this depressive reaction is characterized by feelings of hopelessness and/or worthlessness. Finally, the dashed line indicates that a short-term depressive reaction may resolve quickly or turn into a long-term depressive episode.

The link between events of this nature and depression was revealed in a landmark study by G. Brown and Harris (1978). These investigators interviewed over 400 women (ages 18–65) living in an area of London. Assessments were made regarding the presence or absence of depression in the preceding year and the nature and number of negative life events the women had experienced. Across the entire sample, 30 percent of the women reported experiencing a severe negative event or chronic difficulty in the nine months prior to the interview; among women who had experienced a bout of depression, this percentage jumped to 75 percent.

The data Brown and Harris (1978) gathered document that depression is often preceded by a negative life event. At the same time, the data also showed that only a minority of women who experienced a severe event became depressed. On the basis of

these and other findings (Paykel, 1979), researchers now agree that negative life events precipitate depression in some, but not most, people. This fact has led investigators to search for variables that determine who becomes depressed when experiencing stress and who does not.

Formally, these variables are known as *diatheses*. A diathesis is a vulnerability factor that influences how much damage a stressful experience creates. For example, the structural integrity of a building constitutes a diathesis. If an earthquake comes, a poorly made building will suffer greater damage than a well-made building will. In a conceptually similar vein, researchers have sought to identify factors that influence whether people become depressed when faced with a stressful experience. As we will see momentarily, some of these vulnerability factors concern the way people think and feel about themselves.

B. Two Self-Relevant Features of Depression: Hopelessness and Worthlessness

In 1917, Sigmund Freud published a book on depression called *Mourning and Melancholia*. Among other things, Freud argued that depression can take two forms. With mourning, depression is a grief reaction to the loss of an actual love object (e.g., the death of a loved one). Mourning is characterized by intense sadness and despair, but not guilt, shame, or self-reproach. With melancholia, depression is a response to a loss of a more psychological nature (e.g., a perceived failure to live up to one's ideals or standards). It is characterized not only by intense sadness but also by self-recrimination and self-deprecation.

Building on these themes, contemporary researchers have distinguished between two self-relevant perceptions commonly seen in depression (see the middle portion of Figure 9.1). People feel *hopeless* when they believe there is nothing they or anyone else can do to bring about a desired outcome or avoid a negative outcome. Hopelessness begets feelings of gloom and resignation, which are important aspects of depression. People feel *worthless* when they think they are weak, deprived, or otherwise globally inadequate or flawed. These perceptions are also prominent features of depression.¹

In some cases, depression is characterized by only one of these perceptions (e.g., a person can feel hopeless but not worthless regarding the loss of a loved one). Other times, both perceptions are present (when a loved one dies, people may feel hopeless that they will never see the person again and guilty about not having spent more time with the person while he or she was alive).

Helplessness is also commonly seen in depression. This term refers to the perception that one is powerless to change an undesirable situation. Helplessness is a subset of hopelessness. People can feel helpless without feeling hopeless (e.g., there's nothing I can do but I know someone who can), but by definition, people who feel hopeless

¹ Figure 9.1 highlights only self-relevant features of depression. However, as will be discussed later, depression is characterized by many other symptoms, including somatic disturbances (e.g., trouble sleeping), motivational disturbances (e.g., apathy), and emotional disturbances (e.g., sadness).

also feel helpless. Helplessness also may give rise to worthlessness. For many people, feeling weak, ineffective, and powerless contributes to a sense of worthlessness.

C. *The Course of Depression: Depressive Reactions and Depressive Episodes*

Figure 9.1 shows one more point to keep in mind as we survey research on self-relevant processes in depression. Some of the work we will review examines why people experience an immediate depressive reaction to an event; other research is geared toward understanding why a depressive reaction persists into a long-term depressive episode. It's important to make this distinction, because depressed reactions to events of loss and disappointment are fairly common. Most such reactions are self-limiting, however, abating within a period of days or weeks. In a minority of cases, these reactions persist or intensify and result in serious disruptions in normal living.

Unfortunately, this distinction between short-term depressive reactions and clinically significant episodes of depression is not always maintained in depression research. Some studies use the term "depressed participants" to refer to people who are experiencing only mild or transient depressive reactions to an event. These reactions, which are often measured by self-report, are not necessarily the same as more extreme or enduring depressive episodes (for discussions of this issue, see [Coyne, 1994](#); [Flett, Vredenburg, & Krause, 1997](#); [Kendall, Hollon, Beck, Hammen, & Ingram, 1987](#); [Vredenburg, Flett, & Krames, 1993](#)). To avoid ambiguity, I will use the term *dysphoria* (rather than depression) when discussing research with participants who have not met a clinical diagnosis of depression.

II. *Self-Esteem Models of Depression*

With this discussion as background, we are ready to consider how self-relevant processes influence the onset and maintenance of depression.

A. *Low Self-Esteem as a Risk Factor in Depression*

The first issue we will explore is whether low self-esteem puts people at risk for developing depression. The question here is not simply whether self-reproach and self-recrimination are symptoms of depression (as discussed earlier). The issue here is whether low self-esteem operates as a stable, predisposing vulnerability factor (i.e., a diathesis). In simpler terms: Are low self-esteem people more apt than high self-esteem people to become depressed in the face of negative life events?

Much of the material we reviewed in Chapter 8 is suggestive of such an association. For instance, Keith Dutton and I found that low self-esteem people suffer greater emotional distress when they fail than do high self-esteem people and that this occurs, in part, because failure leads low self-esteem people to feel *bad* about themselves ([Brown & Dutton, 1995b](#); [Dutton, 1995](#); [Dutton & Brown, 1997](#)). These findings do not establish that low self-esteem people are at greater risk for developing depression, but they are consistent with this idea.

George Brown and his colleagues (e.g., [Brown & Harris, 1978](#); [Brown, Andrews, Harris, Adler, & Bridge, 1986](#)) have offered even more definitive evidence that low self-esteem is a risk factor for depression. Initial support for this conclusion came from the

study by Brown and Harris (1978), which we discussed earlier. Recall that Brown and Harris found that many of the women who were depressed had previously experienced a stressful life event, but not all women who had experienced a stressful life event became depressed. Additional data analyses revealed that certain social characteristics increased a person's risk for developing depression. These included the early loss of one's mother in childhood and the lack of an intimate, confiding relationship in adulthood. Brown and Harris speculated that these factors put people at risk for developing depression by lowering self-esteem. In this model, then, prior social experiences involving the loss of a loved one or a lack of intimacy give rise to low self-esteem, and low self-esteem, in conjunction with a subsequent negative life event, increases the risk of depression (Brown, Bifulco, Veiel, & Andrews, 1990). Figure 9.2 shows the model.

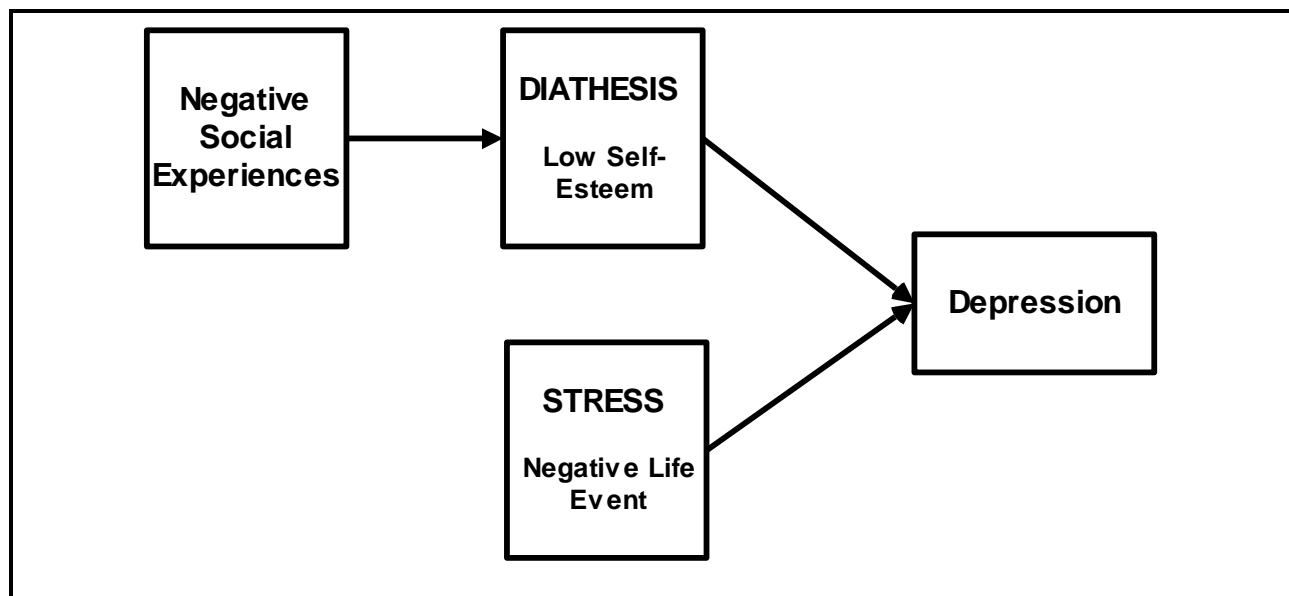


Figure 9.2. **George Brown's model of self-esteem and depression.** Negative social experiences (particularly the loss of one's mother in childhood and the lack of an intimate, confiding relationship in adulthood) give rise to low self-esteem. Low self-esteem then acts as a diathesis for depression when a negative event occurs. (Source: Brown & Harris, 1978, *Social origins of depression: A study of psychiatric disorder in women*. London: Tavistock)

G. Brown et al. (1986) conducted a longitudinal study to test this model. In accordance with predictions, low self-esteem (as indexed by the number of negative self-referent statements a participant made during an interview) functioned as a vulnerability factor when accompanied by a stressful life event. The effect was such that women with low self-esteem were nearly twice as likely as women with high self-esteem to develop depression when faced with a negative life event. Additional investigations have found similar support for G. Brown's model (Andrews & Brown, 1993; Brown, Bifulco, & Andrews, 1990; Miller, Kreitman, Ingham, & Sashidharan, 1989; Roberts, Gotlib, & Kassel, 1996), suggesting that low self-esteem puts people at risk for developing depression when negative life events occur.

