A COMPARATIVE STUDY OF DEPRESSION BETWEEN KOREAN AND SCOTTISH MOTHERS AT THEIR TWO IMPORTANT LIFE-STAGES

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Submitted for the Degree of Ph.D.
at the University of Glasgow

Department of Psychology
1990

ACKNOWLEDGEMENT

I wish to express my gratitude to Dr. Gisela Dimigen as supervisor of this thesis for her advice, encouragement and patience during the course of this study.

I am grateful to Aileen, Anna, Chung-ja, DeeDee, Erica, Isobel, Mary, Maureen, Pamela, and Ruth for their friendship and support.

Finally, I wish to share my work with all the mothers who participated in this project with the wish that it can take a small part in promoting a better understanding of their lives.

I cannot close the work without mentioning the love and suffering of my family.

SUMMARY

This is a comparative study of the depression experienced by Korean and Scottish mothers at two life stages: the postnatal stage; and the stage where the child is ready to leave secondary school education. The study investigates:

(1) differences in depression scores between the two life stages as well as between the two cultures;

(2) the relationship between depression and (a) the attributional style of mothers in respect of matters concerning their child, (b) social support system, (c) recent life events;

(3) how these relationships vary with the life stage of the mother and cultural influences, and

(4) what is the most important related factor of depression for these mothers.

The study is based on a sample of 361 middle class mothers (216 Korean and 145 Scottish mothers).

Depression was assessed by using the Beck Depression Inventory (1978), while attributional style was measured by using the Mother's Role Questionnaire which was specially designed for this project. The social support system was measured by the Social Support Inventory which was also designed specifically for this

project. Life events were assessed by using the relevant part of the Miller's Coping Schedule (1987), which was also revised for the purpose of this research.

Main results

A. Depression:

(1) Within each culture there were no significant differences in the levels of depression experienced by the mothers at the two life stages sampled.

(2) Cultural differences in depression were found:

(a) Korean mothers, at both life stages, showed significantly higher total depression scores than did their Scottish counterparts.

(b) Korean mothers showed significantly higher scores overall items in the Beck Depression Inventory not only somatic scales but also cognitive-affective ones.

B. Relationships between depression and independent variables:

(1) a) A significant relationship between the social support system and depression scores of mothers was found. This was particularly notable in the case of the support received from other people.

b) Cross-cultural sub-groups showed significantly different support systems.

i) Support systems were more highly related with the depression scores of the Scottish than the Korean mothers

ii) Overall areas of the support systems related better with depression scores of the Scottish mothers, whereas practical help did for the Korean mothers, especially for the old Korean group.

iii) The spouse was identified as the most important and effective supporter for both the Scottish groups of mothers and the young Korean mothers.

(2) Although Korean mothers attributed internally and Scottish mothers attributed externally, the relationship of depression with attributional style was not significant.

(3) The number of recent life events showed significant, yet low correlations with depression scores. However, no specific type of event showed a significant relationship to depression.

(4) For the Korean mothers, the social support system was the only factor which was significant to the

depression. With the Scottish mothers (especially the old group) the attributional style and number of recent life events were important as the social support system.

These results were discussed and the theoretical implications were considered.

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CHAPTER ONE

INTRODUCTION

Depression and its relationship to physical and mental well-being has been a topic of interest and discussion for a long time. There are two main approaches to the study of depression: biomedical and psycho-social. The biomedical approach to depression has involved the study of severely disturbed psychiatric patients, which composes a small proportion of the general population. Caution is therefore required when investigating depression in the general population. We can investigate whether internal and external factors are related to depression, irrespective of the physical changes involved. Psycho-social perspectives emphasise the interactional processes of internal and external resources of a person which is more appropriate for the investigation of depression in the general population.

According to psychoanalytic tradition, the main source of "melancholia" - depression in their terminology - was a "loss" or "deficit" of a loved object (Freud, 1917). Since then most psychologists have employed the concept of "loss" in one form or another. The behaviourist approach shares this same idea of "loss" or "deficit" in proper positive reinforcement

(Lewinsohn, 1970, 1986). The cognitive explanation of depression, too, proposes that the main factor in an individual's "vulnerability" (Brown et al., 1978) or lack of "hardiness" (Kobasa, 1979, 1982, 1985), is the loss or deficit or either external or internal resources.

It seems clear that depression cannot be fully explained in purely intrapsychic terms. Rather the explanation lies in a range of external factors along with the interaction between internal and external entities. In recent years there has been growing interest in some of the factors which might contribute to depression: 1) attributional style (internal factors); 2) social support systems (external resources); and 3) life events. Some studies have shown that attributional style is related to depression (Abramson et al., 1978; Seligman et al., 1987). Social support systems have been acknowledged by many studies as having negative relationships with depression (Cohen et al., 1985; Sarason et al., 1986), while stressful life events have been related to depression since Holmes et al.'s (1976) study.

Since depression has been associated with the process of interaction between a person and his or her environment, a cross-cultural study may contribute

important insights into the understanding of depression (Hinkle et al., 1982) where a culture provides the natural setting for this interaction. Yet most of the studies of depression have adopted an intra- rather inter-cultural approach, often comparing minority ethnic groups with a majority Caucasian population.

To date there appears to be no studies which compare a European and un-related Asian population on depression in relation to life events, attributional style, and social support systems. This study observes people from different cultures who are experiencing certain life-events, their differing attributional styles and external resources (social support), and relates these variables to levels of depression. It is expected that different reactions will be found due to perceptions of the same kind of event varying between people who have different backgrounds and cultures.

Depression in women has attracted much attention because of the large numbers of women, (as opposed to men), who seek help for depression. It is estimated that for adults in industrialised countries, depression is twice as common in females as in males (DSM-III-R, 1989). Furthermore, the differences in depression rates between married women and single women raises the issue of "strain - depression" among married women (Aneshensel, 1982, 1986).

Yet this issue of the role of motherhood in the high incidence of depression has largely been ignored. Mothers have been the target of study mainly in terms of their influence on their children's well-being (Parker, 1983; Rutter et al., 1987), while the impact that children have on their mothers' health has received little attention. Once the focus is transferred from motherhood as an instrument for the child's well-being to the mother as an individual, it becomes evident that there is a necessity to consider the reverse process, namely the influence of the child on the mother. There are several studies which pay attention to mothers around the childbearing stage, such as Atkinson et al. (1984); Bennett (1981); Cutrona et al. (1982, 1983); and Grossman et al. (1980). Although on-going difficulties in the lives of mothers' with young children were highlighted as a vulnerability factor in depression (Brown et al. 1978) they have received far less attention.

The mythologised mother's role expectation (Badinter, 1981) influences the mother herself in carrying out her role, and also the expectations of other people who expect her to act accordingly. Therefore, cultural differences in a mother's role expectation can create different degrees of stress. One can also expect to see a cultural influence on mothers in terms of both

the internal and external resources they have available to cope with this stress. For instance, some stages of motherhood are more stressful in one culture than in others. We might find some relationships, such as family members or friends are more important as external resources serving a support function than the relationship with the spouse in other cultures. It would be worthwhile to observe the consequences of these in terms of the depression experienced by mothers and the relationship to both internal factors (mothers' perception of stress at certain life stages and their attributional styles) as well as to the effectiveness of their external resource mobilisation (social support system).

However, this research does not intend to compare the different phenomena between cultures, but rather to find the common processes and principles behind the observable differences or similarities. This study accepts the importance of the function of perception throughout the stress process, and the fact that perceiving stress and reacting to it is not possible in a vacuum, free from the person's cultural background.

1:1 Identifying problems:

This study compares the depression scores of Korean and Scottish mothers who are experiencing comparable life events. Two main stages were selected where signs of depression have been widely reported: 1) the postnatal stage of motherhood (which has been particularly highlighted in western societies, and virtually unknown in Korea); and 2) the stage where a child is ready to leave secondary school education (which is clearly noted in Korean society, yet fairly unknown in western society).

It is expected that Scottish and Korean mothers will show their attributional style in the way they treat the affairs and concerns of their children. It is anticipated that Scottish mothers will attribute in an "individualistic" way while Korean mothers will adopt a more "inclusive" or "collectivistic" approach (for a full discussion see pp.41-46). These can be thought of as "external" and "internal" attributional styles respectively. It may also be the case that the external resources available to the mothers differ in terms of functioning and quality.

This study investigates whether either stage of motherhood in the cultures (Korean and Scottish) bears

any relationship to depression. A further aspect of investigation concerns the mothers' relationship with: a) attributional style (internal factors); b) social support system (external resources); and c) life events (perception of external events).

1:2 Focus of the study:

The primary objectives of the study are the following:

(1) to investigate whether there are any differences in depression between the two life stages tested;

(2) to investigate whether there are any differences in depression between the two cultures;

(3) to analyse the relationship between depression and several other independent variables such as:
   a) attributional style and depression;
   b) social support system and depression;
   c) life events and depression; and
   d) most important to depression among the related variables, i.e. attributional style, social support system, and life events.

The secondary objective of this study is to compare Korean and Scottish mothers at both stages regarding:

(1) attributional style

(2) social support system

(3) life events.

1:3 Methodology

The objectives of the present study demand the comparison between Korean and Scottish mothers in two different life stages- namely the postnatal stage and the stage when the child who is ready to depart from secondary education. The total number of subjects who participated in the study were 362 (217 Korean mothers and 145 Scottish mothers).

For the collection and analysis of the data we relied on quantitative (i.e. : "etic" approach) and qualitative methods (i.e. "emic") (Stein et al., 1986). Five different questionnaires were used for measuring five different variables in this study: 1) "Personal Data questionnaire" for the personal and family background information; 2) "Beck Depression Inventory" (1978) for depression; 3) "Mothers' Role Questionnaire" for attributional style; 4) "Social Support Inventory" for social support system; and 5) "Life Event Questionnaire" for life events.

1:4 The Structure of the study

This study is divided into seven chapters. The first chapter, "Introduction", covers the main objectives of the study, and briefly introduces the method and format of the study. The second chapter "The Life of the Korean Mother" reviews the socio-cultural background and life of the Korean mothers. The third chapter deals with the theoretical perspectives of depression. Chapter four covers the theoretical basis of the other variables in the study - that is attributional style, social support system, and life events. The fifth chapter discusses the hypotheses of the study, and documents the methodology behind the study. The results are in the chapter six, and discussed and explained fully in chapter seven. Case studies are appended.

CHAPTER TWO

THE LIFE OF THE KOREAN MOTHER

Introduction

This section will review the socio-psychological background of the Korean mother. Brief background information concerning traditions, value systems, family life, the position of women in society, the education system, and the attitudes and mental health of mothers in Korea will be covered. These aspects will be compared with the Scottish mother's life (i.e. western life styles). Characteristics of Korean mothers' lives will be emphasised in relation to the present situation.

2:1 Background Information Concerning Korean Life

Korea's geographical location is in the Far East from the Western point of view, and is a small penisula located between China and Japan. For about five thousand years Korea has struggled to exist as a homogenous society. The Republic of Korea (South Korea) is one of the most densely populated nations in the world. The capital city, Seoul, has the highest population density in the country: over 10 million people now live in this industrialised city.

The last Yi dynasty was founded on Confucianism, and it adopted Confucianism as the state cult. Its influence on Korean life is evident up to the present time. The residual influences from Confucian ideology cannot be erased from the Korean character. Therefore, we have to mention briefly some of the main points in Korean Confucianism which are relevant to the mother's well-being.

Firstly, Confucianism has a patriarchal value system which is based on filial piety. The head of the extended family is the first born male and he occupies a central position in the extended family. His role includes being the family representative and supervisor, responsible for the family wealth, and the performance of rituals. The position carries considerable prestige but is a heavy one, with the idea of the family as a model for all other social institutions in the nation. For instance, the political leader (eg. king) perform the role of father and the people are his children.

Secondly, Confucianism emphasises the importance of blood ties. An individual is not just an individual, but a person who is the son or daughter of the parents, grandchild of the grandparents, and so on back to ancient ancestors in the past and to future descendants

ahead. The members of the family are interdependent and form an especially tight knit in-group from which others are excluded.

Thirdly, Confucianism promotes a strong preference for male children. Women believe it essential to have a son who will carry on the family line. Traditionally, failing to bear a son was one of the seven legitimate reasons a wife could be expelled from the family. This left such women with virtually nowhere to go. They could not return to their own family as a married daughter was considered a stranger because, after marriage, she was considered to belong to her husband's family until her death.

Since Confucianism's main focus is the family, a woman's life starts with marriage, bearing a child (preferably a son), and nurturing him, and this situation of Korean women has been well documented by Korean social scientists (Choi, 1977; Lee, 1986; Lee, 1968; Park, 1975; Park, 1979; Yoon, 1986). In general they conclude that men in Korea enjoy a prestigeous status whereas women are seen as being in an inferior position, carrying out insignificant domestic tasks in an isolated world. This picture of Korean women is not really an accurate one since many studies tend to view the facts out of context where interpretation is

coloured by western standards and ideals. For instance, because of the emphasis Confucianism places on the family the homemaker's role is considered an important central one, with heavy responsibilities as compared to work outside the confines of the family. Confucianism makes the gender role differentiation very clear; Oriental philosophy of 'yin' (陰 :shadow, female) and 'yang' (陽: light, male) does not allow the dominance by one over the other, rather it emphasises harmonious co-existence which is symbolised in the national flag of Korea.

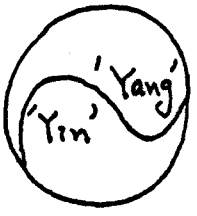

Fig. 2-1: 'yin' and 'yang' in the flag

Yoon (1986), for example, wrongly interpreted the "oriental idea" because of her western way of thinking. She used a Korean proverb, "the male is a seed and the female is a field" to explain female passivity and seeming inferiority yet she over looked the positive characteristics of the female role as the "soil" which is upheld in Confucian tradition.

This idea of "dominant - subservient" is a relatively new one and has evolved as a result of the new western style education system, based on individual competition which was introduced into Korea during the last century. The traditional value of the female role disappeared under the influence of the new educational system by minimising the function of education through family.

In actual fact there has been no distinction between the respect given to both men and women from, for instance, the junior members of the society. Similarly there is mutual respect between husband and wife and both are respected as parents and as elders in the society. As a woman earns her credentials, she experiences no handicap if she wishes to be a leader of the society. For instance, it is interesting to note the remarkable differences in the numbers of female priests of religions that originate in the East and those of religions transmitted through the West. For example, female priesthoods are Buddhism - 40.2%, Zen-Buddhism - 74.4%, Cheondoism - 38.6%, and in other less widespread religions - 59.3%, as compared to Christian Protestantism - 3.4% and Catholicism there are none (Ministry of Cuture and Information, 1984). This would indicate that women find it easier to perform this role in Eastern rather than in Western culture.

2:2 Family life

1. The Husband and Wife Relationship

In traditional terms, the primary goal of marriage is to produce many offspring, particularly males who will perpetuate the patriarchal family system. Patriarchal kinship laws regulate marriages and underpin the relationship between man and wife. According to the oldest Korean book to promote proper conduct among housewives 'Nae hoon' (內訓, 1475) written by Queen So-hae in Yi period, marriage should be seen in terms of a 'good' tie between two families rather than the relationship between the individual man and woman. The Korean custom of a woman keeping her family name after marriage can thus be understood in these terms, rather than as an individualistic feminist right. According to this ancient book, the main object of marriage is to perform the proper sacrifice for the ancestors and to continue the family line by producing offspring.

The criteria for the selection of spouses are personality and conduct as well as having received a proper teaching about the traditions within the original families. Selection of the daughter-in-law is considered very important because she is the one who is responsible for the whole of the domestic life. Having

been well brought up in a similar family background is considered a more reliable factor for the selection of a spouse than either wealth or social status. Daughters about to be married were well prepared for their new lives with their parents teaching them to: "be careful and always respect your parents-in-law and never disobey them"; "be diligent day and night so that you never miss any tasks at home" (Nae hoon, p. 73-74).

Changes have proceeded more or less in the direction of people choosing their own partners. However, even when choosing their own partners, parents still excercise a considerable influence by approving their choice. For the foreseeable future, it is probable that marriages based on the joint decision of two generations will continue (Lee, 1986).

Traditionally, husband and wife have clearly differentiated roles. The basic assumption is derived from 'yin - yang': female and male are different, therefore, a proper relationship between husband and wife should be based on an acceptance of this difference. A man was not supposed to know or interfere in home affairs. He was expected to recognise his wife's right to make decisions concerning homemaking. The word 'couple', "nae-oe" (내 외),

literarily translates as 'inside-outside', which means that a couple were not seen in public together, and lived separately 'inside the home' and 'outside the home'. The house structure was designed in such a way that the places where each spouse stayed was separate: the husband lived, entertained and conducted business in an outer quarter of the house, while the wife stayed in an inner quarter. The high wall and gate between the inner and outer areas prevented free contact.

