

A STUDY OF ATTRIBUTIONAL STYLE IN DEPRESSION COMPARED WITH SCHIZOPHRENIC AND NORMAL PATIENTS

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SUMMARY

Seligman and his associates have advocated a particular attributional style in depressive patients. The present study aims at investigating attributional styles in depressive patients, in comparison to schizophrenic and non-psychiatric medical patients. A matched sample of 30 depressive, 30 schizophrenic and 30 medical patients was selected from out-door and indoor facilities of psychiatric centre and S. M. S. Hospital, Jaipur. All the patients were administered Seligman's (1981) attributional style questionnaire.

The results revealed that depressive patients have a specific attributional style in which patients attributed negative outcomes to internal, stable and global causes. The findings of this study are discussed in context with Seligman's theory of learned helplessness.

Individuals differ in the extent to which they are vulnerable to depression. When confronted with equivalent life stress, some persons become clinically depressed whereas others become mildly depressed or do not become depressed at all. There have been variety of approaches in explaining depression proneness in terms of genetics, biochemical, psychodynamic, behavioural and social models.

In the recent past, there has been increasing interest in the role of cognitive style as vulnerability factor in depression. It is widely believed that depressive patients attribute their failures to internal factors (i.e. self blame, negative body image, guilt, intrapunitive, use of introjection etc.) whereas successes are attributed to external factor (such

as luck and simplicity of task etc.). Weiner (1972) proposed that individuals tend to attribute their success or failure mainly to the four following causes; ability, effort, task difficulty and luck. These causes were classified on two dimensions: locus of control (later called locus of causality) and stability, within the first dimension ability and effort were considered internal, since they originate inside the person. Within the second dimension, ability and task difficulty were considered stable, since they do not change over time, while effort and luck were considered unstable, since they may fluctuate from time to time. These two dimensions were found to be important determinants of the individual's affective reactions cognitive reactions of expectations for future success, and behavioral reactions in achievement situations. In addition, a dimension of intentionality, referred to later as controllability, has been added to the model (Weiner, 1979). This dimension differentiates the causes in terms of the volitional control that the person has over them.

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Some causes are controllable, (e.g. effort), while others are uncontrollable (e.g. ability).

These dimensions are important in the understanding of affective reactions of pride and shame, to success or failure and the change in perceived probability of success for future outcome (Weiner, 1974). Thus, for example, individuals feel more pride when they attribute their success to internal causes. Also, attributions of failure to unstable controllable causes result in higher expectancies for future success than attributions to stable—uncontrollable causes. Furthermore, the type of causes individuals utilize to explain their successes or failures are important determinants of their achievement-related behaviour.

Weiner's achievement related behaviour model is part of the attribution theory, which attempts to understand naive—common—sense explanations of individuals with regard to the causes of events, of their own behaviour and of the behaviour of other people. The assumption is that understanding the attributions makes it possible to predict peoples reaction better. The foundations of attribution theory were laid by Heider in his extensive discussion of the phenomenology of social perception (Heider, 1944). The focus of the attribution theory is on the layman's analysis of causation. It is, therefore, important to examine the subjective causal explanations and their subjective meaning in order to be able to understand how they effect behaviour (Heider, 1958; Jones, 1972; Kelley, 1971 and Weiner, 1972).

Recently, Seligman et al. (1979) have proposed depressive attributional style. They have argued that three attributional dimensions are crucial in explaining human helplessness and depression, internal-external, stable—unstable and global—specific. Abramson et al. (1978)

speculated that individual differences should exist in attributional style and postulated the existence of a depressive style. Depression-prone individuals should tend to attribute negative outcomes to global, stable and internal factors. In addition, although not specifically predicted by the reformulated helplessness model of depression, attributing good outcomes to external, specific, and unstable factors might increase vulnerability of depression.