B. **Self-Worth Contingency Models of Depression**

Self-worth contingency models provide another perspective on the role of self-

esteem in depression. These models begin by assuming that people strive to feel good about themselves (i.e., to satisfy their self-enhancement needs). People prone to depression have highly conditional feelings of self-worth. They feel good about themselves when certain conditions are met (e.g., they are in a romantic relationship; they are succeeding at their work or schooling) but bad about themselves when these conditions are not being met. Depression arises, according to these models, when experiences threaten these “conditions of self-worth” and people perceive they won’t be able to meet their self-enhancement needs in the future (see Figure 9.3).

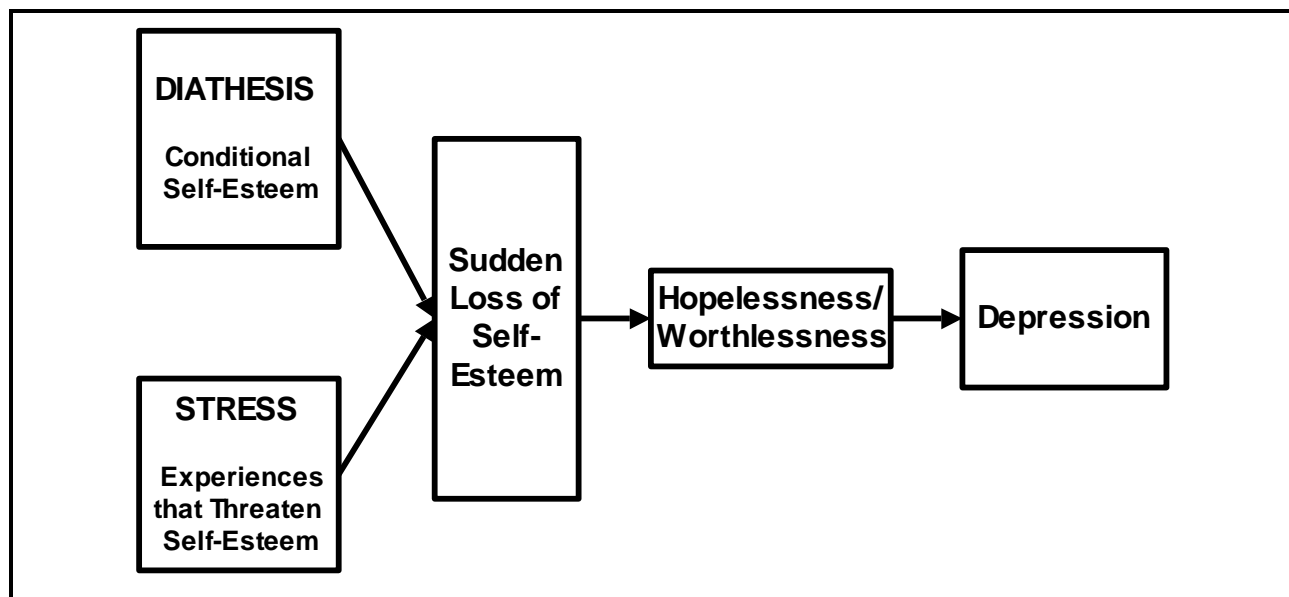


Figure 9.3. **Self-worth contingency models of depression.** Highly conditional self-esteem is a diathesis. Depression arises when negative events threaten these “conditions of self-worth” and people perceive they will no longer be able to meet these needs in the future.

1. **Psychoanalytic Models**

Self-worth contingency models of depression were first developed by theorists working within the psychoanalytic tradition. [Rado \(1928\)](#) and [Fenichel \(1945\)](#) argued that people prone to depression have excessively high interpersonal dependency needs. They desperately seek approval and reassurance from others, and depression arises when they fail to receive it. The situation is much like that of a young child who hungers for the constant and undivided attention and affection of others.

[People with high interpersonal dependency needs are] never able to get enough care and attention. . . . When these needs are frustrated, as they are bound to be, the already low level of self-esteem, which is without significant other resources to shore it up, is further lowered, and clinical depression results. ([Hirschfeld, Klerman, Chodoff, Korchin, & Barrett, 1976, p.384](#))

[Bibring \(1953\)](#) subsequently expanded this analysis to include other sources of self-worth. On the basis of his clinical experience, Bibring distinguished three types of self-ideals commonly held by depression-prone individuals: (1) a heightened need to be loved, appreciated, admired, and respected; (2) an exaggerated need to be strong, capable, successful, and independent; and (3) an inordinate need to be good, loving, moral, and

virtuous (see also, [Strauman, 1989](#); [Strauman & Higgins, 1987](#)). According to Bibring, people holding these lofty ideals become depressed when they believe that they are presently failing to meet these standards and will be unable to meet them in the future. Essentially, they give up hope, concluding that they are inadequate to realize their aspirations. Note, then, how this model combines elements of both worthlessness (inadequacy) and hopelessness (the belief that one will never be able to live up to one's ideals).

2. Social Identity Model of Depression

[Oatley and Bolton \(1985\)](#) have offered a conceptually similar analysis with a strong interpersonal emphasis. Their model assumes (1) that people often derive their feelings of self-worth from their social roles, and (2) that other people are needed to enact these roles. Depression arises, according to the model, when the loss of another person jeopardizes a highly valued social role and the person has few alternative sources of self-worth available. From this perspective, people vulnerable to loss are those who base their feelings of self-worth on a limited number of social roles (see also, [Linville, 1987](#); [Thoits, 1983](#)).

The empty-nest syndrome provides a paradigmatic example. A woman who derives her primary identity from her role as a mother is vulnerable to depression when her children leave home because she is no longer able to effectively enact that role. Depression is especially apt to occur when the woman has few (if any) other sources of self-worth available. A similar sense of despair afflicts some workers when they retire from life-long occupations and have no alternative sources of fulfillment.

3. Congruency Models of Depression

Congruency models of depression (e.g., [Arieti & Bemporad, 1978](#); [Beck, 1983](#); [Blatt, Quinlan, Chevron, MacDonald, & Zuroff, 1982](#); [Bowlby, 1973](#)) integrate the various self-worth models we've been discussing. These models assume that there are two personality types prone to depression. One of these is highly dependent on social sources of approval; the other is highly dependent on achievement outcomes. Table 9.1 presents a description of each type.

Table 9.1. Congruency Models of Depression

| Depression-Prone Personality Type | Bases of Self-Worth | Events that Threaten Self-Worth | Themes Expressed During a Depressive Episode |
|---------------------------------------|---|--|--|
| Conditional interpersonal orientation | Interpersonal relationships; excessive need for acceptance, support, and approval | Social exclusion, rejection, or disapproval | Loneliness, loss, abandonment, rejection |
| Conditional achievement orientation | Achievement outcomes; meeting internalized standards and goals; excessive needs for success, power, and control | Failure to achieve goals or attain standards | Inadequacy, personal failure, guilt, self-recrimination. |

People with a conditional interpersonal orientation have inordinately high

interpersonal dependency needs. They require the acceptance and love of others in order to feel good about themselves. They like themselves when they perceive that these needs are being met but dislike themselves when they perceive that these needs are not being met. Of course, everyone feels better about themselves when they believe they are liked and respected by others. But for people with high interpersonal dependency needs, the need for approval and affection is constant and virtually insatiable.

People with a conditional achievement orientation base their feelings of self-worth on their ability to succeed and exercise control over the environment. They feel good about themselves when they succeed but bad about themselves when they fail. Meeting these standards is no simple matter, however. Individuals with a conditional achievement orientation tend to be perfectionistic. They hold extremely high standards and are rarely satisfied with their level of accomplishment, even though these achievements are often considerable (Blatt, 1995).

In tests of this *congruency* model, researchers have looked at whether depression is most apt to arise when a negative life event is congruent with, or matches, a person's personality type (e.g., Hammen, Ellicott, Gitlin, & Jamison, 1989; Hammen et al., 1985; Robins, 1990; Robins, Block, & Peselow, 1989; Segal, Shaw, Vella, & Katz, 1992). The prediction is that negative interpersonal events (e.g., the break-up of a marriage) are more apt to precipitate depression in people with a conditional interpersonal orientation than in people with a conditional achievement orientation, but that negative achievement-related events (e.g., a significant personal failure) are more likely to precipitate depression in people with a conditional achievement orientation than in people with a conditional interpersonal orientation. So far, tests of this congruency hypothesis have produced mixed support for the model (Coyne & Whiffen, 1995). Although people with a conditional interpersonal orientation appear to be particularly vulnerable to the effects of negative interpersonal events, people with a conditional achievement orientation do not appear to be more vulnerable to negative achievement-related events (for an exception, see Hewitt & Flett, 1993).

C. ***Labile Self-Esteem as a Risk Factor in Depression***

Because people with conditional self-esteem base their feelings of self-worth on their current outcomes, their self-esteem seems to fluctuate over time. Recognizing this fact, investigators have used fluctuations in self-esteem (termed *labile* or *unstable* self-esteem) to predict the onset of depression (Butler, Hokanson, & Flynn, 1994; Kernis, Granneman, & Mathis, 1991; Roberts, Kassel, & Gotlib, 1995; Roberts & Monroe, 1992, 1994).