This custom is not strictly observed in contemporary Korean society, but the words "inside person" (안 사람) which indicates "wife" and "outside person" (바깥 사람) which indicates "husband" are still commonly used. The contemporary wives' role is still kept quite independent from the husbands', and the control they have over family finances cannot be overemphasized. It is the wife who decides how the husband's salary will be spent and, generally speaking, she would not consult him about a purchase, no matter how big or small. For instance, typically Korean wives buy their houses without their husbands' approval: in some cases husbands do not even know about the newly purchased house until the day they move in.

The ideal wife is patient, generous, and more considerate than her husband, and this enables her to

carry out all matters without her husband's help or advice. Still when offering advice about her husband's conduct she should do so "with soft touch" (Nae hoon, p. 82). Playing the role of wife is a most difficult task, and is only successfully performed through very hard work (Nae hoon, p. 87).

It is accepted that the conjugal relationship will change and develop during the course of the marriage, due to such factors as having children and ageing. Once a woman becomes a mother, her power as a mother becomes almost absolute in the traditional family. The wife is treated as an equal object of filial piety, side by side with the husband. Traditionally, the proper way of addressing each other as husband and wife is in the form which denotes respect. Recently there have been changes in this with either the husband dropping the ending which denotes respect (brought about by the Japanese influence), or both parties dropping the special honorific endings. This latter aspect, originates from the western idea of equality between the sexes. However, the ideal way of talking between husband and wife is still to use mutual honorific endings.

Another aspect of the traditional type of conjugal relationship is more role performance oriented where

Kim (1987) referred to it as 'task-oriented relationship'. The exemplary wife was responsible for her husband being a respected member of society and for his success in economic and political life. The husband's success or failure is therefore attributed to the wife who is praised for positive outcomes and despised for negative ones. Several mythological fairy tales and historical stories from Korea demonstrate the practical codes of conduct for wives. Many stories describe how hard women work for their families success where the wife sacrifices to help her husband succeed in society. For instance, mixing with the 'right' people, helping with, or raising money for, a business venture, taking over some of the family responsibility, and praying. Prayer plays a central role in this effort many women pray every night at church for their husbands'success. They recognise that they cannot control everything and so "lean on" a superhuman power.

Expression of emotion and affection has been comparatively suppressed in the traditonal marriage. Marriages were arranged by the matchmakers, who knew both of the families well, and the decisions were taken by the elders in the family. The contracting parties in a marriage have usually never seen each other before the actual wedding night. It is natural

for them to start their new life without any emotional affection of love which westerners think essential in their marriage. The marrying couple expect that emotional intimacy will grow naturally in everyday life throughout their long life together. Even if they cannot build up affectionate emotion in the marriage, as long as each party performs his/her role properly, the marriage can be stable in the traditional family. There is the fundamental rule to be observed by every married man, that, "one should respect his wife who has shared his adversity" (조강 지처). The man who divorces a wife who has shared and overcome family difficulties and poverty, is considered unacceptable and unfaithful (by using the expression "less than an animal"). This remains true in contemporary society.*

Although the new generations still have sympathy with the former ways, recent trends in marriage, based

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* A woman with experience of a modern education in both Korea and America, now a permanent American resident, tells the true story of her grandmother who lived with her eldest son's family, away from her husband, after he went to live with his concubine until the remaining last short span of her grandmother's life. Even though the other woman enjoyed a passionate life with her grandfather, she never had status. Whereas her grandmother was considered wise and right to endure the hard life with dignity, until her grandfather returned to his loyal wife, restoring her life fully in every way.

on western ideals, mean that married couples nowdays expect more from each other emotionally. However, they are not brought up to show the mutual affection and appreciation which promotes this emotional intimacy and when their expectations are not met, as is often the case, they run the risk of dissatisfaction.

If the wife could not bear a child, there were two ways, traditionally, to cope with this difficult situation. One way was adoption among the same blood family, selection usually being sought among young nephews. The blood tie is so important in emotional as well as in practical terms - such as similar characteristics inherited within the family physically, psychologically, and socio-culturally - that it is considered risky to adopt a stranger. It was believed that some day the adopted child would look for his own natural parents and turn away from the adoptive parents. Despite the strong emphasis on traditional blood ties it is now the case that childless couples adopt unwanted infants, but still disguise it as their natural baby to the outside world.

Another ancient way of solving the problem of childlessness, which is no longer in use and illegal, is the method of adopting a substitute wife or husband for the couple. Usually they tried a substitute wife

first, and if it did not work out then, on very rare occasions, a substitute husband would be sought.

2. The Parent and Children Relationship

The parental role is to teach and rear the children. To do so parents should not follow their natural love for their children, rather they have to teach them proper conduct. The mother is especially responsible for the behaviour of her children. Korean tradition does not believe in inborn traits, but rather believes in the impact of nurture. They say "you make a person" which means one raises a child. Mischief on the part of children is considered the consequence of bad teaching by the mother.

It is still believed that filial loyalty is the key factor in the traditional parent-children relationship. And while it is true the children are expected to show total obedience to them, this filial loyalty is not forthcoming without tremendous life-long input from the parents.

Filial loyalty is obligatory for the children but until they reach the point of being parents themselves children can hardly be aware of what real filial piety

means.*

It is almost impossible to find people who practice the original teachings of filial codes and ritual formality today, but the essence is identical even though it may differ in practice. The traditional codes are based on the idea that the child belongs to the parent totally. For instance, one of the strict codes was that when the father died, the son was supposed to mourn by staying at the grave side three or five years without proper meals or living accomodation. It is still true that children stay in the parents' home until they get married. In some cases, even after marriage, the son is not allowed to go abroad to study or work, because he must stay with his elderly parents. The ideal living arrangement for elderly people is that they live with the eldest son, in his home, as one family. If this is not possible for some inescapable reason, any other arrangement will be thought of as strange and all of the family members will feel uneasy about it.

Industrialisation and social change have led to

* There are a number of sayings that demonstrate this: "it is not possible to be a real filial child before being a parent oneself", "parent makes filial child of one's own", and "love flows like water from high places downward" i.e. the filial relationship is not mere loyalty from children to parents, but it's origin comes from parent's sacrificial love.

increased mobility among young people and a living away from the parents' is on the increase. According to the Economic Planning Board report (1960, 1966, 1970, 1975, 1980), the 'two generation households' increased from 63.9% in 1960 to 68.5% in 1980, whereas the 'three or more than three generation household' decreased from 28.6% in 1960 to 17.0% in 1980.

However, unlike the western nuclear family, physical or geographical distance does not create psychological distance between generations in Korean families. For example, even after children have set-up their own homes away from their parents, they still have automatic and unconditional rights of access to the families' wealth, resources and support if they need it. The support - practical, emotional and material - that family members receive from each other is so much taken for granted that no one expects to show or receive an explicit appreciation for it.

Despite all the changes in contemporary Korean society, traditional family ties remain. The 'inclusion'* relationship of mothers with their children is still a life-long one even for the seventy year old son and

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* The concept of "inclusion" will be discussed in section, pp.41-46.

his mother in her nineties.

The Different Treatment of Boys from Girls

Traditionally boys and girls were treated differently because of their gender role differentiation. Boys were prepared for future participation in outside society according to the social strata they belonged to. Girls were trained for the future role of undertaking family matters. Contemporary Korean society does not constitutionally limit females from participation in every field of society at all levels. We cannot deny, however, that there is institutional discrimination against female participation as well as a lack of readiness and motivation among the female population as of yet (Park, 1984). Yet this is changing.

Increasingly, Korean women aspire to paid jobs as well as their work at home. All mothers keep in mind both possibilities for their daughters. They put as much effort and emphasis on girls formal education as for boys. Girls are allowed the same amount of time for study, and mothers expect them to be as competitive as boys in achieving academic success. Formerly, girls were expected to spend a certain amount of time on household chores, but nowadays mothers feel their

daughters can develop these skills after they marry. It is no longer the case that Korean girls are expected to do household chores at the expense of their formal education.

Traditionally there has been a boy-preference in Korean society, but the government's policy to curb population growth is changing that. Since the 1960s, couples have been encouraged to have no more than two children, and there are now more families without boys than before. It is inevitable, therefore, that daughters in the "girl only" families are being treated as sons would be, where the daughters would take over the role a son would be traditionally expected to do. Parents invest time and effort for a daughter as much they would do for a son.

Other Social Relationships

The range of relatives is wide, but important, because they all share common ancestors. It is an important task for women to maintain good relationships among them. It is considered right to show warmer concern towards relatives than towards one's own children: observing the rule of 'proper duty' before 'private affection'. This is not easy to do but is highly valued (Nae hoon, p. 172).

Relatives who maintain frequent and effective contacts may be considered almost like immediate family members, whereas relatives who rarely encounter each other are held at a distance. Depending upon the occasion, people include relatives by the degree of closeness. Traditionally, it is accepted a wife will neglect her own relatives when she takes on responsibility for her husband's relatives. But in reality, women feel more comfortable with their original families and tend to keep close natural support relationships. Women have the advantage of receiving support from two families: their husbands' and their original ones; from the former they have to earn it, from the latter they can take help and support for granted without any effort being required.

Koreans enjoy mutual support within "pseudo-familial groups" (Park, 1983), which can be formed by people who share common origins whether blood tie or cultural tie. For instance, friends as well as seniors and juniors in school or university, people from the same region, or who share the same family name.

It has been important to have good relationships with neighbours and friends of the same sex. Korean tradition does not believe in heterosexual friendship.

One of the traditional rules is that from the age of six, male and female should not sit together in the same room alone. There is a saying that "neighbour is cousin" which emphasises the importance of close interactions between neighbours.

People keep life-long friends usually from their school or university days. Once they make friends with each other, they can expect empathic support of any kind - practical or psychological - throughout their lives. Between loyal friends, conscious efforts do not have to be made to express affection or appreciation of any kind. Without any overt expression they know that they can count on each other in any situation when they are in need. Frequently, the close friends play a more significant role than family members or close relatives.

A traditional all female gathering which provides a legitimate outing for women to see their friends regularly is a "gye" (계)*, which is a get-together for a private informal banking, whereby women obtain large sums of money for their family needs. At the same time they can talk about their problems and

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* It has ancient origin in Korean history as community mutual help group. See Lee, K.B., New Korean History. (Seoul, 1964).

receive guidance from each other while having lunch together in a comfortable setting. Whatever activities women take part in they should always have direct or indirect connection with family welfare.

2:3 Education System

Korean people believe in the function and value of education in general. They think virtue and wisdom can be attained by learning and they respect learned people. One important reason for the high zeal for education can be found in Korea's historical tradition. In the old Korean system, governmental officials were selected through a state examination 'kwagoe' (과거), which tested the knowledge of Chinesc classics and the creative use of knowledge. Only people from literati section could try the examination, and they became the ruling class of the society. Therefore, providing education for your children is a most effective investment. You cannot lose your knowledge whatever may happen in a rapidly changing society.

The modern version of reading Chinese classics is associated with a good formal education. It is well believed by people that only a good education can guarantee their children's future security and success even though there are some unusual success cases who lack any formal education. It is considered far too risky to follow such unusual models. They have to take the safest way and cannot risk their children's future. Therefore, the university entrance examination which is controlled by the Department of Education in the state

government is comparable to the traditional state examination. The competition is more severe because it is open to everyone. Academic achievement, especially passing the university entrance examination is a most important matter, not only for the specific student, but for the whole family.

1. School System

Children start schooling at 6 years of age. They attend primary school for 6 years and go on to secondary education which comprises 3 years of middle school and 3 years of high school. By the time they reach the stage of entering university it becomes comparable with the stage of finishing secondary education in the U.K. The number of high school graduates who intend to go on to higher education is three times the number of university places available in Korea. The ratio becomes greater when account is taken of the pupils trying for entry for the second or third time. According to the report done by the Ministry of Education (1986) the advancement rates of high school graduates into university or college are 32.6 % among female and 39.7 % among male. Up to this level of education there are no differences between the male and female populations.

Some sex-differences are noticeable in choosing major subjects with the male dominated subjects being engineering (31.5% vs. 2.8%) and social sciences including law (27.9% vs. 9.7%), whereas females prefer education (27.7% vs. 7.2%), art /music (12.3% vs. 1.8%), language /literature (19.7% vs. 9.3%) and science (15.1% vs. 7.3%) (Ministry of Educaiton, 1983). The subjects which males choose are vocationally oriented towards industry or government, or law.

There is, in practice, institutional discrimination against women in the job market (Park, 1984). This frustrates women who want to work. Discrimination includes: large differences in pay scales (average income of women is only 48.3 % of that of men); separate regulations concerning marriage, child birth and related matters (eg. women should resign when they marry or have children); discrimination regarding promotion and different rules apply to retirement benefits (eg. women should retire five years earlier than men). Of course there is attitudinal discrimination too, but this is harder to pin point and much more subtle.

Women with higher educational achievements show a higher incidence of leaving their jobs due to "marriage or childbirth related" reasons (49.4% of

university graduates whereas 24.2% among middle school graduates in 1984 record of Department of Labour). Reasons for taking paid employment differ according to educational level: women who choose to work because of economic reason are 43.9% among middle school graduates and 10.9% among university graduates; women who look for meaningfulness in work are 9.4% among middle school graduates and 23.5% among university graduates (EPB, 1980). The profession which seems to suit women best is teaching in secondary schools or higher educational institutions as these have twice yearly long vacations, which well accord with children's school holidays, and the general work environment is pleasant.

Women are highly motivated to get on in the job world (Jung, 1981), however their socio-economic needs are not as urgent as men's. This is especially so in the case of middle class women with a background of higher education as they tend to have married wealthier husbands. Among the female work force in 1984, university graduates represent only 2.4% as compared to 60.1% of primary and middle school graduates in paid employment (Ministry of Labour, 1985).

Competition for university places is severe at all levels of ability for both sexes. Pupil with lower ability try hard to get in to any university while the young people of higher academic ability have to compete with each other to get in to the better universities. The choice of university affects not only career prospects but marriage prospects too, as those with a good education can make a better marriage. University education is considered almost the norm among the middle class population. It is hard to a find suitable spouse unless you have a university degree. Indeed, it is now becoming the case that young people need to have postgraduate education if they wish to find a better marriage partner. The advancement rates to postgraduate level are 5.6% among female university graduates, and 9.8% among male university graduates. For the limited number of posts available in higher educational institutions there are already a surplus of Ph.D.s who cannot be accommodated. This is especially true of women rather than men.

2. Family and education:

Each year there are many tragic cases of suicide among young people who are under pressure due to university entrance exams. The number of pupil suicides in 1986

was 100, and 103 in 1987 according to government reports (Han, 1988). Year after year there are cases reported in the media of mother's committing suicide after finding their children's unsuccessful examination results. The figures may, in reality be higher, because suicide is not allowed in the Confucian value systems. The individual's body is inherited from the ancestors, through the parents, and is precious, therefore it should be well kept and respected by everyone. Suicides are extreme cases, but all the families which have children at this university examination stage experience grave stress.

The presence of intergenerational inclusion in Korean families is easily observable during the exam season. For instance, we see the cases of successful students who have top scores for the best universities saying to reporters that their success was solely due to their mothers' efforts, and that they had only done the right thing for their mothers. They usually say "I finally did filial duty to my mother". In the opposite case, the unsuccessful students or those who anticipate their unsuccessful outcome, they feel miserable for their mothers. Some of them sadly do commit suicide. We see the same rationale in the suicide notes which read, almost without exception, that they wanted to make their parents happy with good examination results which

they could not achieve (Han, 1988). Mothers usually deny or do not want to see the possibility of their children's extreme psychological reactions to pressure. And yet they have to push their children to concentrate only on studying. They are put into the "examination hell" (입시 지옥)!

2:4 Mother's Life in Korea

To be a complete adult person in Korea one should be married. If one dies before one is married people will consider the person's spirit to be wandering around restlessly, forever rootless and imcomplete. Marriage means having children as soon as possible, preferably sons. Men would like their wives to be healthy and intelligent in order to produce healthy and clever children. Therefore, a women's educational achievement is considered an advantage in allowing them to make better marriage contracts, not because they can make a good inspiring companion, but mainly so that their children will inherit their intelligence and nurture them better.

The ultimate contribution which women can make on this earth is to be successful mothers. Entire dedication to children, without any reservation, is seen as the most desirable goal in a woman's life. There is no

alternative role which is comparable to this one. Mothers cannot differentiate their lives from those of children. They will get the blame as well as the praise for their children's failures or successes.*

1. Stress of Mothers

At the beginning of motherhood, woman are allowed to enjoy and relax. That is the stage at which she is pampered the most. For three weeks after giving birth to her baby, she is supposed to be in bed all the time, with lots of help from her extended family members including her original family as well as the husband's family. She does not have to take care of the infant by herself, and the household chores are taken care of by others. No strangers or guests are allowed to visit during those three weeks for the protection of the infant and the mother from germs and strain.

If the new mother is put into the position of having to deal with the situation by herself, she finds it

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* "The Best Mother of the Year" is chosen annually on Mother's Day. The decision is made according to her children's successful achievement in Korean society rather than her own achievement. For instance, a mother who produced many Ph.D.s among her children was the recipient of the award.

extremely difficult. There was a case of a well educated 25-year-old Korean women (eldest among her siblings) who had a baby in a Scottish hospital, and who did not know what to do with her infant and driven to tears. This frightened the hospital staff who made arrangements so that at least one of the nurses could be with her at all times.