There are three important studies which have examined attributional patterns in depressed and non-depressed college students. Rizley (1978) found that depressed students viewed internal factor as more important in causing their failures on a member-guessing task than did nondepressed, students. Similarly, depressed students viewed external factors as more important in causing their successes on the task than did nondepressed students. In line with Rizley's findings, Klein et al. (1976) reported that depressed students tended to attribute failure on discrimination problems to internal factors, while nondepressed students tended to attribute failure on the problems to external factors. Finally, Kupier (1978) found that on a word-association task, depressed students attributions for failure were more internal than nondepressed students attributions for failure. Contrary to expectation, the attributions of depressed and nondepressed students did not differ for success.

In another study by Seligman et al. (1979), where depressed college students were compared to non-depressed college students, it was found that depressed students attributed bad outcomes to internal, stable and global causes as measured by an attributional style scale. In addition, depressed students attributed good outcomes to external and

unstable causes.

All these studies were done on mild depression found in student population. Any attempt to generalize from mild depression to clinical depression is hazardous because the two phenomena may be different in kind not in degree. Thus studies on depressive attributional style need to be tested in clinical depression. Furthermore, whether this style is specific to depression alone or other psychiatric patients (such as schizophrenia etc.) needs to be further examined. Such a study was conducted recently by Raps *et al.* (1982). This study revealed that unipolar depressed male patients ($n=30$) were more likely to attribute bad outcomes to internal, stable, and global causes than were nondepressed schizophrenics ($n=15$) and nondepressed medical patients ($n=62$). The depressed patients were more even handed in their attributions for good versus bad events than the other patients. These results support the existence of the depressive attributional style in clinical depression postulated by the reformulated learned helplessness model and indicate that it is not a general characteristic of psycho-pathology. This hypothesis of depression has not been tested in Indian contexts. Therefore, the present study aims at investigating attributional style in depressive patients in comparison to schizophrenics and nonpsychiatric medical patients.

Sample

A group matched sample of (Age, sex, education, onset of illness) 30 depressives, 30 schizophrenics and 30 non-psychiatric medical patients were selected from outdoor and indoor facility of psychiatric center and S. M. S. Hospital, Jaipur. All the patients were males. The mean age of depressives, schizophrenics and medical patients was 32 years, 25 years and 30 years respectively. All

the patients were educated upto high school or above. They belonged to middle class socio economic status.

Tools

All the patients were administered Attributional Style Questionnaire (Seligman, 1979). It consists of questions on 12 hypothetical situations. Half of the situations are good events; half are bad events. Of the 12 situations 6 had an affiliation orientation and 6 had an achievement orientation. Thus, the scale consisted of four subscales (i) achievement situations with a good outcome (e.g. you apply for a position that you want badly, such as an important job, etc. and you get it). (ii) achievement situations with a bad outcome (e.g. you have been looking for a job unsuccessfully for some time). (iii) affiliation situations with a good outcome (e.g. you meet a friend who compliments you on your appearance); (iv) affiliation situations with a bad outcome (e.g. you go out on a date, and it goes badly).

For each situation, the subjects were asked to name the one major cause of the outcome described. The subjects then rated each cause on a 7 point scale how important each situation would be if it happened to them.

Results

Table 1. presents the mean attributional-style scores of three patient groups for six attributional measures (internal, stable and global means both bad and good events). F values from the appropriate univariate ANOVAS was computed on the specific scores, using patient group as the classification factor. Results indicate that depressive patients attribute their bad events (failures) much more to internal, stable and global causes than their schizophrenic and medical counterparts. Furthermore, depressive

Table 1. *Mean Attributional-Style Scores for Patient Groups*

Event	Depressives (n=30)	Schizophrenics (n=30)	Non-psychiatric Medical patients (n=30)	F (2, 87)
Bad ⁺				
Internality	5.43 (1.22)	3.80 (1.88)	4.26 (1.89)	6.85**
Stability	5.36 (0.95)	4.40 (1.58)	4.76 (1.54)	3.58*
Globality	5.30 (1.21)	4.56 (1.74)	3.96 (1.88)	4.79*
Good Internality	4.00 (1.26)	5.20 (1.92)	4.63 (1.90)	3.52*
Stability	4.16 (1.13)	5.50 (1.05)	5.00 (1.15)	10.65**
Globality	4.43 (1.47)	5.63 (1.17)	4.76 (2.15)	4.08*

Note: Figures in parentheses are standard deviation.