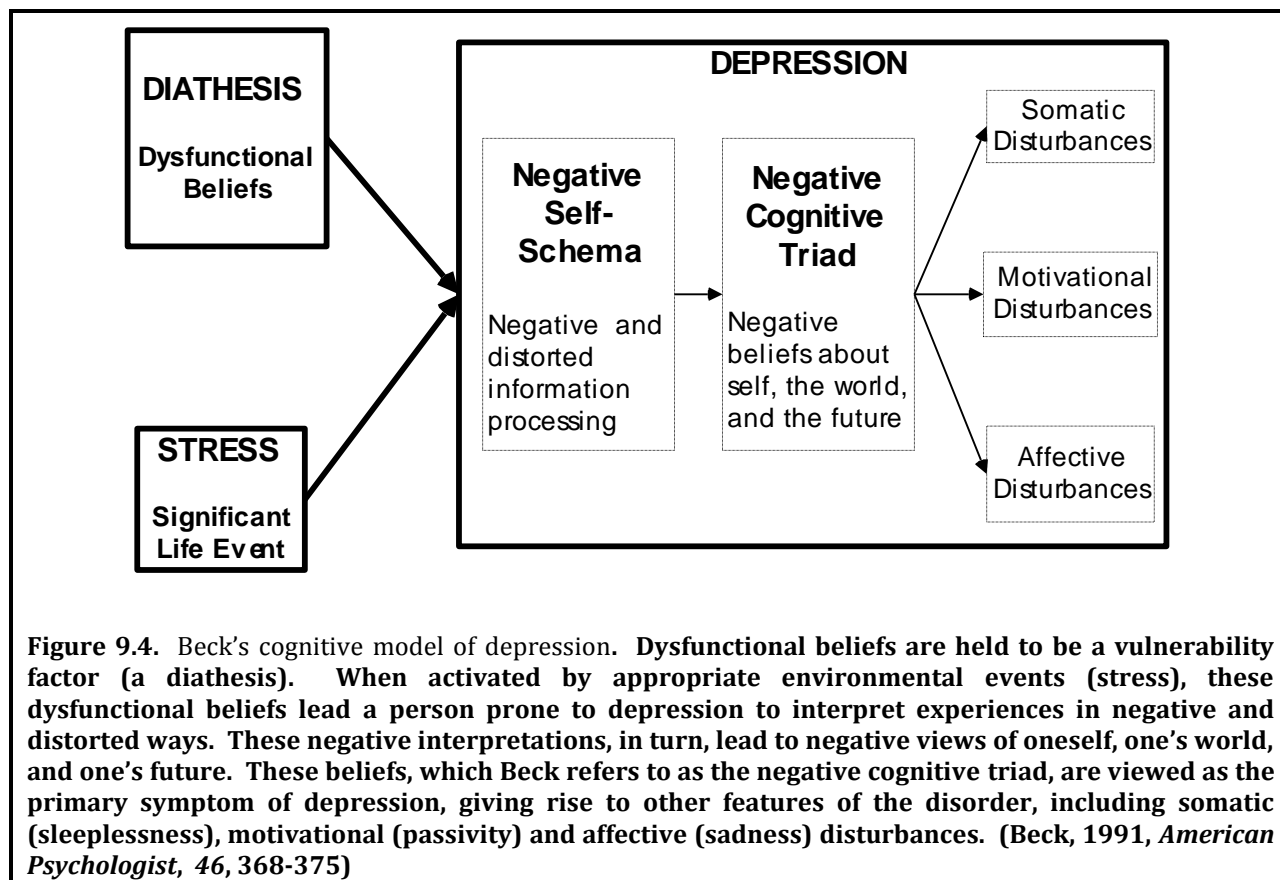
An investigation by Butler et al. (1994) illustrates this approach. These investigators measured self-esteem over the course of 30 days in a sample of college students. This allowed them to calculate an index of (1) average self-esteem level (high or low) and (2) self-esteem lability (how much self-esteem varied from one day to the next in response to daily events). Among other things, Butler et al. found that *low self-esteem* was not a risk factor for dysphoria but that students with *labile self-esteem* were more apt to become dysphoric in the face of negative life events than were students with stable self-esteem. These results are consistent with the claim that *labile* or *reactive* self-esteem is a better predictor of depression than is a constant level of low self-esteem (but see Roberts et al., 1995).

It is somewhat difficult to interpret these findings, however. In Chapter 8, we likened self-esteem to the love most parents feel for their children. Whether conditional love can be considered true love is debatable. In my opinion, a parent who loves his child on some days but not on others doesn't really love his child at all. In a similar vein, a person who only feels good about himself when things are going well doesn't have true high self-esteem. For this reason, I consider labile self-esteem to be a form of low self-esteem, one in which feelings of self-worth are highly conditional and, therefore, volatile.

III. **Beck's Cognitive Theory of Depression**

Self-esteem theories of depression emphasize that people's feelings toward themselves are a risk factor for depression. Other theories focus on the role cognitive processes play in depression. These theories assume that depression is maintained (and perhaps caused) by the manner in which people think about themselves and process personal information.

Aaron Beck was one of the first theorists to advocate this position (Beck, 1967, 1976; Beck, Rush, Shaw, & Emery, 1979). As a therapist with an active clinical practice, Beck sought to understand the nature of depression in order to devise effective treatment strategies. Beck began by developing a precise description of the disorder, with special attention given to distinguishing primary symptoms from more secondary ones (on the assumption that if he *cured* the primary symptoms, the secondary ones would resolve as well) (Beck et al., 1979). As his work has evolved, Beck has added causal elements to his descriptive account of depression. Figure 9.4 presents a schematic representation of his theory, based on some of his most recent work (Beck, 1991; see also Haaga, Dyck, & Ernst, 1991).



A. **Theoretical Model**

1. **The Negative Cognitive Triad is the Primary Feature of Depression**

Beck's most central assumption is that depression is principally a cognitive disorder characterized by three negative, self-relevant beliefs: (1) a negative view of the self (when depressed, people believe they are defective, deficient, and worthless); (2) a negative view of the world (when depressed, people are dissatisfied with their current life situation and believe the world is making unreasonable demands upon them); and (3) a negative view of the future (when depressed, people are pessimistic about their ability to attain desired outcomes). Beck refers to these beliefs (which encompass feelings of hopelessness and worthlessness) as the *negative cognitive triad* and assumes that they are the central feature of all types of depression. This means that other aspects of depression, such as somatic disturbances (e.g., trouble sleeping), motivational disturbances (e.g., passivity and withdrawal), and affective disturbances (e.g., intense sadness), arise in response to these beliefs (Beck et al., 1979, p.11).

Beck also believes that these thoughts have an automatic, reflexive quality. They seem to appear "out of nowhere," without provocation or conscious awareness. As depression worsens, they become increasingly repetitive and intrusive. In extreme cases, they may virtually dominate thinking, making it difficult for the depressed person to concentrate and engage in normal activities. A large part of the therapy Beck developed to treat depression involves monitoring these thoughts, noting when they occur and under

what circumstances. By doing so, Beck argues, one can gain control over these thoughts and eliminate them (Beck et al., 1979).

2. **Negative Self-Schemas in the Maintenance of Depression**

Figure 9.4 also shows that negatively biased information processing supports and maintains these negative beliefs. Beck discusses these information-processing tendencies in terms of a negative self-schema. As noted in Chapter 5, schemas are hypothetical cognitive structures that guide the processing of information. According to Beck, people who are depressed possess a negative self-schema that leads them to process personal information in a negatively biased and distorted fashion. They dwell on the negative aspects of their life and interpret events in self-defeating ways. These tendencies, in turn, fuel and sustain the negative cognitive triad. A negative self-schema thus explains “why a depressed patient maintains his pain-inducing and self-defeating attitudes despite objective evidence of positive factors in his life” (Beck et al., 1979, p.12).

Beck believes that these interpretations are often distorted and illogical and that they result from faulty information-processing tendencies (see also, Ellis, 1962). These tendencies include (1)*selective abstraction* (focusing on a detail out of context), (2)*arbitrary inference* (drawing conclusions in the absence of supporting evidence), (3)*overgeneralization* (applying conclusions too broadly), and (4)*absolutistic or dichotomous thinking* (the tendency to think in categorical—black or white—terms). To illustrate, imagine that a friend forgets to return your phone call. A depressed person will interpret this oversight as a sign of disrespect and an indication that he or she is entirely unlovable. These interpretations persist, Beck argued, even in the face of evidence that more benign interpretations are plausible (e.g., the friend simply forgot or never got the message).

In milder depressions the patient is generally able to view his negative thoughts with some objectivity. As the depression worsens, his thinking becomes increasingly dominated by negative ideas, although there may be no logical connection between actual situations and his negative interpretations. As the prepotent idiosyncratic schemas lead to distortions of reality and consequently to systematic errors in the depressed person’s thinking, he is less able to entertain the notion that his negative interpretations are erroneous. (Beck et al., 1979, p.13)

Beck contrasts the biased and illogical information processing found during depression with that found in nondepressed individuals. According to Beck, nondepressed individuals process personal information in a logical and unbiased manner, generally reaching accurate and rational conclusions. We will have more to say about this aspect of Beck’s theory in Chapter 10.

3. **Dysfunctional Beliefs as a Vulnerability Factor in Depression**

Dysfunctional beliefs form the third component of Beck’s cognitive theory (see top left-hand side of Figure 9.4). Dysfunctional beliefs are excessively rigid beliefs about oneself and the world. They develop early in childhood and involve unrealistic and perfectionistic standards by which people judge themselves. For example, a person prone to depression is apt to endorse the following statements: “If I do not perform as well as others, it means that I am an inferior human being,” or “My value as a person depends

greatly on what others think of me” (Beck et al., 1979).

According to Beck, these absolutistic, contractual beliefs (which parallel the conditions of worth we discussed earlier) make a person vulnerable to depression when a matching life event occurs. By way of illustration, imagine that a person experiences the unwanted dissolution of an important interpersonal relationship. If the person possesses a matching dysfunctional attitude (“I am nothing if a person I love doesn’t love me”), the person begins to view the situation in unrealistically negative terms. The person may assume excessive responsibility for the event, selectively recall other failed romantic involvements, and so forth. These information processing biases lead to the negative cognitive triad (a negative view of oneself, one’s life, and one’s future), which triggers other aspects of depression.

4. **Summary**

To summarize, Beck’s model assumes that a depressive episode begins when a significant life event (e.g., the death of a loved one; losing one’s job) makes contact with one or more dysfunctional beliefs. The confluence of these factors activates a negative self-schema, characterized by negative attentional and interpretational biases. These biases, in turn, give rise to the negative cognitive triad and other symptoms of depression.

B. **Empirical Research**

Beck’s work has inspired scores of studies (for reviews, see [Barnett & Gotlib, 1988](#); [Coyne & Gotlib, 1983](#); [Haaga et al., 1991](#); [Ruehlman, West, & Pasahow, 1985](#)). This research can be divided into three areas: (1) Do depressed people exhibit the negative cognitive triad? (2) Do depressed people process information in a negatively biased and distorted fashion? and (3) Are dysfunctional beliefs a vulnerability factor in the development of depression?

1. **Negative Thinking during a Depressed Episode**

There is ample evidence to support Beck’s claim that negative thinking is an important aspect of depression. Numerous studies have found that people who are currently depressed regard themselves, their current life situation, and their future in more negative terms than do nondepressed people (for reviews, see [Haaga et al., 1991](#); [Ruehlman et al., 1985](#)). These tendencies generally occur only for self-relevant judgments, as depressives are usually not more negative than nondepressives when making judgments about people “in general” ([Garber & Hollon, 1980](#); [Haaga et al., 1991](#); [Hoehn-Hyde, Schlottmann, & Rush, 1982](#); [Schlenker & Britt, 1996](#)).