Bringing up children is a family matter with assistance coming from the adults in the family. Everyone in the family tries to provide the right environment for the child. While Koreans strongly believe that there are innate characteristics and talents inherited from previous generations, they believe just as strongly in environmental influences. They think, for example, that they have to move house if the neighbourhood influence is not good. There is a story repeated in almost every family and used as a model, which tells one of the wise man's widowed mother who moved house three times until she found the right atmosphere for her child: next door to a school, where the child would be able to overhear the pupils reciting Chinese Classics. The rest of the family will go along with major decisions of this kind because they benefit a child's education.

Having many children is one of the 'five cardinal blessings' (五福), but it is also a large burden for mothers. As the proverb goes, "trees with many branches cannot stay still in peace even in a slight breeze" i.e. you should expect to have some trouble concerning one or other of the children. Another proverb which is a direct paradox to the blessing of having many children states that "a person without any child is the luckier one". Korean mothers usually think being a mother is not a matter of enjoyment but a matter of duty. They do not think they choose to have children, but that they are destined to have them.

Unlike Western mothers, Korean mothers with relatively young children are often told by the older generation that the burden of motherhood is nothing much yet. They will tell you that you should enjoy the fun of having children while they are young, and you can expect to have much more anxiety over the children later when they reach more difficult ages. It is said that motherhood gets harder as the child grows older.

Generally speaking, the codes of conduct in Korea always accord with adult standards. Since less is expected of pre-school children, the attitude to them is more relaxed. Indeed discipline for pre-school age children in Korea is much less strict than

it is in the west. However, this changes abruptly when they start school. From that moment on children are expected to behave almost like grown-ups. In fact, the start of school usually means the end of toys and childish play. Even though Korean mothers have heard about adolescent behaviour, most cannot accept or recognise it in their own children. The gap between reality and expectation is so great that Korean mothers experience much stress during their child's school years (Park, 1979).

Successful academic achievement, which is the only objective criterion, cannot be accomplished by everyone - only a small minority of the population will ever reach the required standards. Most mothers set up this difficult goal for their children (and indirectly for themselves). The mothers' commitment to pursuing the goal is made much earlier than the child's one. The mothers, alone, will carry the necessary concern for the goal. Later, mother and child will share a mutual concern, such as the university entrance qualification, with extreme anxiety. Mothers can be more uptight about their children's performance than the children, because they anticipate the unpredictability of their children's future. At the same time they are helpless because they are not the ones who take action. Korean mothers tend to attribute blame to themselves (internal

attribution) on whatever issues concern their children. Confucian teachings on women provide mothers with an 'inclusive' attitude, which might be relevant to their internal attributory attitudes.

2. Inclusion (vs. individuality)

The notion of motherhood can be understood properly only as a cultural and social entity rather than as a natural role (Badinter, 1980). Accordingly, we can expect to see a wide variety of mothers due to cultural differences. Until recently explanations about gender role-taking have been based on individualism and dichotomy. However, such interpretations are not satisfactory in explaining Korean mothers' behaviour. As we look more closely at the life of contemporary Korean mothers, we shall see that educated Korean women show individualistic tendencies before they become mothers. This may be due to their western style of competitive education which is relatively free from the influence of the Confucian family tradition.

This does not matter much for the mothers while the children are young, because child rearing in the early stages is a joint project for the whole family, and mothers receive support from the whole family. However, from the time her child starts to participate

in events outside of family the mother assumes shared responsibility with her child throughout life. That does not necessarily mean that the intensity of the relationship between mother and child is reciprocal. A Korean child can go his or her own way without experiencing any lingering backward attachment to the mother figure. It is a one-way relationship much in the nature of a stream which flows from a high place (parents) toward a low place (child).

The analytic unit of the Korean mother's behaviour or mind is not necessarily the individual person. The mother's behaviour might include her child in itself. "Inclusion" does not mean that the mother has the sole power as in the case of the "imbalanced relationship" where one individual has power over another such as that described by Sullivan (1984). Sullivan sees relationships in terms of a set of "I - you" which are comprised of one individual "I" to, or with, another individual "you" as the agencies. Imbalance in a relationship is always possible with one party having power at the expense of the other. The 'inclusion" concept would not run this imbalanced power structure, because the mother does not expect her children to reciprocate. The child "takes for granted" the benefits from the mother.

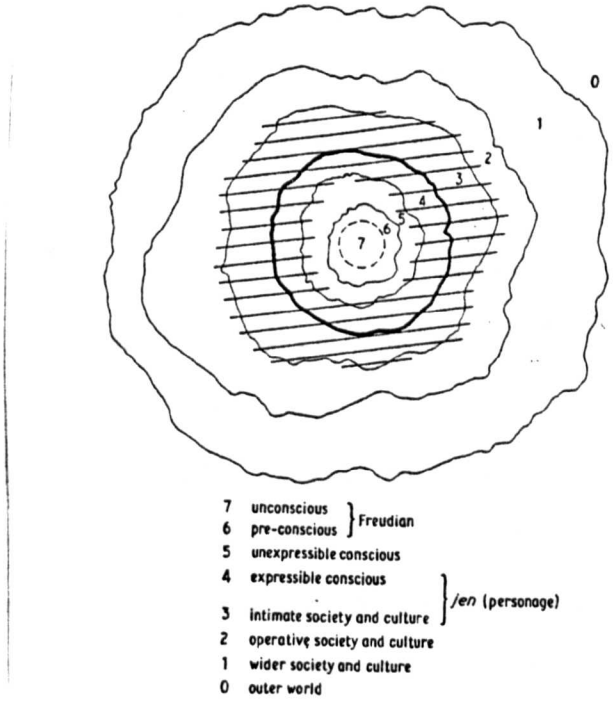
By western standards good mothers raise children to be independent individuals without imbalanced relationships, whereas by Korean standards the degree of inclusion is the mark of the goodness of the mothers.

Some western psychologists have found that women in general (compared to men) act in the manner of communion rather than agentic way: calling it "alterocentric". This suggests that females center more of their feelings, enjoyment and ambitions on something outside of themselves (Bakan, 1966, pp.113-114). Cross-cultural observations between Korean and western women indicate that Korean women are even more "alterocentric" as far as their families are concerned than are western women.

For instance, Hsu (1985) describes the structure of self in layers from inner most layer toward the outer layer: 1) 'unexpressible conscious'; 2) 'expressible conscious'; 3) ' intimate society and culture'; 4) 'operative society and culture'; and 5) 'wider society and culture'. Greater self, (大我) covers all the layers in subjective terms, and the smaller self (小我) encompass up to intimate society of spouse and children. Personage, 'jen' cannot stand alone in Oriental cultures as the western 'individual' does with

only the first two layers of consciousness both expressible and unexpressible. For westerners, the outer layers belong to the objective outside world. (see Fig.2-2)

Fig.2-2: Man, culture, and society



Note:This figure is from Hsu, 1985, p.28.

When one tries to explain the difference in concept of self and social behaviour between westerners and non-westerners, there is a tendency to give the impression that the experience of living as a westerner is more complicated (Hsu, 1985, p.36) because one has to work for every relationship one wants to hold. One example

of this, as Hsu observes, is the westerner's need to lavish emotions on pets. This has been argued to be a phenomenon which arises because of the scarcity of permanent inhabitants for his or her layer of "intimate society".

Hsu's theory emphasizes the hardship of the westerner's alienated loneliness, but nobody seems to point to the other side of the coin which is that relationships are not always as smooth as one would like them to be in the lives of non-westerners. One carries more of the burden and strain when involved intimately with close family members and relations.

On the one hand, families can, and do, provide a built-in support system which is often not an object of appreciation because it is part of the self, taken for granted. On the other hand, families are the cause of much stress, because of the complexity of the relationships and burdens that these may involve. Mothers who consider their children's lives as their own, clearly demonstrate this complex and intimate pattern.

Lack of social skills or competence is considered to be an important factor for mental health either as a symptom or as the cause of the symptom. According to

Hsu's suggestion (1985), a socially mature person has to win approval from his or her peers after establishing independence from parents, thus the relationship with unrelated peers is bound to be more unstable and requires more constant effort to maintain it. Consequently, the western individual will develop social skills while working towards psychosocial homoeostasis and the expansion of social relationships (Sarason, 1986). Whereas non-westerners are surrounded by people who are intimate relations, and do not have the same need or opportunity to develop social skills. It is hard to find Koreans expressing their appreciation of one another yet this is a seemingly basic social skill necessary to the enhancement and growth of a support system in the west. Koreans feel rather uneasy with verbal appreciation because it makes them aware that there is distance between the relations or because it is far too flattering and forced.

3. Psychological Well-being

According to Seligman et als' (1987) "learned helplessness theory" and self-control model of depression, the Korean mothers' inability to control events in their children's lives may lead to a state of helplessness and depression. Although the mother cannot control either the effort or the ability of her

child, she attributes the matters of the child internally due to inclusion, bringing upon herself feelings of personal helplessness. Even if she is deeply involved with her child, the child is the one who is going to do the work on his or her own and this is out of the mother's control. However, she will tend to attribute the result to herself or in the last resort luck.

Indeed often she tries to get help via superhuman means such as fortune telling, and religious rituals of any form. This is not direct but "secondary control" (Weisz et al., 1984) of the self: by using her belief system the mother keeps her composure. It is not an effective means of coping because Koreans are look for concrete results rather than emotional easiness on the way.

While a Korean mother is trying to achieve via her child, pleasure seems to be very important to the western mother. The degree to which a western woman enjoys being a mother seems to act as an indicator of how good she is in that role. If a mother cannot enjoy her motherhood all the time, (which is not possible in reality), she feels something is wrong with her. In other words, a western mother is asking for a reward from her child in terms of getting pleasure while a

Korean mother does not look for pleasure out of her role. Korean mothers carry out their duties without ever questioning their own feelings.

Another factor which may lead Korean mothers to experience depression is the lack of social skills which leads people to receive very little positive reinforcement from others (Lewinsohn, 1975; 1986). Certain social skills are only relevant in a specific culture; social skills required in one culture might be different from those needed in another. For instance, expressing appreciation seems to be one of the basic social skills in western society, whereas Koreans need to learn to read anothers' mood without verbal communication. It is better to be slow expressing oneself in Korea, especially for woman.

4. How Do Mothers Manage?

The biggest issue for a Korean mother is how she can make her child get through the university entrance examination successfully. The mother and child are willing to pay any price for this success. To begin with the mother will attempt to be, and work, with her child completely. At this stage it is true to say that mothers follow virtually the same schedule as their child. For example, a mother would not go to bed

before her child such that she is up very late, she has to wake her child up very early, but must rise even earlier herself to prepare everything for the child and other family members. That means she actually sleeps less than her child does, usually not more than 3 or 4 hours. She also should detect her child's mood and be careful, so as not to upset the child. They say that "it is like walking on thin ice for a whole year (or longer if the child fails and tries a second or even third time)".*

A second way of coping is through friends and neighbours who are going, or have gone, through this process and are willing to share helpful information to improve their children's chances. However, since competition has become so severe this type of cooperation between mothers is scarce. The only

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* One mother told me she sat outside of her son's room at all times so that she could bring him whatever he wanted whenever he wanted it in the way of food or drink. Another woman who has a 'second timer' (her son, has been experiencing depression, saying that "even looking at the door of her son's room makes her heart heavy as a rock". Even after her son went off abroad to study at an American university, she still felt depressed when the exam season approaches. She and her husband hate a piece of music which they happened to hear for the first time when their son had the exam. Another mother in a similar situation told me in tears that "I was on the verge of suicide. It was possible to commit suicide, I was so near to that point". She said she can never face going through the same process again which is coming up in the next five years for her two younger children.

practical help mothers can rely on nowadays is from high school teachers and the private tutors they hire to improve the child's academic abilities. But there always remains anxiety and uncertainty because everyone else is doing their best too.

Thirdly, some mothers have the means to send their children abroad if they fail, which can be an exit from a desperate situation. But the majority do not have the financial means, and they prefer their children to remain in Korea at any cost since they fear the child may lose their identity if they live in another culture from such an early and receptive stage of life. (It is generally accepted that the right time to go abroad for study is when one reaches the stage for postgraduate work, preferably in the company of a marriage partner.)

It seems, therefore, that there are few alternatives for coping with the stress other than to face it directly and struggle with it. The final resort is usually religious or superstitious belief. All the formal religious practices are followed by most women on top of some form of superstitious practice. Fortune tellers are prosperous, especially those who can predict the actual mark of the examination and can prescribe a charm against ill luck. Mothers try to

keep the children away from slippery foods (such as sea weed soup and noodles) and provide sticky foods, because the Korean expression of failure in an exam is "slipping down in the exam" and success in an exam is "sticking to the university". A common scene on the examination day found throughout Korea is that of mothers putting sticky foods, such as sticky rice cake or toffee, at the university gate and praying. Even some Christian church members provide those sticky foods for the examination candidates among their congregations.

5. Other Welfare Issues for Women

Korea is not a welfare state yet and personal welfare has to be taken care of by the family unit. All problems have to be worked out within family. It is relatively less problematic for the middle class to solve problems within families due to their relative wealth. Some of the newly arising social problems which need to be tackled are of particular concern to women including divorce, unwed mothers, economic participation outside of the family and elderly people.

According to the Court Administrative Office, Annual Report on Court statistics, divorce rates have increased from 0.28 % in 1965 to 1.16 % in 1980, yet still an insignificant numbers as compared to western statistics.

The exact number of unwed mothers are unknown, but it is widely acknowledged that they are increasing in number. Because of the intolerance of Korean society towards unwed mothers, it is easy to imagine the difficulties they will encounter. The attitude of the public towards an unwed mother is very inflexible: as it is a disgrace to herself and to her family, she usually goes into hiding (Lee, 1986). Since having an abortion is not too difficult, it is assumed that most middle class single women who become pregnant can afford to have a termination before it is too late to avoid family disgrace. It is, therefore, normal that we did not have any single mothers among the subjects of this study.

Married women employees are much fewer in numbers than single employees (never married or widowed) and fewer women with college educations are working than those with secondary school educations. This means fewer middle class mothers are employed than women from other (lower) social classes.

Female life expectancy in Korea is higher than male (69.07 years vs. 62.70 years) according to EPB report (1979). Elderly women are better equipped to adjust to family life than elderly men are. The difficulty, without a social security system, is mainly the matter of the independence of economic life of elderly people. This is dealt with individually in middle class families without making it a social issue, because it is natural to support one's own parents in the traditional value system. To claim an attendance allowance from the state to stay at home to look after one's own mother (as happens in the U.K.) seems strange to the average Korean women. Rationally it is understood that a welfare state system is the ideal, but emotional feelings remain with a family oriented system.

The Korean mothers' stress is never-ending, but considering the situation and social system, it would not be too far removed from the truth to say that the most difficult stage in a Korean mother's life, especially a middle class mother, is when her child is preparing for the university entrance examination.

CHAPTER THREE

DEPRESSION

Introduction

This chapter deals with the theoretical understanding of depression, especially depression as a cognitive emotive state of mind. The first section briefly reviews the concepts of depression as described in the psychological literature. In the second section of the chapter, the definitions of depression as used in this study, which are derived from various perspectives, will be discussed. The third section deals with some important theoretical explanations about the aetiology of depression, while the following section identifies the important factors (internal and external) which influence the aetiology of depression. The fifth section deals with cross-cultural studies on depression, and the final section deals with the measurement of depression.

3:1 The Concepts of Depression:

Depression has been recognised for over some 2000 years. Hippocrates labelled it "melancholia" in the fourth century, and more recently it has been very

aptly described as "the common cold of psychopathology" (Coyne, 1986; Gilbert, 1984). The term "depression" has come to encompass everything from a transitory mood state to a severe debilitating illness. At present the two predominant models of depression are medical and psychosocial. Depression is thus, seen as being either primarily a physical illness linked most probably to biological or genetic factors or alternatively as arising from stress and life events - the "curse of civilization" as Coyne (1986) puts it.

The controversy over psychogenic versus somatogenic depression has long raged in psychiatric circles: the exogenous - endogenous debate. Modern approaches to classification, dating from Kraeplin's (1855-1926) nosology (quoted in Zilboorg et al., 1941), emphasize exogenous factors, especially in the milder cases of depression (Kraepelin, 1921). Recent contributers to the debate have developed and refined the terms. For instance, the neurotic - psychotic distinction (Bowman et al., 1951); the exogenous, endogenous and psychogenic trichotomy (Ewalt, 1948). "Psychotic" depression and "endogenous" depression have been regarded as synonymous, likewise "neurotic" depression and "reactive" depression (Magnusson et al., 1987).

The development of a biomedical perspective of depression has depended upon pharmacological research and advances in anatomy, neurophysiology, and biochemistry. However, most of the biomedically oriented researches in this area have been conducted with severely disturbed psychiatric patients. Therefore, caution is needed when generalising from such findings to the whole population which includes only a small proportion of mood disordered people (between 3 to 8 percent of the general population, according to Baldessarini, 1986). Of these a small minority are treated by psychiatrists (1 in 5 treated, 1 in 50 hospitalised).