+ Means of 7-point scales; higher scores indicate greater internality, stability and globality.

* $p < .05$, ** $p < .001$

patients attribute their goodevents (successes) much more to external, unstable and specific causes than schizophrenic and medical patients.

Table 2 and 3 provide pairwise differences on mean attributional scores both

for bad and good events. Relative to both comparison groups, the depressive patients tended to offer more internal, stable and global attributions for bad events. Relative to the schizophrenic patients (but not to the medical patients),

 Table 2. *Pairwise differences on Mean Attributional Style Scores for Patient Groups (Bad Events)*

	Mean Difference	t	p
<i>Internality</i>			
Dep. Vs. Schizo.	1.63 (5.43-3.80)	3.70	<.01
Dep. Vs. Med.	1.07 (5.43-4.26)	2.65	<.01
Schizo. Vs. Med.	0.46 (3.80-4.26)	1.04	n. s.
<i>Stability</i>			
Dep. Vs. Schizo.	0.96 (5.36-4.40)	2.66	<.01
Dep. Vs. Med.	0.60 (5.36-4.76)	1.66	n. s.
Schizo. Vs. Med.	0.36 (4.40-4.76)	1.00	n. s.
<i>Globality</i>			
Dep. Vs. Schizo.	0.74 (5.30-4.56)	1.72	n. s.
Dep. Vs. Med.	1.34 (5.30-3.96)	3.11	<.01
Schizo. Vs. Med.	0.60 (4.56-3.96)	1.39	n. s.

Table 3. *Pairwise Differences on Mean Attributional-Single Scores for Patient Groups (Good Events)*

	Mean Differences	t	P
<i>Internality</i>			
Dep. Vs. Schizo.	1.20 (4.00-5.20)	2.66	<.01
Dep. Vs. Med.	0.63 (4.00-4.63)	1.40	n. s.
Schizo. Vs. Med.	0.57 (5.20-4.63)	1.26	n. s.
<i>Stability</i>			
Dep. Vs. Schizo.	1.34 (4.16-5.50)	4.62	<.01
Dep. Vs. Med.	0.84 (4.16-5.00)	2.89	<.01
Schizo. Vs. Med.	0.50 (5.50-5.00)	1.72	n. s.
<i>Globality</i>			
Dep. Vs. Schizo.	1.20 (4.43-5.63)	2.79	<.01
Dep. Vs. Med.	0.33 (4.43-4.76)	0.76	n. s.
Schizo. Vs. Med.	0.87 (5.63-4.76)	2.002	<.05

d. f. = 58

depressive patients tended to offer more external, unstable and specific attributions for good events.

Discussion

The main finding of this study is that depressive patients have a specific attributional style for their failures and successes in comparison to schizophrenics and medical patients. Depressive patients made much more internal, stable and global attributions for bad events than did non-depressed medical and schizophrenic patients. Thus, this attributional style is not characteristic of schizophrenics and only belongs to unipolar depressives. This finding is in line with the recent study done by Raps *et al.* (1982).

With regard to attribution of depressive patients for good events it was observed that these patients tended to offer more external, unstable and specific attributions. However no significant difference was found in depressives and medi-

cal patients on internality and globality for good events.

It can be concluded that unipolar depressed patients perceived the causes of bad events as much more internal, stable and global than non depressed, schizophrenic and medical patients. Such an attributional style predisposes individuals to depression and maintains depressive symptoms once they are present (Raps *et al.*, 1982). Implication and utility of this study is that interventions to change this depressive attributional style may be of great value in the therapy of depression.

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