Although these findings support Beck’s model, other evidence suggests some qualifications. Depressed people consistently display *relative* negativity (i.e., they describe themselves more negatively than do nondepressed people), but they do not always display *absolute* negativity (i.e., they do not always describe themselves in strongly negative terms). Instead of exhibiting self-abasement and self-deprecation, they often evince modesty or slight self-glorification ([Pelham, 1991b](#)). In fact, one survey found that feelings of worthlessness and inadequacy (which Beck assumes are central features of all types of depression) are present in only two-thirds of clinically diagnosable cases of depression ([Buchwald & Rudick-Davis, 1993](#)). This means that a sizable proportion of depressed

people do not show strong evidence of negative thinking.

2. **Information Processing during Depression**

The manner in which depressed people process personal information is a second area of research relevant to Beck's theory. [Derry and Kuiper \(1981\)](#) examined this issue in the context of an experiment on memory for self-relevant material. Using a modified version of the self-reference task developed by [Rogers, Kuiper, and Kirker \(1977\)](#), see Chapter 4), Derry and Kuiper had depressed and nondepressed participants rate a series of adjectives for their self-descriptiveness (Does the word describe you?). Half of the adjectives were negative in tone and centered around depression-relevant themes (e.g., helpless, gloomy); the other half were positive in tone and were unrelated to depression (e.g., capable, loyal). Later, the participants were unexpectedly asked to recall as many of the words as they could remember.

Figure 9.5 presents some of the results from this investigation. The left-hand panel shows the results for the trait endorsement measure. The nondepressed participants rated positive attributes as far more self-descriptive than negative attributes, but the depressed participants rated positive and negative attributes as equally self-descriptive. In terms of content, then, this finding provides evidence that although depressives are more negative in their self-descriptions than are nondepressives, they are not negative in an *absolute* sense.

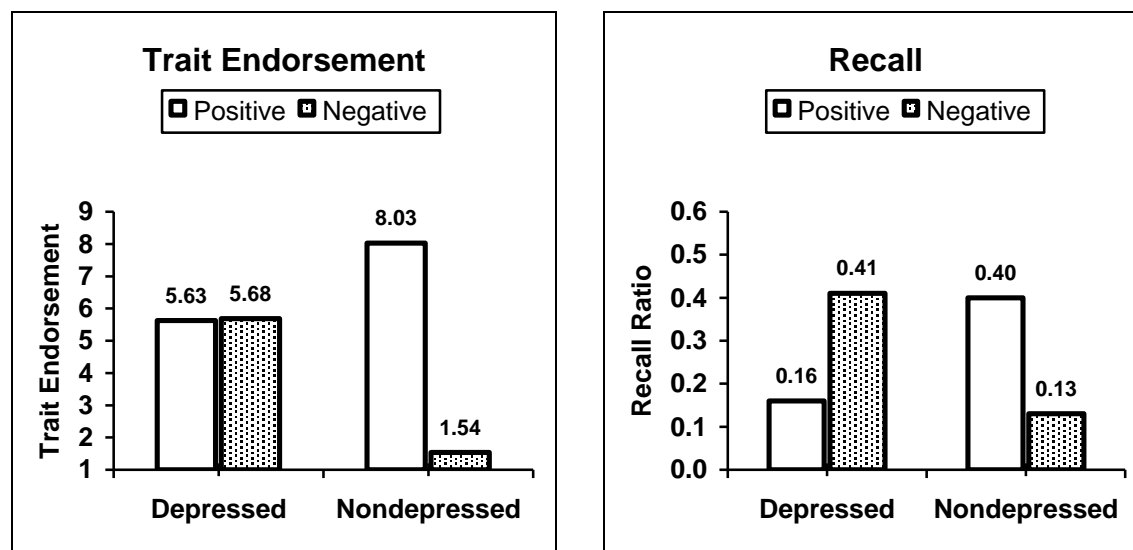


Figure 9.5. Self-schema functioning in depressed and nondepressed participants. The left-hand panel shows that depressed participants rated positive and negative adjectives as equally self-descriptive, but nondepressed participants rated positive adjectives as more self-descriptive than negative adjectives. The right-hand panel shows that depressed participants recalled a greater proportion of negative than positive adjectives, whereas nondepressed participants did the opposite. (Source: Derry & Kuiper, 1981, *Journal of Abnormal Psychology*, 90, 286–297)

The right-hand panel of Figure 9.5 shows the results for the recall measure. Depressed participants recalled a greater proportion of negative than positive self-descriptive attributes, but nondepressed participants recalled a greater proportion of positive than negative self-descriptive attributes. These findings support Beck's assertion

that depressed people exhibit superior processing for negative personal information.

An investigation by [Bargh and Tota \(1988\)](#) provides additional support for this conclusion. Modifying Derry and Kuiper's (1981) procedure, Bargh and Tota had nondepressed and dysphoric participants indicate whether a series of positive and negative trait adjectives described themselves or the average person. Participants in the control condition made these judgments under normal conditions, whereas participants in the experimental (memory load) condition were asked to remember a six-digit number while making these judgments.

The critical dependent variable was the speed with which participants made their decisions. The memory-load manipulation requires conscious attention and therefore competes with (and impairs) the conscious processing of other information. It has little effect, however, on the automatic processing of information, as such processing, by definition, does not require conscious attention. If depressed people process negative (but not positive) personal information in a rather effortless, automatic fashion, the memory-load manipulation should have little effect on the speed with which they judge the self-descriptiveness of negative traits, but it should slow down the speed with which they judge the self-descriptiveness of positive traits. Just the opposite pattern should occur for nondepressives, who presumably process positive (but not negative) personal information in an effortless, automatic fashion.

The data shown in Figure 9.6 provide considerable support for these predictions. The left-hand panel presents the data for self-relevant judgments. The data show that the memory-load manipulation had little effect on the speed with which dysphoric participants judged the self-descriptiveness of *negative* attributes, but it significantly slowed down the speed with which they judged the self-descriptiveness of *positive* attributes. This pattern is reversed among the nondepressed participants.

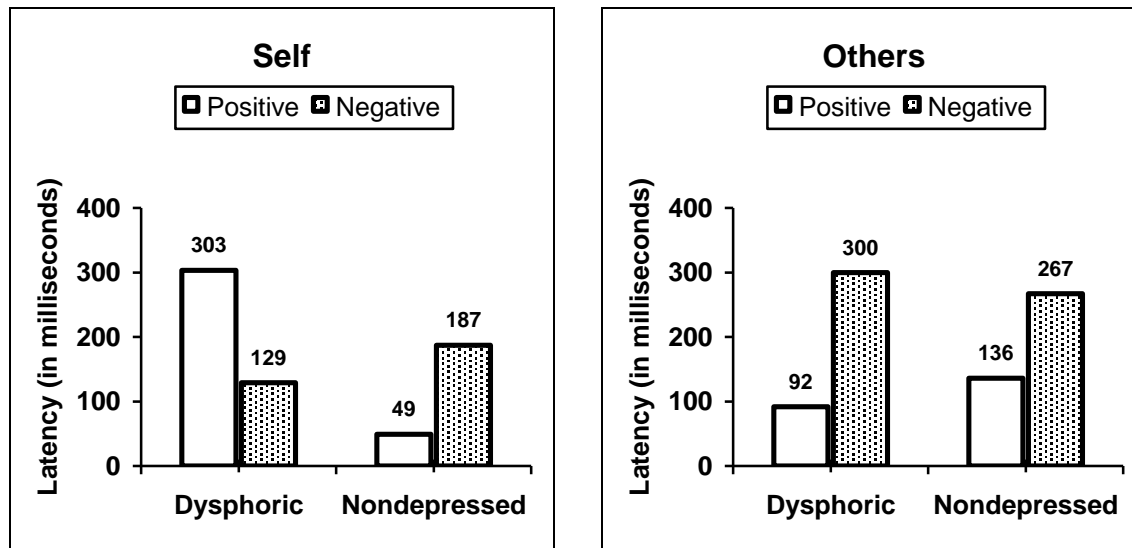


Figure 9.6. The speed with which dysphoric and nondepressed participants made judgments about self and others as a function of memory load. **The left-hand panel shows that the memory load manipulation had little effect on the speed with which dysphoric participants rated the self-descriptiveness of *negative* attributes, but it did slow down the speed with which they rated the self-descriptiveness of *positive* adjectives. The opposite occurred among nondepressed participants. The data in the right-hand panel show that these differences did not extend to judgments of other people, as here the memory-load manipulation had a similar effect on dysphoric and nondepressed participants. Together, these results are consistent with the claim that depressed people process *negative personal* information in a rather automatic fashion. (Source: Bargh & Tota, 1988, *Journal of Personality and Social Psychology*, 54, 925-939)**

The right-hand panel shows the results for judgments of other people. There is no effect of participant status here. Among both dysphoric and nondepressed participants, the memory-load manipulation significantly slowed down the time it took to make negative judgments of others, but it had little impact on positive judgments of others. Taken together, these findings are in accordance with the claim that depressed people process negative personal information in an automatic, unintentional fashion (see also [Gotlib & Cane, 1987](#); [Gotlib & McCann, 1984](#)).

3. ***Dysfunctional Beliefs as a Diathesis for Depression***

To this point, we have seen that people who are currently depressed view themselves in (relatively) negative terms and show superior processing for negative personal information. These findings are generally consistent with Beck's model. The third aspect of Beck's theory—whether dysfunctional beliefs constitute a vulnerability factor for depression—has received less support ([Barnett & Gotlib, 1988](#); [Coyne & Gotlib, 1983](#); [Haaga et al., 1991](#)).

Dysfunctional beliefs are presumed to be stable, cognitive structures. When activated by appropriate environmental events, they lead people to process information in negative ways and to become depressed. The most straightforward (and definitive) way to test this aspect of Beck's theory is to conduct a longitudinal study in which researchers (1) first measure dysfunctional beliefs in nondepressed people and (2) then follow these people over time to see whether those who hold dysfunctional beliefs *and* experience

relevant life events during the course of the study develop depression in the manner specified by the theory. [Barnett and Gotlib \(1990\)](#) performed such a study, but they did not find support for Beck's model.