Since our study deals with the general population and not specifically manic depressives, we will adopt a psycho-social perspective. Below we discuss depression in terms of a: 1) non-disease model; 2) loss or deficit; 3) human perception of external factors; 4) cultural influence; and 5) depression in mothers.

1) Depression as a non-disease

Gilbert (1984) discusses the historical development of the understanding of depression, shows the inadequacy of a simple disease model of depression. He points out that even in the absence of any biological cause, a

depressive syndrome can develop. For a full discussion of the inadequacies of the disease model of depression, and one of the reaction of a person to the matrix of psychological, social and biological factors (see Chapter one of his book). The psychoanalytic concept of depression, the "melancholia" which describes the loss of pleasure in almost all activities (Freud, 1917), supports the idea of depression as a non-disease. The psychodynamic tradition proposes that melancholia emerges from changes in external factors interacting with internal ones.

2) Loss or deficit

The concept of "loss" has been widely employed by psychologists in one form or another. Psychoanalysts for instance see the "loss" or "deficit" of a loved object as the main source of "melancholia" which is believed to produce an "ego loss" (Freud, 1917). The explanation of depression in the cognitive approach, also, proposes that the main factor is an individual's "vulnerability" (Brown et al., 1978) or lack of "hardiness" (Kobasa, 1979, 1982, 1985), the loss or deficit of either "external resources" (i.e. material or social resources) or of "internal resources" (i.e. self confidence or any other important meaning of one's life). The behaviourist approach (Lewinsohn, 1976,

1986) shares this same idea of "loss" or "deficit" in terms of lacking the proper rate of "response-contingent positive reinforcement".

It seems, for each of these approaches, that two main factors were involved: one is the external resources from which the loss occurs, and the other is the internal resources, from which the loss is perceived and experienced.

3) Perception of external factors

It is clear that depression cannot be fully explained in purely intrapsychic terms. Rather the explanation lies in a range of external factors along with the interaction between internal and external entities. Cognition plays an important role in depression, through perceiving one's external factors. Moods are a subjective accompaniment of a person's recognition of the match between how she/he perceives her/himself (internal resources) and the situation (external resource) and how the person would like them to be (Ryle, 1982, p.41). People are born with the tendencies to react emotionally, but learn emotional patterns, which are passed on from one generation to the next within families and cultures (Flach, 1974). Thus it can be argued that ways of expressing emotions

are social constructs (Amon-Jones, 1985; Averill, 1982; Lazarus et al., 1970), and are inevitably influenced by cultural factors. The resources which an individual can call on to cope with depression are, therefore, subject to cultural patterns and forces, as discussed below.

4) Cultural influence

A culture can influence emotions in various ways (Lazarus et al., 1970). For example, culture influences emotions through the perception or appraisal of stimuli. Cultural factors also exert an influence on expression of emotions such as the appropriate response, the boundaries or possible responses, the coping strategies that can be employed, which are all dictated by cultural factors. Acceptable reactions to a given situation are usually very clearly defined. Furthermore culture also influences emotions through the shaping of social relationships and value systems- the intent of which is to make people comfortable in their environment. And certain conventional forms of emotional behaviour both stem from and reinforce the particular socio-cultural structure. Emotion can be seen as a psychological reaction to a perceived situation which is governed by previous experiences and life events. Emotional reactions, in a sense,

encapsulate a person's life history (Arnold, 1970). It is important to know the person's interpretation of the stimulus situation in order to understand the emotional experience that the person is undergoing and its expression. This is essential in appraising and interpreting the experience the person is currently undergoing. The importance of human emotion is well expresed by Arnold as being the "matrix of all experience and action" (1970, p.177).

Depression, like any other emotional reaction, is a function of a particular kind of cognition or appraisal influenced by cultural factors. Marsella (1985) commenting on the cultural influence on mental disorder said:

> "Even if certain biochemical processes maybe universally operative in the etiology of mental disorders, it is obvious that the individual's appraisal and behavioural response to these processes must be filtered through culturally conditioned experience. Further, the social response to the behaviour pattern must also reflect cultural influences. Certain cultural traditions may, by the response they condition to various behaviour patterns, maintain, enhance, and encourage a symptom's development." (p.284)

Culture works as a situational condition with both external (institution) and internal representations (belief systems and values) and is a contributor to the developing psychological disposition to depression.

5) Depression in mothers

Depression in women has attracted much attention because of the large number of women, as opposed to men, who seek help for affective disorders. Depression in women is a health problem of some magnitude. A study conducted by Weissman et al. (1977) looking at the incidence of depression in U.S. community from 1945 to 1970 found that the ratio of 1.6:1 through to 2:1 existed between females and males. It is estimated that for adults in industrialised countries, depression is twice as common in females as in males (American Psychiatric Association, Diagnostic and Statistical Manual-III-R, 1989).

When one notes the kind of depression symptoms, as Beck (1974) indicates, they are in fact similar to the ones which women can easily identify as being part of their personal life experiences. Depression symptoms tend to be stereotypical female characteristics, such as being passive or self-critisizing.

One attempt to explain why women experience higher rates of depression was made by a feminist psychologist, Chesler (1974). She believed that the symptomatology of depression was merely an intensification of traits which normal socialisation

processes induce in women, such as passivity, dependence, self-depreciation, self-sacrifice, naivete, fearfulness, and failure. She described depression as the female way of responding to stress just as schizophrenia, with its overt hostility and aggression, is masculine in style. What she suggested is that the prevalence of the disorder among women is related to their gender-roles.

The explanation of the prevalence of depression in females in terms of gender-role socialisation has been questioned with the support of data showing the significant differences between married and single women (Radloff, 1986). Married women scored significantly higer than single women. The difference in depression rates between married women and married men is greater than those between single men and women (Aneshensel, 1981, 1986). Therefore, it was argued, the strain of the role which the married women occupy in relation to other family members is the main reason for the higher prevalence of depression in married women (Aneshensel, 1986).

Women, compared to men, have a less clear distinction between 'self' and 'other' where they tend to place more emphasis on caring and are more attuned to the need of others (Gilligan, 1982). Furthermore, the

asymetrical nature of the women's role among family members can create a support gap, particularly if support is not reciprocated. This is most apparent when there are family members who are going through stressful stages, and whose needs for support are immense. Belle (1982) labelled this phenomenon "contagion of stress" passing from the child to the mother or from the husband to the wife, for that matter, as even though the woman may not be the central figure in the crisis, she still experiences the stress with the family member.

Research from a traditional point of view, has looked at the instrumental value of mothering, concerned mainly with the producing and nurturing of the offspring (Gerson, 1984). There has been a continuous effort made to study parental, especially the mothers' influence on the children's well-being (Parker, 1983; Rutter et al., 1987). It is clear, though, that once the focus is moved from motherhood as an instrument for the children's well-being to the mother as an individual with an independent identity, then the emphasis should be equally on the welfare of the mother. Indeed, even people in the psychoanalytic discipline are moving away from their traditional view of personality development, that is one-way parental influence towards the children. They have discovered

that children are not just the passive recipients of environmental stimuli but have become aware of the necessity to consider the reverse process (Rutter et al., 1987) and the possiblity of interaction between parent and child (Parker, 1983).

Depression among mothers requires more attention from the scientific community (Rickel et al., 1984). It has been generally acknowledged that for any mother, having young children by itself can be a significant source of stress (Longfellow et al., 1982). There are several studies which paid attention to mothers around the childbearing stage (Atkinson, et al., 1984; Bennett, 1981; Cutrona et al., 1982, 1983; Field, 1984; Grossman et al., 1980; Kumar et al., 1984; Nicolson, 1986; O'Hara, 1983; O'Hara et al., 1982, 1984,; Paykel et al., 1980). Bennett, Grossman, Atkinson, Cutrona, for instance, examine the stressful, new experience, within a socio environmental context, while others are interested in biomedical impacts, such as hormonal changes. If depression is biomedical in origin, the degree of depression should not be different cross-culturally.

Brown et al. (1978) pointed out that on-going difficulties in the lives of mothers with young children who lack proper resources, can provoke

depression. They found the absence of a job and confidant/partner, and the number of children who are under 16 years old, are factors which led the mothers to depression.

One can also expect to see a cultural influence on mothers in terms of both the internal and external resources they have available to cope with stress. For instance, some stages of motherhood are more stressful in one culture than in others, and we might find some relationships (such as friends or family members) more important as external resources serving a support function than the relationship with the spouse in other cultures. It would be interesting to find out the consequences for their depression for the mothers' perception of resource mobilisation and its effectiveness when under stress.

3:2 Definition and Nature of Depression

Depression in terms of the cognitive-emotional framework is associated with "the negative frame of mind, the psychological construct" (Higgins et al., 1981). The negative frame of mind associated with depressives has been interpreted as: "the inaccessibility of the positive constructs" (Isen,

1984) and "the accessibility of negative constructs" (Kuipers et al., 1981).

Krantz (1979) defines depression as "distortion" of the cognitive process which interprets events, by organising, elaborating and reconstructing actively with the negative frame of mind. The end result of the distortion is negative, pessimistic and self-depreciating.

On the other hand, behaviourists prefer to use operational definitions of depression, which refer to the syndrome of behaviours that have been identified in descriptive ways by depressed individuals (Lewinsohn, 1986).

We will review both the cognitive model of depression and the operational definition.

(1) Cognitive model of depression

According to Beck (1980) there are three specific concepts to explain the psychological substrata of depression: 1) the cognitive triad, 2) schema, and 3) cognitive errors (faulty information processing) (p. 10-20). The fundamental idea is that the depressive character is one of negativity in view of the

motivational behaviour. Beck believed the signs or symptoms of the depressive syndrome were the consequences of the negative cognitive patterns.

It may be argued that the negative view in the cognitive model can itself be a common factor in depressive symptoms rather than the underlying cause of depression. However, it is not identical to the operational symptoms, because it is not observable, but is latent or underlying the observable symptoms.

a) Cognitive triad:

Beck (1980) found three kinds of negative views in depressed people, and explained this by "triad":

> "The cognitive triad consists of three major cognitive patterns that induce the patient to regard <u>himself</u>, <u>his future</u>, and <u>his experiences</u> in an idiosyncratic manner." (p. 10).

The basic component of the triad is the depressed person's negative view of him/herself. In the negative view, one tends to believe that because of one's defect, inadequacy, disease, or deprivation, one is undesirable and worthless, and one becomes critical of oneself. The second component of the triad is the tendency to interpret one's ongoing experiences in a negative way. One interprets one's interactions with

the environment as a defeat or deprivation through one's preformed negative conclusions. Naturally, the third component of a negative view of one's future may follow.

b) Schema of depressive thinking

This concept of depressive structural organisation is helpful in understanding the maintenance of the depressive attitudes. Relatively stable cognitive patterns form the basis for the regularity of interpretation of sets of situations. The term "schema" designates the stable cognitive patterns. The function of a schema is relating of the person to the circumstances and moulding, classifying, or selecting data into cognitions. As Beck (1980) noted:

> "Thus, schema constitutes the basis for screening out, differentiating, and coding the stimuli that confront the individual. One categorises and evaluates one's experiences through a matrix of schemas." (p.13)

The degree of depressive symptoms depends on the degree of ability to view one's negative thoughts with accuracy and objectivity. As the depressive symptoms become more severe, one's thinking becomes increasingly dominated by negative ideas without any appropriate actual clues. If one is completely occupied with extremely negative schema, one would not respond to the

changes in one's environment, and schema becomes autonomous. In milder depression the person is generally able to view the negative thoughts of their own with some objectivity. Alloy et al. (1979, 1980) argued that this pessimistic state is a more "realistic" depression in contrast to the unrealistic optimism which can be misinterpreted as non-depressed health.

c) Cognitive error:

Cognitive error is when a systematic fault in information processing sustains the person's belief in the validity of the negative concepts despite the presence of contradictory evidence (Beck, 1980). According to the mode of responsive process there are six "responsive sets" which may lead to error: 1) arbitrary inference which refers to the process of drawing a specific conclusion without the supportive evidence or with contradictory evidence; 2) selective abstraction consists of conceptualising the experience on the basis of fragmented features of the situation; 3) over-generalisation covers the pattern of conclusion on the basis of isolated incidents and applying the concept across the related or unrelated situations; 4) magnification and minimalisation are reflected in error in evaluating the significance or magnitude of an

experience that is so exaggerated it creates distortion; 5) personalisation is the person's proclivity to relate external events to himself without any basis for making such connection; and 6) absolutistic, dichotomous thinking is the tendency to place all the experiences in one of two opposite catergories. Depressives are more likely to adopt the negative categorisation in describing themselves.

Beck adopts the terms "primitive" versus "mature" modes in organising reality. He puts the label "primitive" on the characteristics of the typical depressive thinking, which appear to be analogous to those Piagetian descriptions of the children's thought pattern (1980, p. 15). "Primitive" versus "mature" patterns of thinking according to Beck are: nondimensional and global versus multidimensional; absolutistic and moralistic versus relativistic and nonjudgmental; invariant versus variable; character diagnosis versus behavioural diagnosis; and irreversibility versus reversibility. Beck thinks the depressive characteristics are closer to the "primitive" mode, for instance total deprivation or defeat (nondimensional), irreversible (fixed), being a loser (judgmental, categorical), and doomed (irreversible character deficits).

The ideal way of defining depression would be integrating knowledge about covert and overt symptomatology. Therefore, the discussion moves onto observable characteristics from the underlying cognitive system. A more tangible definition of depression can be found when we look into the depressive symptoms in a descriptive sense, which will also be helpful for the assessment of depression.

(2) Operational definition of depression:

The term "depression" is conventionally used to cover a wider range of emotional disturbances than was the case when psychiatrists confined their attention to patients referred to psychiatric hospitals. What exactly is a criterion of "depression" is far from clear and the theory and practice of psychiatry are still changing and evolving (Snaith, 1987; Fabrega, 1982). "Depressed mood" is too diffuse a concept, too ill-defined, covering the areas of symptoms from affect through behaviour, motivation, physiology to cognition. Snaith (1987) thinks that, of all the states, "anhedonia" emerges as the central and most reliable symptom of depression. A similar notion is found in Hamilton's (1982) definition of the expression "flatness".

Even if we agree with Snaith, it is still a complicated matter because the ability to experience pleasure would be manifested in a variety of ways in life and also it depends on the importance of pleasure in the cultures. Some societies might not put as much value on pleasure as others, since some value more practical accomplishments such as diligence and perseverance (Morsbach, 1978).

Even though Snaith emphasised "anhedonia" of depression, his depression scale included eight items of somatic symptoms among twenty two (Snaith et al., 1976). For example, symptoms of sleep disturbance, appetite, tiredness and headache.

According to Shaw (1979) the general agreement of symptoms of depression are:

1. Affect: moods range from sadness, a tendency to cry, to lack of emotion.
2. Behaviour: a decrease in the rate of behaviour and a reduction of the individuals social skills, as well as a decrease in the caring for others progressing to a complete loss of attachment.
3. Motivation: the desire to avoid routine aspects of life and to be a passive rather than an active participant in life; the extreme being suicidal.
4. Physiology: loss of appetite, weight loss, sleep

disturbance, loss of libido, fatigability

5. Cognition: negative attitude toward the self, one's experience, and the future. These may cause negative events, and lower the decision-making skills.

3:3 The aetiology of depression:

Psychoanalytic approaches were boldly speculative in theorising aetiology of depression from clinical insights: the lost object becomes an ego loss which is reflected in a loss of self-esteem and punishing self-criticism. Childhood loss has been investigated by many psychoanalysts.

Numerous authors attempted to explain the cause of depression in their own way. For example, Newman et al. (1983) describe "field dependency" of depression as the result of the dynamic interaction of instincts and counter-instinctual force, while Kanfer et al. (1983) explain the role of "self-efficacy" in depression in the state of discrepancy between the interpersonal relationships. Siverman et al. (1985) discuss "maladaptation" as the cause of dysfunctional thinking of depression, while others such as Klinger (1975) believes the "blocked goal" leads to impairment

of normal incentives. Alloy (1979) talks about "realistic depression" labelled by their accuracy in judgment between their response and outcome, while Powell (1984) sees depression as "perceptual defence" from unpleasantness. Kuiper et al (1982) argue "subjective bias" in information process, similarly Pietromonaco (1985) finds depression from negative thought" which pervades all other kinds of thought. Gotlib (1982) and Lobitz et al. (1979) find "self-reinforcement" which interact as social skills rather than self-control model in terms of depression, while Zuk (1983) uses the explanation by "diffusion" in depression due to the loss of identity or self. Williams (1986) takes position of "seeking relief" by escaping or soliciting help in an unbearable situation, whereas Carver et al. (1983) and Forrest et al. (1975) share the idea of "self-punitiveness" because of a high standard of being intolerant of failure to meet the standard or generalising a single failure more broadly to the self-concept. Brewin et al. (1984) take "responsibility in negative outcome" beyond the power of control, Oatley et al. (1985) find people depressed when they lack alternative sources of self-definition. While Keen (1984) sees depression as the pessimistic "human possibility", Power et al. (1986) discuss "coalitional organisation mental model" of depression with negative aspects, inaccurate and illogical criteria.

These explanations which try to explain the cause of exogenous (reactive) depression can be classified by three perspectives. The first regards depression from an "internal" origin, the second from an "external" origin, while the third views depression from an "interaction between internal and external factors".

Among the three most prominant theories of depression (Blaney, 1977), Beck's group and Seligman's collegues belong to the first category of "internal" origin, while Lewinsohn explains the origin of depression by "external" factors. Beck and his collegues (1974) explain the root of depression as a negative set of cognitions about oneself, the world, and their future (referred to as the"triad", see p.67). Seligman and his collegues (1979, 1984, 1987) find its root in helplessness perception due to the attribution of the non-controllability of the situation. Whereas, Lewinsohn (1974, 1986) believes that the low rate of positive reinforcement can cause depression.

According to Beck the way a person thinks (perceives) is the most important influence on emotional, motivational and behavioral aspects of depression. If a person has a negative frame of mind (i.e., the "triad") he or she will perceive all the events negatively. Beck (1974) used the concept of "latent

state" to describe the phase before the actual depression which was activated by the stressful experiences. His model focuses on an already organised negative frame of mind, and which shapes the processing of new experience into depression.

Therefore, the "latent negative state" can be traced back to the very original experience, which caused the negative schema. Although Beck suggested that the experiences of failure in childhood were assimilated to the negative schemata of triad, he did not seek an origin of depression from that failing experience of childhood, rather from the negative schemata which came about from that experience. It can be argued that the negative cognitive frame of mind can be seen as the underlying basic symptom of depression rather than cause of depression.

While Lewinsohn's idea is based on the importance of external reinforcement in the emerging process of the negative state of the depressed mind, it can be said that his deterministic mechanism over looked the important internal cognitive process leading to depression.

The theory of attribution of bad events, (that is the helplessness model of depression which deals with a

person's internal mechanism when he or she confronts bad events) is required to be introduced in further detail. Then, with the acknowledgment of the complexity of the aetiology of depression, we will discuss the interactional resource mobilisation model, which deals with both external resource factors and internal attributional factor.

Attributional explanation of depression:

Seligman et al. describe the origins of depression as their style of explaining the reasons why people get depressed when they experience uncontrollable bad events. Abramson et al. (1978) argued in their reformulated helplessness theory that there are three relevant dimensions in the explanation of the event. Firstly, the causal explanation of bad events may be something about the person (internal explanation) , or it may be something about the circumstances (external). This dimension affects self-esteem following the events. Secondly, the cause may be stable and long lasting in time or unstable and less permanent. These explanations affect the chronicity of helplessness. Thirdly, the cause may affect global outcomes or may be limited to a specific event, and this explanations influence the pervasiveness of the event.

Causal explanations provide the risk factor which may determine whether the person becomes depressed especially when the person has an "internal", "stable", and "global" explanation style. According to the helplessness reformulation, an individual with this characteristic way of explaining bad events, will be more likely to become depressed. Seligman et al. (1987) concluded a review of this literature by saying that:

> "The cross-sectional studies show that a characteristic way of explaining bad events as internal, stable, and global co-occurs with depressive symptoms. The longitudinal studies show that this depressive explanatory style precedes the development of depressive symptoms. The experiments of nature indicate that this style results in depression once bad events are encountered." (p.135)

Seligman et al. are interested in the internal logic of the mind when one encounters a bad event and how one interprets the cause of the event.

Shortcomings of the attributional explanation

The attributional explanation raises two main issues. These are the lack of interaction between internal factors and external resources, and the question of the definition of a "bad event".

a) Lack of interactional perspectives

Seligman et al. are quite confident about the relatedness of attributional style and depression, but as they admit, they have yet to solve the question of the emergence of the explanatory style itself. Some preliminary studies indicate that the attributional style may be acquired from parents, particularly the primary caregiver (Seligman et al., 1984), and/ or through education and peer groups (Dweck et al., 1980), and finally, the reality of one's first traumatic loss (Seligman et al., 1987, p.136).

Socio-cultural influences on the formulation of the attributional style are also important, either through parents or other socialising agents. Yet the helplessness theory has only been concerned about the introspective mechanisms of depression such as individual self-control, while neglecting the interactional process between the internal (such as self concept emerged under the influence of culture) and external resources (such as cultural value systems).

b) "Bad events": the question of individual control

According to the "bad explanatory style" of Seligman et al. depression emerges when "bad events are encountered" (1987, p.132). Seligman and his collegues are interested in the bad event only as it impinged on the very person who is supposed to be the target. However, what happens when a bad event occurs affecting someone else, but matters as much to the person as to the target person.

Oatley (1988) raises the question and suggestes that there are two classes of approach to the understanding of significant events, "instrumental" (or "mechanistic") and "social". He consideres Seligman and his collegues' explanation deals only with the "instrumental" aspect, whereas he finds that a social aspects of a role is significant.

However, as far as the conceptual scheme is concerned, both "instrumental" and "social" events arise from the interruptions in the individual's self-definition goal. Therefore, individual controllability is the main concern not only in "instrumental" events, but also in the "social" cognition of disruption in role plans or goals.

Since the explanations of depression by both Seligman and Oatley are based on individual plans or goals, a question can be raised whether the attributional explanation can be applicable over the events of collective behaviour beyond the individual person as a unit of control.

Given the shortcomings in attributional explanation, which originate from using only the individual internal factors for the explanation of the aetiology of depression, a more comprehensive explantion of "resource mobilisation" will be discussed next which considers psycho-evolutionary aspects of resource mobilisation for people under stress.

3:4 The psycho-evolutionary aspect of resource mobilisation in depression

Basically theories of the stress related behaviour are rooted to the view that behaviour is a function of characteristics of the "person" (the internal resources) and of the "environment" (the external resources) (Lewin, 1935; Murray, 1938). Stress occurs only to the extent that there is some mismatch between the person and his/her environment. Furthermore, also a person reacts to their environment or social

conditions only in terms of the meaning of the situation to themselves.

After a lifelong dedication to the subject of stress, Selye (1985) defined stress as "the nonspecific (that is, common) result of any demand upon the body" (p. 17). But the fact should not be overlooked that his theory of General Adaptation Syndrome (GAS), which associates stress with illness, is essentially biological under the hypothetical assumption of "adaptation energy" (1952). However, he admitted that psychogenic stress is the most common and by far the most important from a medical point of view (1979). GAS is a triphasic syndrome produced by diverse nocuous agents in sequence of 1) alarm reaction, 2) stage of resistance and 3) stage of exhaustion.

Mikhail (1981), and Monat et al. (1985), reviewed research which attempted to integrate Selye's approach to the effect of stress on the person's body (GAS theory) with other factors, such as psychological and sociological aspects. Lazarus and his collegues' (1966) coping theory, Brown and Harris's (1978) sociological origin of depression, and Hobfoll (1986) and Kobasa's (1979) understanding of resistance (internal resources as inner strength), are some among several efforts which have contributed to this line of study.

Along the same line of thought, Gilbert (1984) made some interesting suggestions on the psycho-evolutionary aspects of stress-coping-and-depression. He began with the assumption that there is an innate basis for depression, however, cognitive processes can amplify or modify the degree of genuine threat which actually exists. This allows for a significant 'linking' of psychological and socio-biological approaches.

Similar to other cognitive theoriests Gilbert (1985) believes that the major premises of the depressive are around "survival-abandonment" themes. They believe that there is an innate psychobiological response pattern which is activated under conditions of perceived abandonment, and which might reduce the chances of survival. If a person in this state perceives that normally practised habits or modes of behaviour and resources are inadequate for handling the demand, then he or she can succumb to a state of helplessness. Even though they began to focus on childhood experiences (Beck, 1980), influenced by the psychoanalytic tradition of "object loss" or "dependency craving", it is important to note that the abandonment problems of an adult are not bound by the limits of childhood experiences (Parkes, 1982; Gilbert, 1984).

Most attention has focussed on interpersonal relationships, and the importance of "meaning" in interpersonal relationships cannot be overlooked. This importance of meaning in social relationships is brought about by learning and not by nature. As Becker (1986) stated: "Thus, culture designs the action scene, and outlines the kind of crises to which the individual will have to adapt."

Another reflection upon the interpersonal relationship carried out by Gilbert (1984) was that people need to give care to others as much as to receive it. He believes the need to give care, and reinforcement is part of our inherited behaviour patterns, linked to our emotional responses. He supports Bandura's idea of 'self-efficacy' (1977, 1978) of the internal perception of mutual interaction between the reinforcing properties of self to others. People are not just a passive mass receiving the effects of external reinforcers, but act in a mutual exchange of actions with one another. Therefore, positive experiences which people can enjoy in relationships are the perceived reinforcement they receive, and the reinforcement they perceive themselves as capable of giving to others (p. 146).

In this argument, the person vulnerable to depression may have a distorted development of self-image, which is not only incapable of eliciting care, but also incapable of being an agent of reinforcement to others. This cognitive factor plays an important role both in the evaluation of the meaningfulness of a stressful event, ('the primary appraisal'), and in the mobilisation of the coping resource ('the secondary appraisal' in Lazarus's term, 1966). It is related not simply to the interpretation of various evaluations, but to their survival relevance, through their capacity to activate biological patterns of response mediating threats to survival.

Coping continues on over long periods of time until people reach the point when they (suddenly) may realise that they can no longer cope. As Gilbert (1984) stated: "Thus, when we observe coping failure in depressed patients, this may be the product of endless attempts which have not worked out" (p. 165). He is in agreement with Brown et al. that depression is essentially a social phenomenon, and which is usually the result of a person's thoughts about his or her world, although everyone takes different paths to reach this point.

It is a useful that Gilbert covers both aspects of "giving" and "receiving" care in his idea of human nature rather than dealing only with the passive position of recipient. However, he still maintains the idea of "abandonment-survival" which indicates the deficiency effects of stress. This suggests that if individuals have more opportunities for reciprocal care with others then they may have less chance of experiencing stress.

However, he did not see the possibility of "excessive burden" or the tightness of the "entangled relationship" originating in the special meaning in lives: in some non-western culture, this can be the opposite extreme to the concept of "abandonment" or "isolation". Some non-western "collectivist" minds which "include" others in itself make "primary appraisals" (which is concerned with the evaluation of the meaningfulness of an event) inclusively. Naturally, they have more chance of experiencing the stress in due course. As one Korean proverb goes "the tree with a lot of branches cannot stay still" which means that the mother who has a lot of children can never be at peace or free from worrying over her children.

Even though they did not mention the effect of "burden" on depression, Brown et al.(1986) found that the onset of depression in British women occured with an increased rate of quite minor events which may trigger depression, even if they are not seen as provoking agents and without any obvious loss. Monroe (1982) suggested that daily hassles maintain chronic disorders as the "stress-maintenence model".

Concomitantly, the "secondary appraisal" (which deals with an evaluation of available and adequate coping resources and options) can be difficult to achieve if the person is inclusive of others. As Lazarus and his colleagues (Folkman et al., 1979, 1980; Lazarus, 1966; Lazarus et al., 1978) point out, when the stress is perceived as beyond coping capacity, it is more likely to be "stressful" than when there is a viable response available. In the inclusive case, the interplay between "primary" and "secondary" appraisal of this situation can create more chance of having an emotional reaction to stress.

When we consider the interplay between a person and his/her environment, "primary" and "secondary" appraisal should be understood as a dynamic concept with a time perspective. It should not be evaluated only by the factual outcome or the simple attribution

but the subjective and objective world should be matched. It should be done either by 'environmental mastery' through making a change in objective environment or by an 'adaptation' via a change in internal resources, or by the 'defence' which modifies the subjective internal as well as external resources.

These objective and subjective matches should be observed as a sequence of time - past, present and future. Therefore, the stressful event is not necessarily the one which actually happened, since it could be a retrospective past or an anticipated future, as well as current (Caplan, 1983, p.42-52).

For instance, it may be possible for mothers to experience similar strain as their children who are preparing for important university examinations for their placement. Similarly with the case of postnatal mothers who are used to employing the coping mechanisms of environmental mastery, adaptation, or defence, they may experience tension in the light of their past experience and future expectation.

If we accept the integrative framework for the analysis of adaptive processes presented in Fig 3-1 the difference in the underlying meanings or values between cultures may modify each component in the process in

addition to the inter-relationships among the domains affecting the behavioural, cognitive, and affective outcome.

For instance, if we anticipated seeing the differences in the self-concept between the two cultural values (i.e. more individualistic Scottish versus more inclusive Korean (Triandis, 1988)), it may be a determining factor for not only the perception of stressors but also the personal as well as external resources.

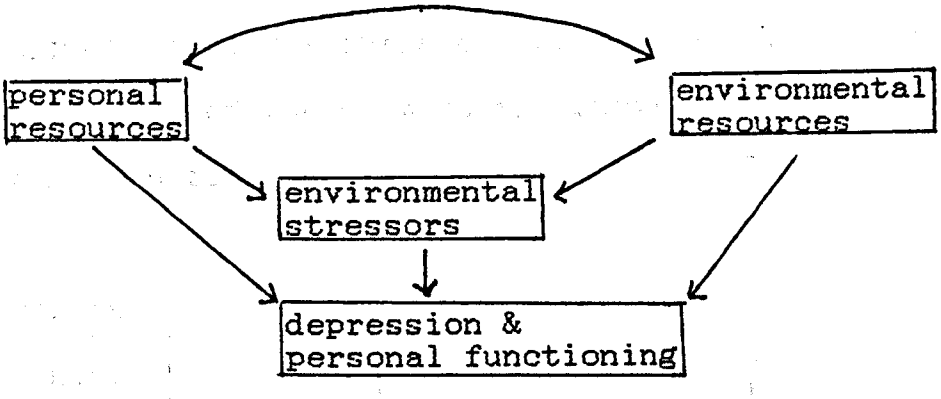

Fig.3-1: An integrative framework for the analysis of adaptive processes and depression (simplified the model by Billings, 1986, p. 332)

It is, therefore, worthwhile discussing this kind of basic factor such as internal ones, (i.e., attributional style) and the effectiveness of external resource, (the social support system), environmental stressors, (stressful ife events) in the two cultures in the following chapter.

Fit between external and internal factors

Caplan's idea of 'person-environment fit' (1983) is appropriate in explaining the process of evaluation in human behaviour in terms of the relative fit. The concepts of "good fit" as comfortable, whereas "too much" or "too little" environmental stimuli are perceived as stressful. We apply this to explaining the stress situations cross-culturally. Too much inclusion (i.e. too little isolation) and too little inclusion (i.e. too much isolation) formuate a hypothetical U - shape curve. Depending upon the placement of the spot on the curve the degree of strain can be noticable.

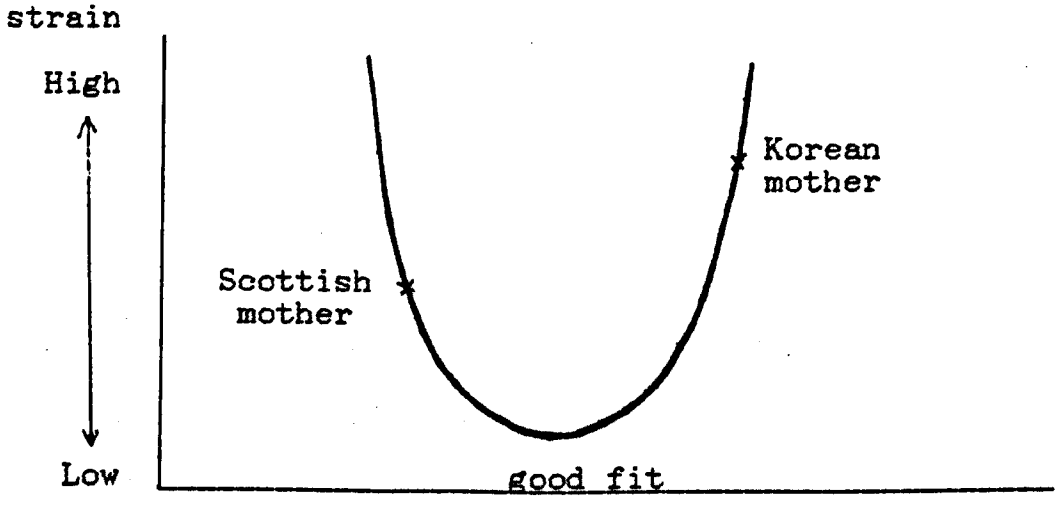

Fig.3-2: Hypothetical shape of the relationship between resource and strain - adapted to Caplan (1983, p.39).

For this study, Korean mothers are probably situated more at the "too much inclusion" (i.e. "too little isolation") end, while most of the Scottish mothers will be located on the other side, "too little inclusion" (i.e. "too much isolation") under the influence of sets of cultural values, which are "collective inclusive" and "individual autonomy"' respectively.