Another strategy is to see whether people who used to be depressed hold more dysfunctional beliefs than do people who have never been depressed ([Lewinsohn, Steinmetz, Larson, & Franklin, 1981](#)). If, as Beck has claimed, these beliefs predispose a person to become depressed, they should be evident even after a depressive episode remits. There is little evidence that this occurs. Although *currently depressed* individuals endorse more dysfunctional beliefs than do nondepressed individuals, these beliefs generally return to normal levels once depression lifts (e.g., [Dohr, Rush, & Bernstein, 1989](#); [Hamilton & Abramson, 1983](#); [Segal et al., 1992](#)).

These results indicate that dysfunctional beliefs accompany depression but do not predict the onset of depression or persist after depression has abated. In consideration of these findings, several theorists (e.g., [Barnett & Gotlib, 1988](#); [Coyne & Gotlib, 1983](#)) have concluded that dysfunctional beliefs are symptoms or concomitants of depression rather than predisposing, causal factors. Like the other negative cognitions Beck describes, they characterize a depressive episode, but they do not cause the disorder.

4. *Understanding the Link between Negative Cognitions and Depression*

Associative network models of memory can explain why negative thoughts accompany depression. Among other things, these models assume that moods are encoded in memory and are linked to mood-congruent cognitions. Happiness is linked to positively valenced cognitions (e.g., blue skies, ice cream, and positive self-attitudes) and sadness is linked to negatively valenced cognitions (e.g., rainy days, famine, and negative self-attitudes). When a mood is experienced, activation spreads to associated concepts, making them more accessible to conscious awareness. From this perspective, a depressed mood primes or activates negative self-relevant cognitions, accounting for the observed association between negative mood and negative self-relevant thinking (for a more thorough discussion of this approach, see [Blaney, 1986](#); [Bower, 1981](#); [Ingram, 1984](#); [Isen, 1984](#); [Teasdale, 1983](#)).

In tests of this model, researchers have experimentally induced positive or negative moods in people and then examined the accessibility of positive and negative self-relevant thoughts. Across several studies, negative self-relevant thoughts have been shown to be more accessible when people are in a negative mood state than when people are in a positive mood state (e.g., [Brown & Taylor, 1986](#); [Teasdale & Fogarty, 1979](#); [Teasdale, Taylor, & Fogarty, 1980](#)). These findings support the claim that depressed moods activate negative self-referent thinking.

An investigation by [Clark and Teasdale \(1982\)](#) provides even more powerful support for this conclusion. These researchers examined the accessibility of positive and negative personal memories in depressed patients with diurnal mood variation. Such patients feel considerably more depressed at one time of day (e.g., early in the morning) than at other times of day (e.g., before going to bed). To measure the accessibility of negative thinking during each of the two states, Clark and Teasdale asked the depressed patients to retrieve memories of real-life experiences in response to a neutral cue word. Consistent with the notion that sad moods activate negatively toned material, unhappy

experiences were more apt to be recalled during the time of day when patients were more depressed.

5. ***The Accessibility of Negative Cognitions and the Persistence of Depression***

At the outset of this chapter, we made a distinction between short-term depressive reactions to negative life events and clinically significant episodes of depression. We also noted that depressive reactions to negative life events are common. Most people grieve when a loved one dies and become distraught when they lose their job. Given this, it becomes important to understand why depressive reactions are transient and short-lived in some people but are prolonged and chronic in others.

Teasdale (1988) has suggested that the accessibility of negative cognitions during the early stages of depression is relevant to this issue. Teasdale assumes that people differ in the degree to which negative moods activate negative thinking and that this link influences the length and severity of a depressive episode. For depression-prone people, negative moods are highly apt to trigger negative self-relevant thoughts and lead to negative interpretations of one's present situation and the future. From this perspective, the particular cognitive factors leading to depression are less important than are the cognitive processes that serve to delimit or prolong this reaction.

Tests of this *differential activation* hypothesis have generally been supportive. Negative moods are especially apt to activate negative thinking in formerly depressed people (Miranda & Persons, 1988; Miranda, Persons, & Byers, 1990) and in people who are at risk for depression, such as those with low self-esteem (Brown & Mankowski, 1993). The accessibility of negative thinking has also been shown to predict the duration and depth of a depressive episode. People who show high levels of negative thinking during depression take longer to recover from depression and are at greater risk for relapse than are individuals who are depressed but show low levels of negative thinking (e.g., Dent & Teasdale, 1988; Krantz & Hammen, 1979; Lewinsohn et al., 1981). This pattern suggests that the nature and accessibility of negative thinking *during* depression influences whether depression is mild and transient or severe and recurrent (Teasdale, 1983, 1988).

The differential activation hypothesis may also explain why research has failed to find that negative thinking predicts the *onset* of depression. Beck's claim that dysfunctional beliefs are latent, cognitive structures implies that they need to be activated by particular experiences in order to be observed (Riskind & Rholes, 1984). Negative moods may be one type of activating (or priming) experience. If so, measuring the accessibility of negative thinking during a depressed mood may identify people at risk for depression (Segal & Dobson, 1992).

C. ***Summary***

Table 9.2 summarizes the issues we have covered in this section. The *concomitant* hypothesis is clearly supported. There is considerable evidence that negative thinking accompanies depression and that depressed people process information in a rather negative manner. There is, however, little evidence that dysfunctional beliefs cause depression, although this *causal* hypothesis cannot be completely dismissed. Finally, there is evidence that negative moods are especially apt to activate negative thinking among people prone to depression (*differential activation* hypothesis) and that the accessibility of negative thinking predicts the severity and duration of a depressive episode (*duration*

hypothesis).

Table 9.2. Negative Thinking and Depression

| Hypothesis | Explanation | Prediction | Support |
|-------------------------|--|--|---|
| Concomitant | Negative thinking accompanies depression. | People who are currently depressed show more evidence of negative thinking than do people who are not currently depressed. | Strongly supported. There is considerable evidence that negative thinking accompanies a depressive episode. |
| Causal | Negative thinking causes depression. | Nondepressed people who exhibit high levels of negative thinking are at risk for developing depression. | Not supported. There is little evidence that negative thinking predicts who becomes depressed or who has been depressed in the past. |
| Differential Activation | The link between negative moods and negative thinking is stronger in some people than in others. | Depression is more apt to occur among people who show a strong link between negative moods and negative thinking. | Supported. Negative moods are more closely associated with negative thinking among people who have been depressed than among people who have never been depressed, and among people who are at risk for depression than among those who are not at risk for depression. |
| Duration | Negative thinking predicts the duration of a depressive episode. | Among people who are depressed, those who show strong signs of negative thinking are more likely to remain depressed than are those who do not show strong signs of negative thinking. | Supported. Among people who are depressed, the strength of negative thinking predicts the duration of a depressive episode. |

In light of these findings, what can we conclude about Beck's model? On the one hand, it seems fair to say that Beck's model provides a very useful descriptive account of depression and clarifies how depression is maintained. In this sense, the model gives important insights into how depression can be ameliorated (Beck et al., 1979). On the other hand, the model has proven to be less successful in identifying risk factors for depression and, therefore, in proving useful for purposes of prediction and prevention.

IV. **Attributional Models of Depression**

Beck's theory is not the only theory to emphasize the role of cognitive processes in depression. Attributional models of depression do so as well. These models assert that the attributions people make for important life events (i.e., Why is this event happening? What

is the cause of this event?) influence the onset, magnitude, and duration of depression. In this section, we will trace the historical roots of the model and consider relevant empirical evidence.

A. **Theoretical Development**

Attributional models of depression grew out of research in experimental psychology, where it was observed that laboratory dogs first exposed to *inescapable* electrical shocks later displayed motivational deficits when exposed to *escapable* electrical shocks (Overmier & Seligman, 1967). Instead of taking instrumental action (such as crossing over to the other side of the room), the dogs seemed to passively accept their fate, *choosing* to endure the shock rather than try to escape it. Maier, Seligman, and Solomon (1969) interpreted these deficits in cognitive terms, arguing that the animals had learned that nothing they could do could alleviate their distress. They termed this (erroneous) perception, *learned helplessness*.

1. **Learned Helplessness Models of Depression**

Seligman (1975) applied these ideas to the study of depression in humans. Seligman speculated that depression arises when people perceive that important life events are beyond their control. Abramson, Seligman, and Teasdale (1978) subsequently modified the theory to include the attributions people make for these events. According to this *reformulated learned helplessness model*, depression results when people (1) perceive that important life events are beyond their control, and (2) attribute these events to causes that are internal (it's something about me rather than something about the situation), stable (it will last forever rather than be temporary), and global (it will affect all areas of my life rather than just this one area). Attributions to internal factors were tied to feelings of worthlessness, while attributions to stable and global factors were linked to feelings of hopelessness and despair (see also, Miller & Norman, 1979; Weiner & Litman-Adizes, 1980).

By way of illustration, consider again a person who is experiencing the break-up of an important interpersonal relationship. Depression is apt to result, Abramson et al. (1978) argued, to the extent that the person attributes this negative event to an enduring and general personal cause (e.g., an inability to get along with other people). Janoff-Bulman (1979, 1982) referred to this type of attribution as a form of characterological self-blame.

Abramson et al. (1978) went on to speculate that some people possess a negative attributional style, defined as a tendency to make internal, stable, and global attributions for negative events. The negative attributional style is thus a diathesis that puts people at risk for developing depression when a negative event occurs (see also, Peterson & Seligman, 1984).