Even if a person is in a situation which is valued in that specific culture, for instance, more "inclusion" for Korean, or more "isolation" for Scottish people, "too much" or "too little" of either is stressful. People tend to complain according to the values of their society. For instance, the Korean mother might complain about "too much worry over their family", whereas Sottish mothers might complain about "being too isolated"

	Scottish	Korean
Valued:	"independence"	"inclusion" ("collectivistic")
Too much "-":	isolation	burden of relations
Relationships: (support)	positive (effective)	negative (ineffective)

People do not stop there, but the culture also influences the effectiveness and effort in improving

the situation (Pagel et al., 1987). The problem of isolation can be solved individually through skill and ability to mobilise social support, which most of the Scottish middle class people are well equipped with. It is not as simple for Koreans to be helped due to their inclusive tendency.

The person who is inclusive may have a tendency to consider other people's support as if it is a natural internal resource. Therefore, if it is unavailable one has more chance to be discontented, or if one has it one is not as keenly perceptive of it and tends not to appreciate it. In the opposite case, if one had individualistic responsibility, then one would appreciate the support of others as an external resource.

Now we will review the cross-cultural studies on depression.

3:5 Cross Cultural Studies on Depression

It has been a widely held belief that non-westerners exhibit differences from westerners in the degree of severity and the quality of depressive symptoms experienced: i.e. non-westerners scored higher than westerners in degree of severity; and they complained more of somatic symptoms than cognitive-affective ones. In this section we will deal with cross-cultural studies in two areas: (1) the differences in severity of depression between cultures; (2) the differences in symptom characteristics.

(1) The Differences in Severity of Depression

It has been widely found that Asians scored higher than Europeans and North Americans on depression scales. Marsella et al. (1975) found that Chinese and Japanese, compared with Caucasian female students, scored higher (on average scored 8.08, 8.12 and 6.49 respctively on BDI). The difference between the Caucasian American students on the one hand, and Chinese and Japanese American students on the other, was significant. Thus subjects of Asian ancestry scored higher on a depression scale than their Caucasian peer group.

In the same study Marsella et al. (1975) tested university students of different ethnic background in America using popular self-report measures of depression: KAS-Hogarty Depression Scale, the Multiple Affect Adjective Check List (MAACL), the Minnesota Multiphasic Personality Inventory Depression Scale (MMPI), and the Zung Depression Scale as well as BDI. When placed in rank, Japanese females came first (meaning most depressed) on BDI and KAS-Hogarty, whereas Chinese females were placed first on MMPI, MAACL and Zung. And they alternated on the second place on these scales except on MAACL which ranked Chinese males in the second position. It is worth noting that Oriental females scored higher than Caucasian females and the male counterparts.

Marsella et al. also pointed out that all these measures were developed with subjects from western sociocultural traditions, which suggested to them the tentative assumption that there may be ethnic variations in both response styles and social desirability (e.g. ethnic variations in giving answers that are socially desirable). These are of great importance in self-report measures. There is certainly good reason to believe that ethnic variables do affect these results.

Zung (1972) found some differences even within European countries. He tested his own Self-rating Depression Scale (SDS) using 1981 normal subjects in six European countries. Rank ordering of the mean SDS indices illustrated Czechoslovakia (N=697) to be highest, followed by Sweden (N=82), Germany (N=64), Spain (N=597), England (N=177), and the U.S.A.(N=364). An analysis of variance indicated that mean indices of Czechoslovakia and Sweden were higher than the mean for all countries combined, and the indices for England and the U.S. were significantly lower ($p<0.01$).

This demonstrated a quantitative difference in depression present in normal adults among the 6 countries, and the author attributed these differences to social and cultural influences. Zung thus suggested that the fundamental signs of depression may have explicit sociocultural influences in the normal individual but are less so in the depressed. He also tried to compare the rank order of depression with suicide rates for these countries, to conclude that the rank ordering of the countries was the same for both depression and suicide rates.

Leff (1981), quoting several studies on the number of psychiatric patients among immigrants in the U.K.

compared with those among the indigenous population, found that the ratio of people who showed the affective disorders was greater among Asians and West Indian immigrants than among the natives. An important source of bias could lie in the methodology of the investigations as the test materials were developed for the natives. Furthermore an alternative explanation might be the stress of living in an alien culture.

The conlusion which can be drawn from the above studies is that there are cultural differences in the severity of depression (i.e. higher depression scores are found among non-westerners than westerners). Differences in symptom characteristics of depression will be discussed in the next section.

(2) The Differences in Depressive Symptom Character

It has been well established that symptoms of depression among non-westerners are characteristically complaints about the body rather than those of thought and emotion. The review papers by Marsella (1980), Pfeiffer (1986), and Racy (1970), summarise the literature on the manifestation of depression across cultures, and all are of the opinion that non-Europeans

did not show "guilt" and that somatic dysfunctions were always found at the core of their symptomatology.

Several cross-cultural studies confirm this. For example, Morsbach et al. (1983) found more symptoms of depression in 120 Scottish women in the 8 days following child-birth than in 131 Japanese women at the same stage, the latter group expressed more concern for their own appearance and the well-being of the infant. The large overlap in the distribution of "maternity blues" symptoms between the two groups showed that a considerable number of Japanese mothers suffer from the "blues" as well, though to a significantly smaller extent and differing in quality.

Cox (1983) also found 18 out of 183 Ugandan women at 6-15 weeks after childbirth who showed depressive illnesses measured by Goldberg's Standardised Psychiatric Interview. He found that Ugandan women would not seek help for their depressive symptoms, and they were less likely to report guilt or self-blame. As Cox (1983) stated: "The Scots were more likely to be concerned with failure to live up to their expectations of the good mother, ... and also more likely to question whether or not they were behaving correctly. They were particularly concerned if they did not show

sufficient affection towards their infants. The Africans by contrast only rarely described such feelings."

Ebigbo (1982) identified a number of complaints among depressed Nigerian patients that would have been unusual for the Europeans such as heaviness and heat in the head, crawling sensations in the head and legs, burning sensation in the body, and feelings of the stomach being bloated with water and moving around the body.

Stoker et al. (1968) compared the symptom profiles of Mexican-American female psychiatric patients (N=25) and Anglo-American female patients (N=25). The Mexican-American showed more agitation and more emotional, whereas Anglo-Americans were characterised by guilt, and psychological and physical retardation.

With regard to the biological measurement of depression, such as Central Nervous System metabolites in urine and cerebrospinal fluid, and psychophysiological indices, the appropriate data is not yet available. Marsella et al. (1984 quoted in Marsella, 1987) compared electrodermal response patterns of Japanese and northern European females in

depressed and anxious states. They found no ethnocultural differences in the absolute amounts of tonic levels, amplitude levels, response latency speeds, recruitment speeds, or recovery speeds.

Marsella et al. (1975) studied Caucasian, Chinese and Japanese normal and depressed subjects. They indicated that Caucasians expressed depression as an existential complaint; Chinese as somatic; and Japanese as interpersonal complaints. Marsella et al. interpreted these differences in association with self structure. If a culture conditions a view of the self in terms of somatic functioning, then somatic symptoms will tend to dominate the picture in depressive symptoms.

A study by Tanaka-Matsumi et al. (1976) investigated the subjective experience of depression among college populations from different cultural backgrounds. The subjects consisted of 150 Japanese-nationals (53 males and 97 females), 158 Japanese-Americans (55 males and 103 females), and 146 Caucasian-Americans (62 males and 84 females). They used the word association method with the stimulus word being "depression". Japanese-nationals gave more external referents, such as weather and colour, while Japanese-American used words referring to internal mood states. Among the Japanese-

Americans, the majority associated the term with internal mood states which refer to negative experiences. For instance, they frequently use "frustration" and "failure". Caucasians used more words related purely to internal mood states.

The authors discuss the results in terms of cultural differences in self concept. The self in the west has been based on an individual-centered model of man, whereas the Japanese individual is a part of an entire social nexus which acts as a unit. Therefore, for the Japanese the subjective experience of depression takes an outer-directed rather than an inner-directed channel. A similar study with Korean university students also associated romantic atmosphere (such as sad music, moonlight) with the depressed mood state (Park, unpublished).

A matched study (Kimura, 1965, quoted by Marsella, 1980) of endogenous depressives admitted to psychiatric clinics in Japan (Kyodo) and Germany (Munich), reported that there is a greater tendency to tolerate depressive phenomena in Japan where depression and suicide have different connotations, which are not entirely negative.

Cross-cultural symptom differences are not only limited to depression but extend to general mental illness. Baskin (1984) studied 20 countries on cross-cultural concepts of mental illness asking people who worked in mental health professions to diagnose some hypothetical cases. He found that mental illness is affected by culture specific social norms. For instance, culture boundedness of symptoms was clearly shown by Qatari women who "failed" in terms of their cultural value systems by not having a child or husband (El-Islam, 1975). The women experienced problems associated with the two "key" organs: the head and the heart. Symptoms include giddiness and heartache expressed as emotional distress and nausea. The syndrome provides the patient with a physical explanation for her failure to fulfill the social expections. The folk illness 'susto' (soul loss) among Hispanic people is another example of culture bound symptoms (Rubel, 1977). It was suggested that the sick role adopted in 'susto' is a conscious choice made as a strategic alternative to the less rewarding gender related and other roles in Hispanic society (Uzzell,1977).

Leff (1981) also raised the question of "culture-bound" symptoms. He accepts their existence and proposes the differences in symptoms originate from the belief

system, and thus the occurence of a symptom may be widespread in a given area. Furthermore, Leff argues, there is often a feature in local mythology which explains the fear or anxiety which gives rise to the symptom.

Cultural differences in interpreting and expressing inner experiences of emotions are reflected in the different vocabularies found in different languages. For example in a number of languages it is impossible to directly translate the term "depression". For instance, the Indo-European group of languages do allow the direct translation of the term "depression", whereas Chinese, Yoruba, and a Nigerian language, do not (Leff, 1981, ch.4). Analysis of these languages reveal that the former group have more differentiated vocabularies, while the latter contain more expressions which describe somatic experiences. Each culture develops its own way of expressing those issuess which seem particularly important, because the function of language is to report the experience as well as to define it.

Althuler et al. (1988) investigated Chinese people who seek mental health care comparing them on DSM-III (Diagnostic and Statistical Manual of Mental Disorders,

Third Edition) criteria and Chinese criteria. He found that there were significant and consistent differences in diagnosing between Chinese and western standards. This was especially true in the area of major depression. Lin et al. (1981) reviewed this study, and indicated that the overall prevalence of mental disorders among Chinese is roughly similar to that reported from other cultures. The main difference lies in the particular ways Chinese patients present their psychiatric problems. Lin et al. agreed with Tseng (1975) regarding the verbal expression of emotion characterised by body-oriented expression in the Chinese culture. This would account for the observation that among 361 consecutive patients in the Hunan Medical College, Psychiatric Clinic, only 1% were diagnosed depressed while 31% had neurasthenia (Keinman, 1982, p.136) (the latter probably would have been diagnosed as depressed in the west). It is widely accepted in China that each person has his or her own worries and emotional problems and that these should not be considered as unusual problems. This leads to problems being conceived and presented in somatic terms based on one's own medical knowledge and orientation.

Somatisation is predominant in Chinese society because somatic illness is an effective and legitimate excuse

to request rest and care from others, while psychological stress is not accepted as a difficulty which requires treatment and care. It is a general expectation in Oriental cultures that a person should endure psychological strain without any expression. Thus patients present their problems in terms of somatic complaints which effectively signal their illness. With culture bound symptoms such as 'shen-ching chuai-jo' (neurasthenia, which predominates among neurotic patients), 'Hsim tsap tsap' (discomfort in the chest and palpitations, but meant to convey that the patient has anxious and depressed feelings), and 'koro' (frigophobia among male population) being typical Chinese complaints.

This is exactly the same practice as is found in Korea where lay people diagnose their family members' disease before they approach professional medical personnel. Every family has its own copy of a medical encyclopedia and its own remedies and cures for all kinds of illness. Usually senior members of the family are the keepers of the family's diagnostic knowledge and prescribe the appropriate treatment for the symptoms.

This willingness to pursue home remedies and treatments was demonstrated by Yoon (1987) who studied the Chinese

community in Glasgow and found that Chinese people do not seek help from their physician at as early a stage in the illness as the indigenous population generally do in Scotland.

Rack (1982) found evidence of culture bound syndromes among Pakistani patients in the U.K. He explained symptoms, such as somatic complaints, as being metaphors, which omit (perhaps even deny) the emotional aspects of the condition: to them, the physical symptoms are the only acceptable ones. An alternative explanation, also suggested by Rack, is that the differences in presenting symptoms may be due to them being interpreted and expressed in different language.

Leff (1981) tends towards the belief that functional psychological disorders were universal. However, the instruments used in all studies were constructed in the west and may have imposed a cultural stereotype on the populations examined. Leff argues that it is necessary to repeat the cross-cultural comparisons with instruments developed in non-western cultures. Marsella (1980) holds similar ideas, and suggests some of the typical (i.e. western) symptoms found in non-westerners might be due to the westernisation of the non-western cultures. It may, therefore, be expected

that Korean mothers who had experienced westernised higher education may well show all round symptoms of depression. It is also possible that the task oriented cultural influences on Korean mothers may lead to them scoring higher on "somatic-performance subscales" than the Scottish mothers. If the weighting on this particular BDI subscale is large then it could lead to cross-cultural differences between the groups of Korean and Scottish mothers being magnified.

A study conducted by Yoo (1961), employed an intensive census visit method in Korean rural communities. He compared his findings with other studies done in Bavaria, Bornholm, the west coast of Norway, Tennessee, Formosa, and Hachijo Island, and which used the same assessment method. In Korea he found that manic-depressive psychosis was less frequent than in any of the other, above mentioned, cultures. He also reported that the rate of manic-depression for Korean women was higher than for Korean men. It is difficult to relate and discuss this in terms of the subjects in this study, as Yoo only looked for cases of psychosis while we did not. However, it is worth noting that Lee (1977) used Marsella's Symptom Check List and also found significantly more depression in Korean women than in Korean men.

We can conclude that based on the objective evidence discussed above, Asian women tend to score higher on depression measures than those from a Europian background and display more somatic characteristics.

3:6 Assessment of Depression

There are two main issues which have to be considered in the assessment of depression: 1) the wide range of symptoms; and 2) the method of assessment. These will be discussed briefly in terms of cross-cultural studies which draw on normal population.

1) Criteria of depression:

It is widely recognised that the term "depression" refers to a heterogeneous group of symptoms that include a number of distinct psychopathological conditions. This creates difficulties when assessing depression.

It is necessary to have operational criteria for the symptoms which characterise depressive disorders. A number of people have dealt extensively with the problem of symptomatology by means of multivariate and factor analytic techniques. For instance Zung et al.

(1974) provided us with one such set of results after reviewing several studies in the line. He divided 20 symptoms into 4 categories:

I. Pervasive affective disturbances
   1. Depressed, sad, and "blue"
   2. Tearful

II. Physiological disturbances
   1. Diurnal variation: exaggeration of symptoms in the early morning and some relief as the day goes on
   2. Sleep: characteristically early or frequent waking
   3. Appetite: decreased food intake
   4. Weight loss: associated with decreased food intake, or increased metablism and decreased rest
   5. Sex: decreased libido
   6. Gastrointestinal: constipation
   7. Cardiovascular: tachycardia
   8. Musculoskeletal: fatigue

III. Psychomotor disturbances
   1. Agitation
   2. Retardation

IV. Psychological disturbances

1. Confusion
2. Emptiness
3. Hoplessness
4. Indecisiveness
5. Irritability
6. Dissatisfaction
7. Personal devaluation
8. Suicidal rumination

The American Psychiatric Association (1987) come up with the following categories of symptoms:

At least five of the following symptoms have been present during the same 2-week perod and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood, or (2) loss of interest or pleasure.

(1) depressed mood most of the day, nearly every day
(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
(3) significant weight loss or weight gain when not dieting
(4) insomnia or hypersomnia nearly every day
(5) psychomotor agitation or retardation nearly every day
(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day

(9) recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

Even though our research interest is limited to cases of minor depression or depressive mood state among the normal population, we have to cover all the criteria for the purpose of assessment. This is, because minor depressive disorders are diagnosed when there are non-psychotic episodes of illness, in which the most prominent disturbance is a prevailing mood of depression. The full blown depressive syndrome is not in evidence but nontheless some features are present (Beck, 1980, p. 360).

It is even more necessary to cover a wide range of symptoms in cross-cultural studies assessing depression, as such comparisons will continue to pose problems until there is world wide agreement on a uniform system for classifying, diagnosing, and quantifying the symptomatology of the various forms of depression (Sartorius et al., 1986, Foreword). If we

try to assess negative thinking patterns and their intensity through a descriptive diagnostic approach, we have to constantly remind ourselves of the fact that those patterns are determined and overshadowed by the specific values inherent to the culture in which the approach was developed. Therefore, depression scales should cover as wide a range of symptoms as possible to try to represent the variety of characteristics found in cross cultural comparisons.