2. **Hopelessness Theory of Depression**

Abramson, Metalsky, and Alloy (1988, 1989) presented a further revision of the model that integrates aspects of Beck's (1976) theory with the reformulated learned helplessness model. The revised theory, called the *hopelessness theory of depression*, is shown in Figure 9.7. Like Beck's model, hopelessness theory represents a diathesis-stress model of depression. The model begins with the occurrence of a negative life event. People

who possess a matching negative attributional style tend to interpret the event in negative terms. They attribute the event to stable, global causes and perceive the event as having broad and important negative implications for their life. This perception, in turn, leads to hopelessness. Hopelessness is defined as the expectation that one is incapable of changing the negative event or altering its adverse implications for well-being. This perception gives rise to a subtype of depression, called hopelessness depression. Finally, if the negative event is also attributed to an internal cause, depression is accompanied by low self-esteem.²

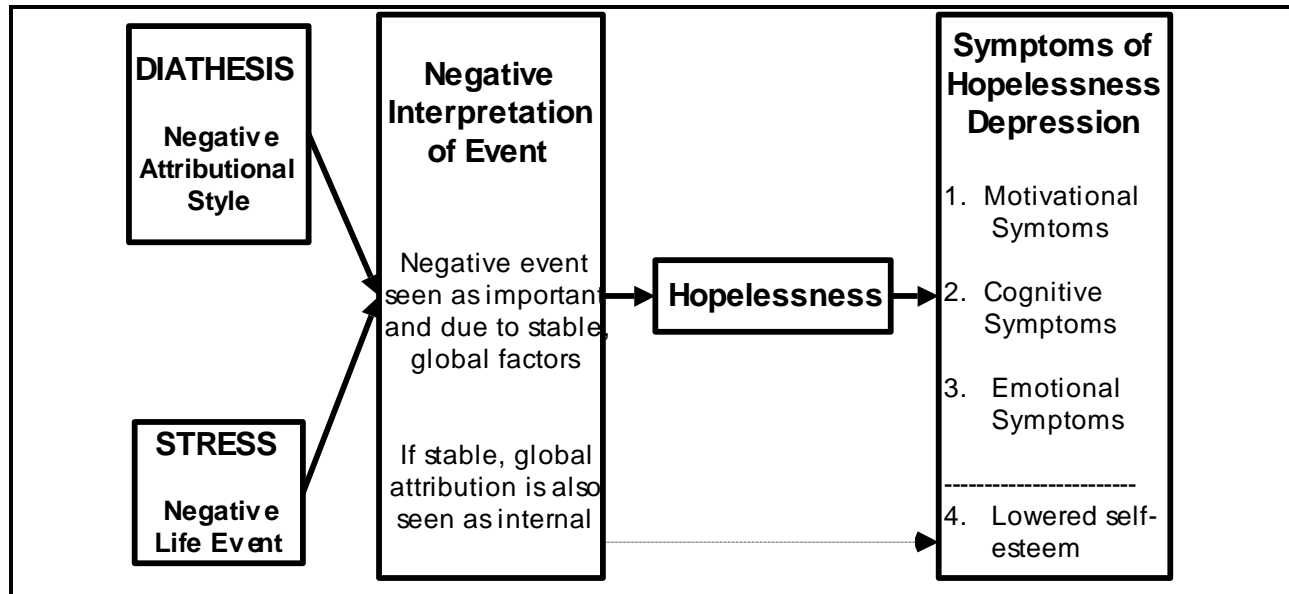


Figure 9.7. **A hopelessness theory of depression.** A depressive episode begins when people with a negative attributional style interpret a negative life event in negative terms. These interpretations, in turn, give rise to hopelessness, which is the immediate cause of a particular subtype of depression. (After Abramson, Metalsky, & Alloy, 1988. *The hopelessness theory of depression: Does the research test the theory?* In L. Y. Abramson (Ed.), *Social cognition and clinical psychology: A synthesis* (pp. 33-65). New York: Guilford Press)

B. **Empirical Research**

Tests of the attributional model generally take two forms. Some studies examine whether people who are currently depressed exhibit a negative attributional style; other studies examine whether a negative attributional style combines with stressful life events to predict the development of depression.

1. **Attributional Style in Depression**

With respect to the first issue, there is abundant evidence that depressed people are

² There is one key difference between Beck's (1967) theory and the hopelessness theory of depression. Beck argued that negative self-relevant cognitions are a defining feature of *all* types of depression; Abramson et al. contend that negative self-relevant cognitions are present in only some types of depression, most notably in the type they call hopelessness depression. A more complete discussion of this and other issues can be found in Abramson et al. (1988, 1989) and Dykman and Abramson (1990).

more apt to make internal, stable, and global attributions for negative outcomes than are nondepressed people (for reviews, see [Brewin, 1985](#); [Coyne & Gotlib, 1983](#); [Peterson & Seligman, 1984](#); [Sweeney, Anderson, & Bailey, 1986](#)). This evidence comes from (1) laboratory studies, in which participants make attributions for experimentally induced failure ([Kuiper, 1978](#); [Rizley, 1978](#)); (2) field studies, in which people make attributions for naturally occurring negative life events (e.g., [Gong-Guy & Hammen, 1980](#); [Zautra, Guenther, & Chartier, 1985](#)); (3) archival data, in which attributions for negative events are culled from diaries or other written or spoken material ([Peterson, Luborsky, & Seligman, 1983](#)); and (4) questionnaire studies, in which a more general attributional style is assessed (see [Peterson & Seligman, 1984](#)).

The majority of the questionnaire studies use the Attributional Style Questionnaire developed by [Seligman, Abramson, Semmel, and von Baeyer \(1979\)](#); see also [Peterson, Semmel, von Baeyer, Abramson, Metalsky, & Seligman, 1982](#)). Portions of the questionnaire are shown in Table 9.3.

Table 9.3. Attributional Style Questionnaire

Please try to vividly imagine yourself in the situations that follow. If such a situation happened to you, what do you feel would have caused it? While events may have many causes, we want you to pick only one—the *major* cause if this event happened to *you*. Please write this cause in the blank provided after the event. Next we want you to answer some questions about the *cause*.

Sample Item 1: You’ve been looking for a job unsuccessfully for some time.

1. Write down the one major cause _____.

2. Is the cause of your unsuccessful job search due to something about you or something about other people or circumstances?

| | | | | | | |
|--|---|---|----------------------|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Totally due to other people or circumstances | | | Totally due to me | | | |

3. In the future when looking for a job, will this cause again be present?

| | | | | | | |
|--------------------------------|---|---|---------------------------|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Will never again be present | | | Will always be present | | | |

4. Is the cause something that just influences looking for a job, or does it also influence other aspects of your life?

| | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Influences just this particular situation | | | Influences all situations in my life | | | |

Sample Item 2: You meet a friend who compliments you on your appearance.

1. Write down the one major cause _____.

2. Is the cause of the compliment something about you or something about other people or circumstances?

| | | | | | | |
|--|---|---|---|---|---|-------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Totally due to other people or circumstances | | | | | | Totally due to me |

3. In the future when looking for a job, will this cause again be present?

| | | | | | | |
|-----------------------------|---|---|---|---|---|------------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Will never again be present | | | | | | Will always be present |

4. Is the cause something that just influences looking for a job, or does it also influence other aspects of your life?

| | | | | | | |
|---|---|---|---|---|---|--------------------------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Influences just this particular situation | | | | | | Influences all situations in my life |

(Source: Seligman, Abramson, Semmel, & von Baeyer, 1979, *Journal of Abnormal Psychology*, 88, 242-247)

The complete Attributional Style Questionnaire consists of six positive hypothetical events and six negative hypothetical events. Researchers then sum across these events and compare the responses of nondepressed and depressed participants. Figure 9.8 presents the findings from one investigation that adopted this approach (Seligman et al., 1988). The data show that nondepressed participants made more internal, stable, and global attributions for positive events than did depressed participants but that the reverse was true for negative events. Another way of looking at these data is to note that nondepressed participants made more internal, stable, and global attributions for positive events than for negative events but that the attributions of depressed participants were balanced and even-handed.

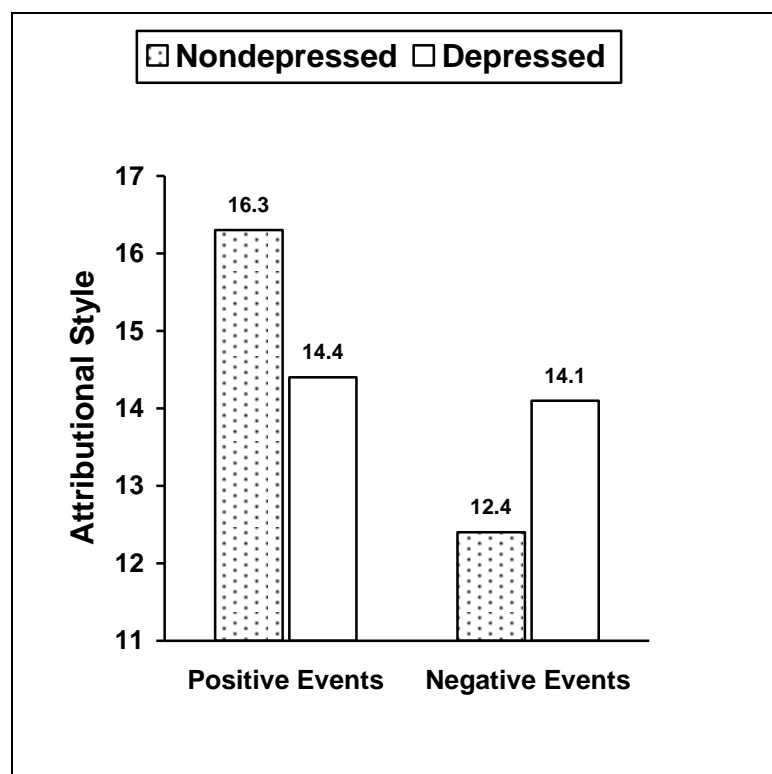


Figure 9.8. Attributional style and depression. (Scores represent a composite index found by summing ratings of internal, stable, and global attributions.) The data show that nondepressed participants made more internal, stable, and global attributions for positive events than did depressed participants but that depressed participants made more internal, stable, and global attributions for negative events than did nondepressed participants. These findings are consistent with the claim that depressed people exhibit a negative attributional style. (Source: Seligman et al., 1988, *Journal of Abnormal Psychology*, 97, 13–18)

2. ***Attributional Style as a Risk Factor for Depression***

To see whether a negative attributional style makes a person vulnerable to depression when faced with a negative life event, [Metalsky, Halberstadt, and Abramson \(1987\)](#) examined how college students with different attributional styles for achievement-related events responded to a poor performance on a midterm exam. Immediately after

receiving their grades, students' emotional reactions depended only on the exam grades they received (students who did well felt good; students who did poorly felt bad). Two days later, however, students who had done poorly on the test were more likely to remain in a depressed mood if they also possessed a negative attributional style. Subsequent research with both college students and younger children has replicated these findings and provided additional evidence that thoughts of hopelessness drive these emotional reactions (Hilsman & Garber, 1995; Metalsky & Joiner, 1992; Metalsky, Joiner, Hardin, & Abramson, 1993). Because these studies only examined the duration of depressed mood, not the development of clinically significant cases of depression, the results must be interpreted cautiously. That being said, the findings are certainly consistent with the claim that a negative attributional style functions as a diathesis for depression when negative life events occur.

V. **Attentional Processes in Depression**

Several times in this chapter we have noted that depressive reactions to negative life events are not uncommon and that an important issue to consider is why these reactions are short-lived and self-limiting in some cases but not in others. Teasdale (1988), you may recall, argued that the accessibility of negative thinking during depression is one factor to consider. Depression is more apt to endure and worsen, Teasdale argued, when negative moods automatically activate negative thinking.

Attentional processes also influence the severity and length of a depressive episode. In this section, we will review three lines of research that have examined this issue.

A. **Self-Awareness and Depression**

One line of research begins with the observation that depressed people tend to be introspective and self-absorbed. They brood about themselves a lot and spend a good deal of time questioning their motives, mulling over their feelings, and examining their personality traits. Consistent with this observation, research with community and clinical samples has found a positive association between depression and private self-consciousness (Ingram, Lumry, Cruet, & Sieber, 1987; Ingram & Smith, 1984; Smith & Greenberg, 1981; Smith, Ingram, & Roth, 1985). Although these effects are not always strong or unique to depression (see Ingram, 1990), there is little doubt that depressed individuals spend more time thinking about themselves than do nondepressed individuals.³

The tendency to focus one's attention inward may influence other aspects of depression. Self-consciousness increases the intensity of emotional states (Scheier & Carver, 1977), particularly negative emotional states (Brockner, Hjelle, & Plant, 1985; Gibbons, Smith, Ingram, Pearce, Brehm, & Schroeder, 1980; Scheier & Carver, 1977). Self-consciousness also can activate

³ Self-awareness and depressed mood appear to be related in a reciprocal fashion. Wood, Saltzberg, and Goldsamt (1990) had participants listen to either sad music or affectively neutral music and then write down "anything that comes to mind" for two minutes afterward. Participants who listened to sad music referred to themselves more often in these essays than did control participants, supporting the claim that negative moods induce self-awareness.

a negative self-image, as people who think about themselves a lot often become aware that they are falling short of their ideals and aspirations (Duval & Wicklund, 1972). These parallels suggest that (1) self-consciousness is a central symptom of depression, and (2) that people who are especially susceptible to self-consciousness during depression may experience more intense and longer-lasting depressive reactions to events than people who are less self-absorbed.

Certain situations may make depressed people particularly self-aware. Pyszczynski and Greenberg (1987b) proposed that depressed people are especially apt to become introspective and self-aware following failure or some other negative, self-relevant experience. To test their ideas, Greenberg and Pyszczynski (1986) led nondepressed and dysphoric participants to succeed or fail at a task that allegedly measured their verbal intelligence. Afterward, participants were instructed to write down whatever thoughts came to mind.

Immediately after failure, both nondepressed and dysphoric participants showed signs of heightened self-awareness (as indexed by the proportion of self-referent statements). Two minutes later, however, nondepressed participants had returned to a nonself-focused state, while dysphoric participants continued to remain highly focused on themselves. These findings are consistent with the claim that depression is characterized by a tendency to stay in a prolonged state of self-awareness following negative outcomes.

This tendency may actually reflect a preference for self-awareness after failure. In another investigation, Pyszczynski and Greenberg (1986) again led nondepressed and dysphoric participants to succeed or fail at an alleged test of verbal ability. Afterward, they gave the participants three minutes to work on each of two puzzles. One of the puzzles was positioned on a table in front of a mirror, so that participants who worked on this puzzle were confronted with their own image; the other puzzle was positioned on a table without a mirror. Nondepressed participants avoided self-focused attention after failure, choosing not to work on the puzzle with the mirror. Dysphoric participants tended to do the reverse, choosing the puzzle with the mirror more after they had failed than after they had succeeded. These findings indicate that nondepressed people avoid self-focusing stimuli after failure but that dysphoric people do not.

Conway, Giannopoulos, Csank, and Mendelson (1993) have offered an explanation for why depressed people seek out self-awareness after failure. They have argued that depressed people think about themselves a lot in an attempt to better understand themselves. They are trying to end their suffering and believe that introspection and intensive self-scrutiny will serve this goal.

B. *Ruminative Coping Style*

Unfortunately, excessive introspection and self-preoccupation are rarely effective mood-management strategies. Susan Nolen-Hoeksema and her colleagues have studied this aspect of depression. Their research begins by noting that people differ in the degree to which they ruminate when they are sad. Some people think a lot about how sad they are and why they feel that way; other people attempt to distract themselves and take their mind off their troubles and worries.

Table 9.4 presents portions of a scale that is used to measure these individual differences. People who score high on this scale are said to have a ruminative coping style. When they are depressed, they think a lot about their symptoms and the possible consequences of these symptoms (Nolen-Hoeksema, 1991a, 1993). It’s important to note that rumination does not involve a focus on the causes of one’s depression. It represents a preoccupation with being depressed (e.g., “What’s wrong with me?” and “How will being depressed affect my life?”), rather than an active, problem-focused attempt to solve one’s problems.

Table 9.4. Abridged version of the responses to depression questionnaire

People think and do many different things when they feel depressed. Please read each of the items below and indicate whether you never, sometimes, often, or always think or do each one when you feel down, sad, or depressed. Please indicate what you *generally* do, not what you think you should do.

| | 1 | 2 | 3 | 4 |
|---|-----------------|-----------|-------|---------------|
| | Almost never | Sometimes | Often | Almost Always |
| 1. Think about how sad you feel. | | | | |
| 2. Think “I won’t be able to do my job/work because I feel so badly.” | | | | |
| 3. Think about how hard it is to concentrate. | | | | |
| 4. Try to understand yourself by focusing on your depressed feelings. | | | | |
| 5. Write down what you are thinking about and analyze it. | | | | |
| 6. Think about all your shortcomings, failings, faults, and mistakes. | | | | |
| 7. Go away by yourself and think about why you feel this way. | | | | |
| 8. Think about how alone you feel. | | | | |
| 9. Think “There must be something wrong with me or I wouldn’t feel this way.” | | | | |
| 10. Think about how passive and unmotivated you feel. | | | | |

Note: To determine your score, add up your responses to all 10 items. Higher numbers indicate a more ruminative coping style. Source: Nolen-Hoeksema, 1991b, *Coding Guide for Responses to Depression Questionnaire*. Unpublished manuscript. Stanford University, Palo Alto, CA)

Several investigations have shown that individual differences in rumination are related to the duration and intensity of depression (for reviews, see Nolen-Hoeksema, 1991a, 1993). A study by Nolen-Hoeksema, Parker, and Larson (1994) provides a particularly compelling demonstration of this effect. These researchers studied 253 bereaved adults who had recently lost a member of their family to illness. One month after

the family member had passed away, participants completed a modified version of the questionnaire shown in Table 9.4 and a measure of depression. Depression was reassessed six months later. Family members who scored high on the rumination scale had higher depression scores six months later than did those who scored low on the rumination scale. [Nolen-Hoeksema and Morrow \(1991\)](#) found a similar effect when they looked at how people coped with a natural disaster—the 1989 San Francisco Bay area earthquake. These studies establish that people who dwell on their sadness experience unusually long and severe depressive reactions to events.

[Nolen-Hoeksema \(1987\)](#) has applied these ideas to understanding sex differences in depression. Women are nearly twice as likely to be diagnosed with depression as are men. Women also tend to stay depressed longer than do men. Biological, social, and cultural mechanisms may all be involved in these differences. Ruminative coping style may be another relevant factor. At least in Western cultures, women are socialized to attend to their feelings and to express and display their emotions more than men. This is particularly true when these emotions are negative. These differences may make women more susceptible to rumination when depressed. In support of this hypothesis, women are more likely to show a ruminative coping style than are men, and once these differences are controlled, sex differences in the duration of a depressed mood disappear ([Nolen-Hoeksema, Morrow, & Fredrickson, 1993](#)).

C. *Unwanted Thinking in Depression*

Nolen-Hoeksema's research treats rumination as a conscious mood-management strategy. Rather than distracting themselves with more pleasant thoughts, people with a ruminative coping style ill advisedly choose to dwell on their negative mood state ([Lyubomirsky & Nolen-Hoeksema, 1993](#)). A related possibility is that some people have difficulty suppressing negative thoughts. Try as they might, they can't quit thinking of their problems and of how bad they feel.

Of course, everyone has had the feeling of having a negative thought just pop into their head. "There's always something there to remind me" and "I see her face everywhere I go" are familiar themes expressed in popular love songs to capture the degree to which a lost love object seems to automatically come to mind. But like everything else, some people are better at putting such thoughts out of their minds than are others. Early in this century, [Freud \(1915/1957\)](#) argued that the ability to exclude unwanted negative thoughts from conscious awareness is a hallmark of mental health. This is accomplished unconsciously (through repression) and consciously (through suppression).

A study by [Wenzlaff, Wegner, and Roper \(1988\)](#) shows how hard it is for depressed people to keep negative material from coming to mind. These investigators had nondepressed and dysphoric participants imagine themselves as a protagonist in a story. The story ended when the participant accidentally killed an infant in a car crash. Afterward, participants were asked to write down any thoughts that came into their minds during a nine-minute period. Half of the participants were in the control condition and were given no special instructions regarding this task; the other half were in the suppression condition and were explicitly told to try *not* to think about the story they had just read. The experimenters then noted the number of times participants mentioned the story in each of

three, three-minute time periods.

Figure 9.9 presents the results from this investigation. The right-hand panel shows the results for the nondepressed participants. Notice that in both conditions, negative thinking declined rapidly between Periods 1 and 2 and remained at a low level during Period 3. Now look at the left-hand panel, which shows the data for the dysphoric participants. Two things are noteworthy here. First, in the control condition, negative thinking remained high throughout the nine-minute period. Second, although the suppression manipulation succeeded in reducing negative thinking between Periods 1 and 2, the dysphoric participants showed a rebound effect during Period 3. In fact, negative thinking during Period 3 was nearly as high for the dysphoric participants in the suppression condition as for the dysphoric participants in the control condition. These findings suggest that depressed people are able to keep negative thoughts at bay only for a limited period of time (see also, [Hartlage, Alloy, Vásquez, & Dykman, 1993](#)).