For instance, if self criticism is viewed as a virtue in a certain culture, then the cultural group may score more highly on the relevant subscale of the depression inventory. For example, Zigmond and Snaith (1983), reviewed measurments of depression and emphasized "anhedonia" as the main feature, yet this is not an essential or necessary feature in other specific cultures. Therefore, it is more informative to include subjective feelings and thoughts as well as somative performance features in the scales.

Even though a scheme which covers all types of depression has yet to be established, the descriptive diagnostic approach, which is based on a wide range of symptoms, provides a basis for determining whether a person is experiencing a depressive syndrome.

2) Methods of depression assessment

A recent comprehensive publication on the assessment of depression edited by Sartorius et al. (1986) covers 21 different kinds of scales used throughout the world. The instruments come in a variety of forms: from a brief rating scale to comprehensive, semi-structured interviews. Generally they can be classified into two methods of rating: the interviewer-rating; and the self-rating.

Of the 21 instruments reviewed by Sartorius et al. (1986) 11 are recommended to be administered by trained interviewers and 9 were designed to be self-administered (one was designed to be administered by interviewers but in practice it is most often used as a self-administered scale). Both methods have their strengths and weaknesses in their ability to detect depression within a general population.

The chief disadvantage of using self-report inventories is that they only reflect the symptoms actually expressed, and are suitable only for people with sufficient insight and adequate vocabularies (Pichot, 1986). The denial, exaggeration, and loss of insight, which depressed patients experience can be a source of problem when using self-rating scales.

Secondly, if the items are graded by severity (eg. "mild", "moderate", "severe", etc.) or by frequency (eg. "rarely", "often" etc.), it may be impossible for people to make such judgements. Indecisive depressed people may be quite incapable of filling in a form, or they might complete it in a random fashion (Hamilton, 1982). These points are valid in cases where the study deals with psychiatric patients. The latter difficulty in making judgements with graded items, which can also be problematic for normal populations, was solved in Beck's Depression Inventory by arranging each item in the form of a separate descriptive sentence.

Technically it is easier to use self-rating methods because these do not require the participation of a competent psychiatrist or professionally skilled person. If raters are not professionally skilled people, there may be problems of inconsistency which can increase the error variance and make it impossible to replicate the experiment. There are several possible sources of error and bias in interviewer rating methods. For example, "logical error", "halo effect", "proximity error", "error of leniency", and "response set" bias (Hamilton, 1982). Interviewer easily use his/her own way of thinking, can be influenced by background informations, or categorize the responses in certain type.

Even if the raters are professional psychiatrists or psychiatric nurses, there can be semantic differences in judgement and in communicating the details of symptoms. For instance, Pinard et al. (1974) found that psychiatric professionals employ the same vocabulary and terminology which differs from that which the patients use to express and describe emotions. Even the same term can have varying nuances to the patient and the psychiatrist. The interpretation of the results must be considered by the subject as a true reflection of his or her state if they are to have any validity to them.

The balance between subjective complaints, on the one hand, and the rater's objective observation, on the other, remains as a central question in the assessment process. However, as this study deals with a relatively normal population equipped with the ability to make and express a certain level of judgment the disadvantages of using self-report methods, as discussed above, can be minimised. It may also be possible to avoid the contaminating effects of raters who have different life experiences - this can be an important source of error in ratings, especially in cross-cultural studies.

In summary, it can be said that while self-ratings which explore mainly subjective feelings of depression may not be the ideal instrument for the study of clinically depressed people, they can be useful in the detection of depressed mood states in the general population. After due consideration, it was concluded that the Beck Depression Inventory should be used for this study, since it provides us with a standardised consistent measure that does not necessarily rely on any specific aetiological orientation. It is also convenient since it permits the use of numerical scores for the comparative study, as well as having an economic advantage over the clinical interview and observation method, which are expensive and time consuming.

A description of the Beck Depression Inventory, and a discussion of its validity and reliability, are detailed below.

The Beck Depression Inventory (BDI)

BDI covers a wide range of human emotional-cognitive experiences which meets the requirements of the variances in culture. Beck, et al. (1961) chose 21 symptoms:

> "on the basis of their relationship to the overt behavioural manifestations of depression and they do not reflect any theory regarding the etiology or the underlying psychological processes in depression" (p. 562).

As far as the cut-off scores are concerned, there is no arbitrary score that can be used for all purposes (Beck et al., 1974, p.163). Beck and his collegues' most recent suggestion as to the cut-off scores computed by summation of values of the 21 symptoms are: mild depression (low) scores are less than 14; moderate (medium) is between 14 and 20; and severe depression is 21 and above (Steer et al., 1986).

Some previous studies adopted different criteria. For example, Beck (1980) used 17 as the point were psychiatric services were needed, and a score of 10 indicated the need for outpatient psychiatric service; Rees (1971) used 10-16 as being mildly depressed, 17-24 moderately depressed, and 25 and over as severly depressed; Bryson et al. (1984) had four categories, 0-9 as non-depressed, 10-15 as mildly depressed, 16-23 moderately depressed, and 24-63 as severely depressed.

This study will adopt the scoring categories of Steer and Beck (1986), as these were adopted after an extensive review of relevant literature and the authors were part of original team who had established the

inventory. Further, Steer and Beck have extensive practical experience of using the inventory which they have consistently employed in their research spanning more than a quarter of a century.

The later version (1978) of the BDI was used in the present study, rather than the 1961 original, as it has been shown to be internally consistent by Beck et al. (1984).

Validity and usages of BDI

The validity and reliability of the BDI is well established. Beck (1984) has recorded 500 further clinical studies done with BDI and innumerable other research has employed this inventory. The first psychometric study was done with 606 patients where the odd-even internal reliability coefficient was 0.86, and the agreement between two psychiatrists was 73 %. The level of concordance in the rating of "depth of depression" within one degree on the 4-point scale was 97 % of the cases (Beck, 1961). Many studies (Steer, Beck, & Garrison, 1986; Steer, Beck, & Riskind, 1986; Hill, et al., 1986; Riskind, et al., 1985; Lips, 1986; Burkhart, 1984; Byerly, 1982; Hammen, 1985; Davis, 1982; Sacco, 1981; Beck, 1984) have evaluated the BDI

with clinical and non-clinical populations and found the levels of internal reliability and validity to be as high as in the original study.

Hill et al.(1986) investigated British university students, and found that while BDI principally measures depression, it also takes account of other apspects of general psychopathology. Gotlib (1984) claimes that BDI measures general psychopathology indiscriminately. However, other studies (Bumberry et al., 1978; Hammen, 1980) seem to support Hill et al. (1986) and conclude that BDI does measure general psychopathology as well as specific aspects of depression, independent of general psychopathology.

Steer et al. (1986) argue against the idea that depression and anxiety co-exist, and may even be causally related. They found that (DSM-III) depressed patients show not only higher average total score (M=26.37, SD=6.94 versus M=14.46, SD=6.10) but higher scores in 'sadness' and 'loss of libido' items than do anxious patients, and are convinced that BDI is a powerful tool for differentiating depression from generalised anxiety disorders.

Factor analytic studies have been done with BDI scores

from several types of clinical sample, for instance alcoholics and heroin addicts (Steer et al., 1977; Steer et al., 1982), attempted suicides (Beck et al., 1973), hospitalized psychiatric patients (Cropley et al., 1966; Weckowicz et al., 1967) and affective disorders (Berndt, 1979; Golin et al., 1979; Steer et al., 1988), as well as nonclinical populations (Campbell et al., 1984). Most have found three general factors emerge - (1) negative attitudes / suicide, (2) performance difficulty, and (3) physiological manifestations (Steer, et al., 1988; Steer, et al., 1986). These can also be divided into two subscales: Cognitive-affective (first 13 items), and Somatic-performance (last 8 items) (Steer et al., 1988). Golin et al. (1979) found four categories of factors: emotional, cognitive, motivational, and vegetative/ physical, in mildly depressed population. On examining the content of Golin's four categories we found the cognitive-affective subscale covers the former two factors and somatic-performance subscale deals with the latter two.

Campbell et al. (1984) factor analysed the BDI scores of 214 depressed and non-depressed groups of cardiac outpatients and came to the conclusion that "it is clearly a useful instrument in terms of its level of

internal consistency". Several studies have validated the BDI on normal and clinical populations (Hill et al., 1986; Hammen, 1980; Bumberry et al., 1978; Meites, 1980; Gotlib, 1984).

The BDI has been used for measuring the effectiveness of treatment for geriatric patients (Steuer et al., 1984; Riskind et al., 1985) and postnatally depressed women (Halonen et al., 1985; Rees, 1971) as well as diagnostic function on substance abuse cases (Steer et at., 1985; Steer et al., 1982; Steer et al., 1977) and attempted suicide cases (Beck et al., 1973). There are also several studies on sex differences in depressive symptoms (Hammen, 1977; Steer et al., 1988). Generally they agree that there are no sex differences in the degree of depression experienced, but there are some differences in the loading of discriminating factors, which can be explained as the result of gender related cultural differences. Men express an inability to cry, a sense of failure and somatic complaints, whereas women show indecisiveness and self-dislike (Hammen, 1977). Steer et al. (1988) classified the differences between male and female populations into 'the combined affective performance' versus 'the combined affective and cognitive' symptoms.

Bryson et al. (1984) tested the BDI on university coeds (N=384) with two methods of administration which were the 'face-to-face' interview and the 'self-administered' method. Scores appeared to be unaffected by the method of administration.

BDI has been used to help establish the validity of newly developed instruments and it has been employed in conjunction with other instruments in assessing a subjects condition (Bloom et al., 1968; Carroll et al., 1973; Spitzer et al., 1967; Lubin, 1966; Hamilton, 1967; Tanaka et al., 1987).

Cross-cultural applications of the BDI are widespread among the east and the west. Translated versions in European languages are widely used while some eastern language translations are also used. Marsella and his collegues employed it along with other scales for Americans from different ethnic backgrounds (Marsella et al., 1975, 1982). They found it to be valid and reliable after cross-validation research on a normal population of different ethnic subjects. Marsella et al. also reported some qualitative and quantitative differences between cultures and gender. Even though the measures were developed with subjects from western sociocultural traditions, they found it more

generalisable to the female population than to the male (1975). Marsella (1982) also found that Chinese Americans express more somatic complaints, Japanese Americans complain more about interpersonal dysfunctions and appearance, and Caucasian Americans voice more existential complaints such as meaninglessness, depressed mood and pessimism.

Similar observations to Marsella's (1982) of the Chinese-American characteristics have been reported by several authors (Tseng, 1975; Kleinman, 1982, 1981; Mechanic, 1986; Chang, 1985), and by Yanping et al. (1986) using the BDI in China.

A reliable measuring instrument should include a wider coverage of affective-cognitive and somatic-performance symptoms. BDI covers a wide range of these human experiences to meet the cultural variances. Which makes it one of the most suitable measures available to assess the level of depressed mood in subjects from a number of cultural backgrounds. The BDI, therefore, satisfies the basic needs of an informative and reliable measuring instrument.

CHAPTER FOUR

THEORETICAL BASIS OF RELATED VARIABLES

As discussed in the previous chapter depression has been mostly related with: attributional style of the person (internal factor); social support system (external factor); and stressful life events. In this chapter we will briefly discuss these three related factors.

4:1 Attributional Style

This section deals with attributional style as one of the basic underlying internal factors which may contribute to the aetiology of depression. Firstly, a brief review of the theory of attributional style will be presented. Secondly, the attributional style will be discussed in a cross-cultural context. Finally, the measurement of attributional style will be considered.

(1) Brief Review of the Theory of Attributional Style

The "attribution theory" originally proposed by Fritz Heider (1958), was that people seek to explain their actions, or events that have occured by attributing

them to some factors. Heider's underlying assumption is that people act as "naive or common-sense psychologists" in attempting to explain their own behaviour. He suggested that there are basically two types of causes involved in any behavioural attribution. Firstly, the internal causes which are inferred: personal "dispositions" (eg. ability or effort of the person), and secondly, there are the external causes including any environmental "situation" and located outside the person (eg. task difficulties or luck). In other words, factors located either within the person, or within the person's environment.

Rotter (1966) made an influential contribution to the development of attribution theory when he introduced the concept of the locus of control. This concept is part of Rotter's (1966, 1982) social learning theory of personality, and represents a generalised expectancy concerning the determinants of rewards and punishments in one's life. At one extreme are people who believe in their ability to control life events (internal locus of control), while at the other extreme are people who believe that life events are the result of external factors such as difficulties of task or luck (external locus of control).

Weiner et al. (1971) added a second dimension to Rotter's concept of internal-external locus of control, which is the variablity over time of the cause. For example some causes are perceived as being constant and stable, while others are considered more variable in terms of their temporal duration, and are thus subject to change. Essentially Weiner et al. proposed a 2x2 categorisation scheme with four extreme positions - that is, external stable; external variable; internal stable; and internal variable.

Yet there were many shortcomings of such a classification scheme. Rosenbaum (1972) pointed out that variations in volitional control, should be taken into account. Such criticism led Weiner (1979) to add a controllability dimension to his scheme. This dimension interacts with both the internal-external locus of control and relative stability over time of the cause.

With these modifications Weiner now proposed a 2x2x2 (Locus x Stability x Controllability) classification scheme to explain the underlying causes of behaviour. The "internal-external" locus of causality dimension refers to the location of a cause (internal or external to the person), the "stable-unstable" dimension relates to the temporal duration of a cause (relatively

constant over time or changing from moment to moment), and the controllability versus pervasiveness of the event concerns the possible freedom to alterate the cause (relatively controllable or uncontrollable).

So the possible combinations (with an example of a student) are: internal-stable-uncontrollable (eg. low aptitude); internal-stable-controllable (eg. never studies); internal-unstable-uncontrollable (eg. sick on the exam day); internal-unstable-controllable (eg. did not study for the particular test); external-stable-uncontrollable (eg. school has hard requirements); external-stable-controllable (eg. particular test was difficult); external-unstable-uncontrollable (eg. bad luck); external-unstable-controllable (eg. friends failed to help) (Weiner, 1986, p.294).

In constructing his theory of attribution, Weiner's guiding principle states that people seek to understand and discover why an event has happened to them. Once the cause, or causes, are identified then effective management becomes possible and future actions can be planned on that basis. This search for a cause is not indiscriminately carried out in all situations. Rather, people tend to search for causes of events that are unexpected, disappointing or important. All these cognitive procedures are aiming for mastery and control

over the encountered situations to prevent future unexpected outcomes or disappointments. We can readily see the emotional share in these cognitive procedures. In other words, both expectancy and affect are often mediated by, and products of, causal attribution (Weiner et al., 1980).

Weiner's attributional model is important, not only because it shows how cognitions influence motivation, but because it emphasizes the clear relationship between emotion and motivation. In attempting to create an attributional explanation, Weiner had explained the subgoal of delineating the specific linkages between the structure of attributional thinking and qualitatively distinct emotional reactions (see Weiner, 1985).

A number of researchers have attempted to apply the concepts of Weiner's attribution model to the phenomenon of reactive depression. The most widely known attributional model of depression is the reformulated learned helplessness model (Abramson et al., 1978, 1980, 1981; Seligman et al., 1979).

Abramson et al. (1978) also identifies three dimensions in their Reformulated Learned Helplessness Theory: 1) whether the cause of the event is something about the

person ("internal" explanation), or is something about the circumstances ("external" explanation); 2) whether the cause is considered to be "stable" or "instable" in terms of time; 3) whether the cause affects "global" outcomes or applies to limited "specific" ones. This model was based on Weiner's 2x2 scheme but adds a third dimension of global versus specificity, which differs from the later addition to Weiner's controllability dimension. Weiner (1985) criticises the third dimension in Abramson et al's model, saying that it cannot be detected in a single empirical investigation across temporal aspects and situations.

Seligman and collegues hypothesize that some individuals have a particular attributional style which makes them more vulnerable to experience depressive symptoms following stressful (bad) events. The risk factor which leads a person to have depression is that he or she has an "internal", "stable", and "global" attributional style. According to the helplessness reformulation theory, the person with this characteristic way of explaining bad events is more likely to become depressed.

Weiner (1985; 1986) emphasizes the past experiences of the person in determining motivation and indirectly implies that there might be some cultural influence on

attributional style. However, in common with most cognitive theorists, Weiner is interested in the attributional style which is associated with individual control or mastery of the individual over his or her own life. Yet some cross-cultural observations provide inducements for the further investigation of this apect. This is especially so in the case of the locus of cause, and whether the differences in self-boundaries are based on "collectivistic" ("inclusive") or "indiviudalistic" criteria.

It seems therefore, to be worthwhile investigating the diversity of the self-boundary between cultures in terms of the attributional unit which determines the internality-externality of the locus of causes.

(2) Cross-cultural observation

It has been a widely held belief that Europeans (or westerners) attribute more internally than do Asians (non-westerners). In other words, Europeans tend to feel more personally responsible for what happens to them, whereas Asians see themselves as being more passive in their social environment. This has been investigated in a number of recent cross-cultural studies.