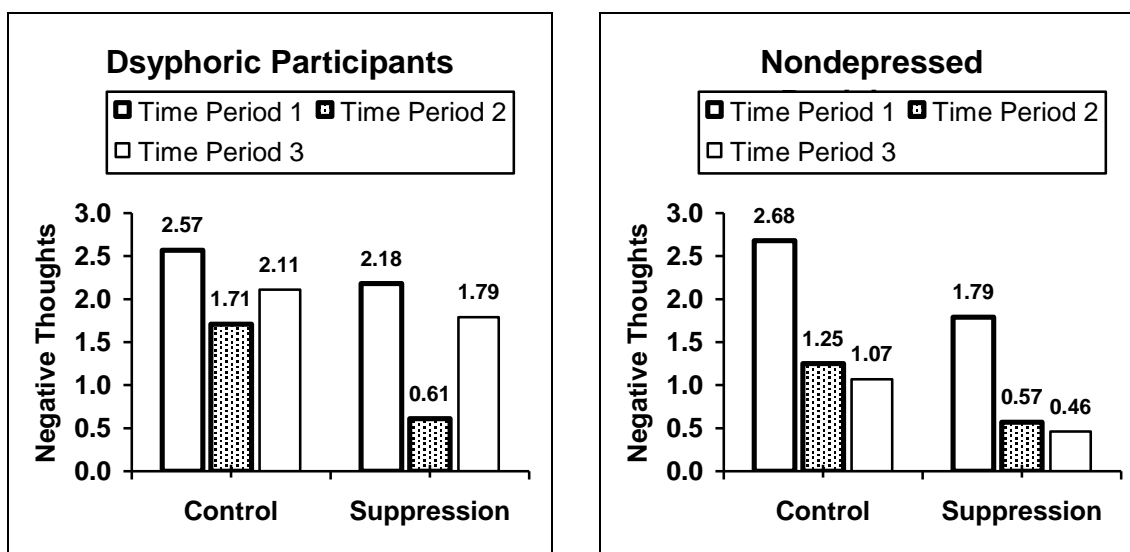


Figure 9.9. Suppression of negative thoughts in dysphoric and nondepressed participants. **The data show that dysphoric participants in the suppression condition were initially able to suppress negative thoughts but that negative thoughts returned after only a few minutes. This pattern of resurgence did not occur among nondepressed participants.** (Source: Wenzlaff, Wegner, & Roper, 1988, *Journal of Personality and Social Psychology*, 55, 882–892)

Learning to replace negative thoughts with more positive ones is a key element in recovery from depression. While this is a principal goal of virtually all therapeutic approaches to the treatment of depression, gaining control of negative thoughts plays a particularly prominent role in Beck's cognitive therapy of depression (Beck et al., 1979). Beck, you will recall, assumes that negative thinking is the primary symptom of depression. If it can be eliminated, the other symptoms of depression (e.g., intense sadness, sleep disturbances, and loss of interest in activities) will abate as well. For this reason, "the most critical stage of [Beck's] cognitive therapy involves training the patient to observe and record his cognitions" (Beck et al., 1979, p. 146). According to Beck, by carefully noting the conditions under which these cognitions occur, the patient begins to gain control over these negative automatic thoughts and eliminate them.

VI. Chapter Summary

In this chapter, we have explored factors that influence the onset and maintenance of depression. A good deal of material has been covered, from a variety of theoretical perspectives. Despite this diversity, there is general agreement on several important matters regarding the role of self-relevant processes in depression (see Figure 9.10).

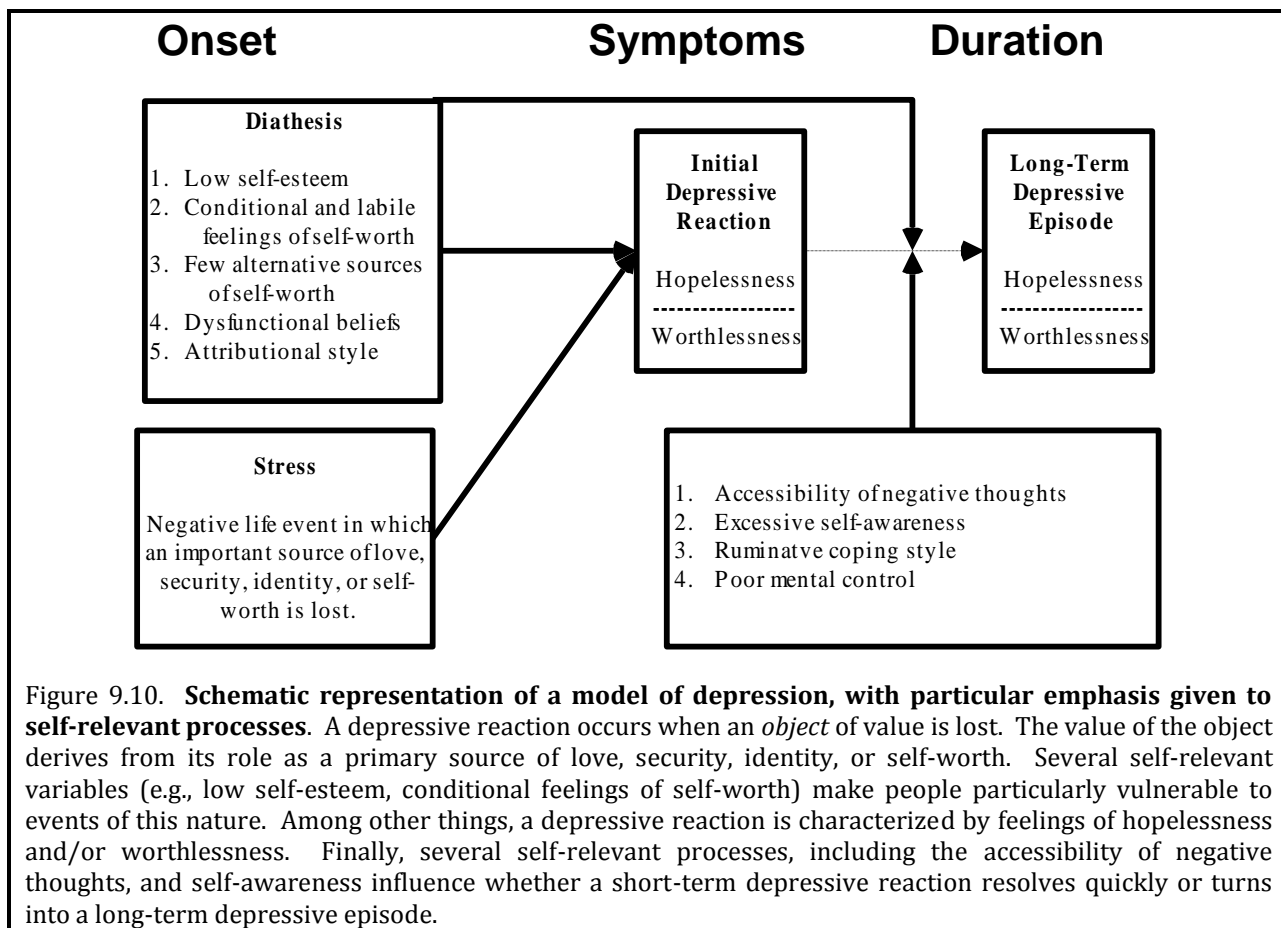


Figure 9.10. **Schematic representation of a model of depression, with particular emphasis given to self-relevant processes.** A depressive reaction occurs when an *object* of value is lost. The value of the object derives from its role as a primary source of love, security, identity, or self-worth. Several self-relevant variables (e.g., low self-esteem, conditional feelings of self-worth) make people particularly vulnerable to events of this nature. Among other things, a depressive reaction is characterized by feelings of hopelessness and/or worthlessness. Finally, several self-relevant processes, including the accessibility of negative thoughts, and self-awareness influence whether a short-term depressive reaction resolves quickly or turns into a long-term depressive episode.

First, self-relevant processes play an important role in the onset of depression. Depression can arise when an important source of love, security, identity, or self-worth is lost and there are few alternative sources of love, security, identity, or self-worth to replace it. Low self-esteem and conditional feelings of self-worth are thought to make a person particularly susceptible to events of this nature. Dysfunctional beliefs and attributional style have also been linked to the onset of depression.

Self-relevant processes also figure prominently as symptoms of depression. Depression is characterized by a negative view of oneself and one's future (i.e., by feelings of worthlessness and hopelessness) and a propensity to selectively notice and remember negative personal information. Negative biases in the interpretation of self-relevant events also emerge during a depressive episode. These effects seem to be unique to the processing of self-relevant information rather than affecting information processing in general.

Finally, self-relevant processes influence the severity and duration of a depressive episode. Depression is more extreme and more apt to linger among people who are highly self-aware and ruminate a lot about their moods. The ability to keep unwanted negative self-relevant thoughts outside of conscious awareness may also play a key role in recovery from depression.

- Depression is a common psychological disorder. Approximately one in eight people will experience a depressive episode in their lives. Most of these episodes remit in six to nine months, but in some cases depression can linger for years. Relapse rates are also high, as people who experience one bout of depression are at increased risk for experiencing subsequent bouts of depression.
- Most depressions arise in response to particular life events. These events involve losses in sources of love, security, identity, or self-worth. The death of a loved one, the break-up of an important romantic relationship, or a significant personal failure are common examples.
- Not everyone who experiences a negative life event becomes depressed, however. Certain factors make people particularly vulnerable to depression when a negative event occurs. These factors are called diatheses.
- Self-esteem theories of depression assert that low self-esteem is a vulnerability factor for depression. In support of this assertion, several studies with community samples have found that low self-esteem people are more apt than high self-esteem people to become depressed in the face of negative life events.
- Self-worth contingency models of depression argue that people with conditional feelings of self-worth are particularly vulnerable to depression. People with a conditional *interpersonal* orientation are susceptible to depression when they experience negative interpersonal events (e.g., break-up of an important relationship); people with a conditional *achievement* orientation are susceptible to depression when they experience negative achievement-related events (e.g., loss of a job).
- Beck's cognitive model of depression holds that depression is fundamentally a cognitive disorder, in which negative self-relevant thinking plays a primary role. When depressed, people view themselves, their world, and their future in highly negative terms, and selectively process and focus on negative personal information. These tendencies, in turn, account for other symptoms of depression, such as sleep disturbances, loss of interest in everyday activities, and depressed affect.
- Attributional models of depression assume that the explanations people give for the negative events in their lives are linked to depression. Depressed people are more apt to make internal, stable, and global attributions for negative life events than are nondepressed people. These tendencies may also put people at risk for developing depression.
- Depression is more severe and long-lasting when negative moods activate negative self-relevant thoughts. Depression is also more apt to endure among people who

are self-aware and ruminate about their moods. Finally, the ability to keep unwanted negative thoughts outside of conscious awareness contributes to recovery from depression.

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