Berry (1982) suggests classifying cognitive styles according to the separation of the self from the environment or as he terms it "field". This led him to develop the concepts of "field-independence" and "field-dependence".* Berry explains these perceptual-cognitive styles as those who have "field-dependent" characteristics tend to rely upon external referents, whereas those who have "field-independent" characteristics rely upon internal referents. This seems to be identical to the "external" or "internal" locus of attribution, as discussed earlier. Berry's interest is based on the ecological aspect of the cultures where the world is classified largely into the industrialised western society and the traditional non-western societies. It is believed that the degree of differentiation in the individual is due to the socialisation process, and this leads to people acquiring more autonomy in the western industrial form of society. Some of the non-western countries (including Korea or Japan) are industrialised. However, as it has been discussed in chapter II the people of the industrialised Korean society are still under the influence of traditional Confucianism.

Evans (1981) used American (N=50) and Japanese (N=56) university students to examine the internal and external locus of control and found that Japanese

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* The concept of "field-dependence" and "field-independence" was used by Witkin (1967) prior to Berry.

students scored significantly higher in ratings of external locus control and, in word-association tests, they used more external terms. Evans suggests this phenomenon is the result of differences in linguistic patterns of self-representation which are also a reflection of the values of the cultural groups.

A number of cross-cultural studies using American and Japanese subjects (eg. Rothbaum et al., 1982; Weisz et al., 1984) have proposed a two-process model of an individual's perceived attribution of control. American subjects, it is claimed, employ mainly "primary" control which operates by them attempting to change or influence existing realities. Japanese subjects, on the other hand, more frequently use "secondary" control methods which leads them to attempt to accomodate themselves to the existing realities of the situation. These differences are usually understood in terms of internal and external control. The case of "primary" control is seen as the individual exercising "internal" control over the environment whereas "secondary" control is seen as the environment controlling the person - external control. This has led to primary control being categorised as internal attribution while secondary control is external attribution.

Azuma (1984), commenting on this research, suggests that there can be subtle differences in forms of "secondary" control linked to feelings of "love and empathy". These differences could act to enhance the persons sense of "maturity" when yielding to the situation, or lead to feelings of "resignation". However, this seems predominantly to be a description rather than an explanation of the above findings. Weisz et al. (1984) accepts Azuma's comments and adds another layer of complexity by explaining Japanese attitudes on this matter in terms of their "in-group" against "out-group" distinction, which shows variety in the attribution unit of the culture.

The cross-cultural differences in attribution of causality may be due to the differences in the self-concept. That is, differences in the way that people see themselves - whether they perceive themselves as being in full charge of their lives, or being interdependent with others. Differences in their self-concept are also the product of differences in the value system common to the population (Hofstede, 1980). The common value system in the society influences its members to adopt an acceptable form of identity (Bleakwell, 1986).

Differences in self-concept between Europeans and Asians have also been observed and discussed in cross-cultural studies. For instance, the white middle class in America have been found to be more in control of their own life as compared to their Japanese counter parts (DeVos, 1985). The former tend to act more autonomously, while the latter tend to act in groups. A simliar pattern was described when westerners were compared with Chinese where the westerner tends to act according to his/her own definition of action, while the Chinese has a tendency to act on "kinship supremacy" (Hsu, 1985). The reasons behind these observable behaviour differences are discussed in some studies in terms of self-concept (Chu, 1985; Bharati, 1985; DeVos, 1985; Johnson, 1985). The fundamental reason has been sought in the belief systems which are seen as important cultural variables between different societies. In the west it is held that everyone is created equal and, therefore, an individual is autonomous. In China the father continues to dominate the children and, therefore, kinship relations govern perception of the self where an indivdual should exist under the umbrella of fatherly love and respect for the mortal father (Bellah, 1970).

The Confucian idea of self lies in the process of an ever deepening and broadening awareness of the presence

of others in one's self-cultivation rather than in a solitary existence (Tu, 1985). Thus, maturity is not measured in terms of individual independence or autonomy, but rather in terms of mutual responsibility among the members of a society. For instance, one of the "five cardinal human relations" (see chapter II Korean mother's life) is that between parent and child where a mature person is not supposed to leave his or her parents but share a reciprocal support system with them.

Johnson (1985) employs the concept of "boundaries" to explain the western mind. Boundaries can be seen as being of two sorts: either they are permeable membranes or rigid barriers (p.109). He suggests that the "independency myth" found in western cultures further inflates the sense of individualism. He explains this in terms of the monotheistic normative systems prevalent in western systems, especially those of the Protestant ethic.

This "self-rule" or "independent" nature dictates the "thought model" which governs one's cognitive representation of self and environment, and leads westerners to hold themselves (as opposed to environmental factors) responsible for their success and failures. They praise highly intentional effort

and skill (internal factors) rather than, for instance, luck or external environmental factors (Nicholls et al., 1985; Rosenbaum, 1972). As Benedict (1947) saw the differences between westerners and Japanese in terms of "guilt" versus "shame" has similar connotations.

This scheme can also be used to explain the Asian's tendency towards externalising attribution. When we observe Asians from this perspective, we can see the Asian's concept of "self" is related to "dependency" and "passivity" but in a negative sense (Metzger, 1981). A number of observers have noted that the "self" of an Asian is "field dependent", which implies that it is a less differentiated one than the self of someone who is "field independent". This can be easily seen among people where the Confucian cultures (DeVos, 1985; Hsu, 1985; Kon, 1984; Metzger, 1981; Sue, 1981), and Hindu cultures (Bharati, 1985) are predominant. For instance, the basic understanding of autonomy in western culture is "self-rule" (Lindley, 1986) which is carried out by an "indivisible individual", while the Hindu core doctrine of self bears a high degree of mental mutuality (Bharati, 1985). Therefore, while in western cultures, an individual is the final unit of the self, people within Confucian and Hindu traditions see themselves existing as social entities, so that

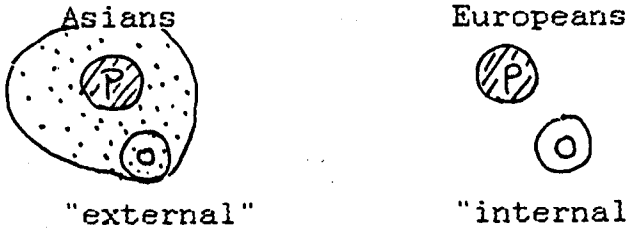
one's self can be in others and the self of others can be within one.

Until recently, most psychologists did not see that it was possible to view the differing values placed on "self" found in Asian cultures from more than one perspective since they tended to emphasise the development of individual self automony. However, it is now necessary to recognise that a broadening awareness of the role of others can be an important aspect in the cultivation of the self. Asian cultures hold that only through the continuous opening up of the self, rather than by the exercising control over the individual self, does one develop a whole identity or "self". Tu (1985), for instance, argues that the concept of self includes not only the "individual" self but some sense of a "collectivist" or "inclusive" self. A more informative understanding of this difference between Europeans and Asians was suggested by Hsu (1985). He proposed that the differences appeared in the element of Asians personage refered to as "jen", which means more than individual, and includes the "layer of intimate society and culture" (see Fig.2-2, p.44). For instance, the "in-group" found in Japanese society would be included in this intimate layer, while family members or pseudo-family members would be included in Korean society.

The presence of the concept of "inclusive self" as compared to that of the "individual self" in a culture can be observed by measuring attributional style. To date, every study on attributional style has assumed the "individual self" as the basis of the attributional unit. The questions only consider attributional tendency over the events concerning the individual, and avoid those aspects regarding the "collective or inclusive" group. Yet various ranges of attributional units should be considered which are dependent upon what is appropriate to the culture. In other words, people from different cultures have different ranges of responsibility. On the one hand, there is the responsibility for only oneself while on the other hand there is responsibility for others (eg. one's children).

Cross-cultural differences in the attributional style have only been observed on the assumption of the individual self as the unit. Therefore it is natural to view autonomous Europeans as attributing more "internally" while Asians who have an "inclusive" unit would be seen as attributing more externally (see Fig. 4-1).

Fig 4-1: Attribution on individual (p) matters

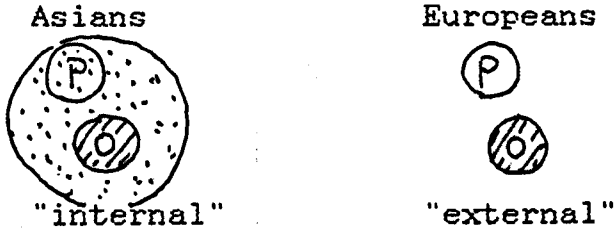


The cognitive theorists have been interested in self-esteem which has unavoidably close associations with the value of individual control or self mastery. They express no doubts about having the individual self as the only unit of analysis. In doing so they leave themselves open to be challenged by the possible existence of differences in the ranges of responsibility.

A different range of responsibility means the difference in the width of the attributional unit. For instance, one end of the range of responsiblity is the responsibility for oneself only, and another may be the one covering a responsiblity for one's children. In those cases, the former would attribute externally only when one is asked about the matter concerning one's child, while the latter would attribute internally over the matter of one's child.

If we investigate attributions in aspect of the others (o) who are included in the "intimate layer" of the self, then people who are inclusive would attribute internally by saying that they are responsible while individualistic people would respond by attributing externally (see Fig. 4-2).

Fig. 4-2: Attribution on matters of others (o)



Shaw (1979) believes that people can be seen as "evaluative organisms" who search for, and assess stimili, with respect to their personal relevance or significance, and where the degree of depression can be a function of such cognitive activity. An attributional explanation of depression can thus be understood as explaining the aetiology of "responsible depression".

Brewin (1985) indicates that important event related cognitions are moral and self-evaluative rather than

pragmatic causal perceptions. People blame morally (responsibly) rather than blame causally for negative outcome (Furnham, 1985). Depression can be explained in terms of being "my brother's keeper" for those who have an inclusive tendency. If one has wider inclusive responsibility one has a greater tendency, or a higher chance, to attribute internally whether the outcome is "good" or "bad".

Measuring the attributional style

For the purpose of measuring attributional style in adults Peterson et al. (1982) developed the Attributional Style Questionnaire (ASQ), which was further revised by Seligman et al. (1984). This self-report instrument has three sections for internality vs. externality, stability vs. instability, and globalisty vs. specificity, of the causes to which subjects attribute good (i.e. positive; attainment of desired goal; success; non-adversive) and bad (i.e. negative; non-attainment of desired goal; failure; adversive) events.

As mentioned above, in this study we are investigating mainly cultural differences in the attributional trend of "internality" vs. "externality" in relation to self concept (either "individualistic" or

"collectivistic"). ASQ (1984) can measure only the "internality" vs."externality" among the subjects of "individualistic" self concept. For example, one question asks:

> "You meet a friend who compliments you on your appearance. Write down the one major cause. Is the cause of your friend's compliment due to something about you or something about other people or circumstances?"

These kind of questions cannot depict the collectivistic (inclusive) attributional unit.

Therefore, the scale to measure the attributional style of the mothers over the aspects concerning their children was developed especially for this project. The justification of thie approach is that we can never see the differences in responsibility unit through individualistic attributional test such as ASQ.

4:2 Social Support System

While attribution theories try to explain internal factors of people's depressed mood, social support theories look at external resources that might influence a person's behaviour and feelings, including depressed mood. The following discussion on the social support issue will cover four subtopics: (1) general information on social support in the health science; (2) definition of social support;(3) nature of social support; (4) social support in cross-cultural context; and (5) a measurement of the social support system.

(1) General information on social support in health sciences

Even before the scientific interest in social support emerged, it was generally believed that people had a fundamental need for social contact. But social contact does not necessarily always lead to positive support, it also can be negative and a source of stress (Kessler, 1985; Rogers et al., 1982; Rook, 1984; Wellman, 1981).

Inadequate social contact has been associated adversely with a person's well-being. For example, the loss of a

relationship has attracted much attention, especially where deterioration of health was concerned (Weiner, 1987). Extreme reactions shown by some of the bereaved spouses, such as falling ill or even dying soon after the partner's death, have been reported by several authors (Berkman et al., 1979; Blazer, 1982; Young, 1982).

As regards the inadequacy of support, Cassel (1976) and Leavy (1983) used comprehensive materials and found that inadequate and low levels of social contact were associated with all kinds of health problems. Deficient social bonds have been suggested as a cause of morbidity (Henderson, 1980). There is an extensive literature on inadequate social and emotional support during infancy and childhood generating a long lasting effect even into adult life (Brown et al., 1978). But this is only mentioned here in passing since the present study concentrated on the support available at the time of the interview and not on the support during childhood.

We can conclude that it is not only the loss of a relationship but also the experience of an inadequate one, involving interpersonal conflict or burden, which can function as an important source of health problems.

Since the mid 1970s, social support has been popularised in health related sciences. Innumerable studies (see the reviews by Cohen et al.,1985; Gottlieb, 1985; Hammer, 1981; Hobfoll et al., 1986; House, 1981; Leavy, 1983; Mitchell et al., 1982; Sarason et al., 1985, 1987; Shaver, 1984; Veiel, 1985) have been carried out using different measurements, subjects, and situations. Some studies used a longitudinal approach while others a cross-sectional one. All indicated that some associations exist between social support and the physical, as well as the mental, state of a person - depression being one of them.

Most of the researchers found that people tended to seek some social support at the time of experiencing stress to cope and that the support system, as a resource, is expected to help people in their affect, thought, and action, through its interaction process (Hobfoll, 1986). Therefore, it is assumed that a person with more or better resources will cope with stress more adequately than somebody with less resources available.

(2) Definition of a support system

Although the concept of social support has become a focal point in research for its potential contribution to a person's well-being, it is surprising to find a lack of consensus concerning the definition of social support and its operationalisation. Many people have pursued empirical research in this area or reviewed the research without presenting any explicit definition (e.g., Cassel, 1976; Cohen et al., 1985; Lin et al., 1981; Sarason et al., 1987). This may be due to the face validity of the concept of social support and its colloquial popularity (Antonucci, 1985).

However, other authors have tried to define social support. One of the broadest definitions is that social support reflects the: "resources provided by other persons" (Cohen et al., 1985, p. 4). Similarly Lin et al. (1979) thought that: "social support may be defined as support accessible to an individual through social ties to other individuals, groups, and the larger community" (p.109).

There are also more descriptive definitions. For example, Caplan (1974) wrote that social support consists of: "continuing social aggregates that provide individuals with opportunities for feedback about themselves and for validations of their expectations of others" (p.4). This support provides resources for a

wide area in times of need. The support system is perceived as: "... attachments among individuals or between individuals and groups that serve to improve adaptive competence in dealing with short-term crises and life transitions as well as long-term challenges, stresses and privations through (a) promoting emotional mastery, (b) offering guidance regarding the field of relevant forces involved in expectable problems and methods of dealing with them, and (c) providing feedback about an individual's behaviour that validates his conception of his own identity and foster improved performance based on adequate self-evaluation" (Caplan et al., 1976, p.41).

Cobb's (1976) definition, excluding instrumental support or counseling, refers to social support as: "information leading the subject to believe that he/she is cared for and loved ... esteemed and valued ... and belongs to a network of communication and mutual obligation" (p.300).

Kahn et al. (1980) defines social support as: "interpersonal transactions that include one or more of the following key elements: affect, affirmation, and aid".

House (1981) coveres more areas in his definition than the above authors: "social support is an interpersonal transaction involving one or more of the following: (1) emotional concern (liking, love, empathy), (2) instrumental aid (goods or services), (3) information (about the environment), and (4) appraisal (information relevant to self-evaluation" (p.39).

Most authors assume that social support "may reduce stress, improve health, and especially, buffer the impact of stress on health" (House, 1981, p.14); or that individuals' attempts at coping can be supplemented and strengthened by the guiding participation of others in that effort. Significant others (i.e. supporters) may suggest alternative techniques and/or participate directly in a person's coping efforts. In other words, social support can be viewed as coping assistance (Thoits, 1984, p.229) or useful (Rofe, 1984, 1986).

The common factors found among these definitions, whether explicit or implicit, are as follows. 1) The support system <u>functions in a stressor-specific fashion</u>, where support differs with respect to the type of adaptational demands. Social support definitions are multi-dimensional due to the multi-dimensional needs of people under the various types of

stress. 2) Social support minimises the negative effects of stressors when they are congruent between adaptational demands and supporting resources (Wilcox et al., 1985). Therefore, the effectiveness of the support system can be shown by the person's satisfaction and well-being.

In other words, social support functions in the coping process at the point of "event appraisal" (or "primary appraisal") and "resource appraisal" (or "secondary appraisal") (Cobb, 1974; Lazarus et al., 1978; Wilcox, 1985). The support system operates by helping people to perceive the stress and find adequate coping strategies.

This, therefore, implies that social support is inseparable from the perceptual processes of the person since support plays its major role primarily by helping the person perceive how he/she interprets his/her environmental problems and the availability and adequacy of external resources. Caplan's idea of the "fit between person-environment" (1983) indicated the importance of the subjective judgement of the "person in environment" at two points: event appraisal and resource appraisal. The suitable subjective fit between the person and his/her environment brings about his/her emotional satisfaction. There is no use for

unsuitable support however fancy or abundant it may be.

On the other hand, those who argue for an objective definition of support have a far more difficult task to attain, because it is difficult to develop an adequate operational definition of actual social support. People who attempted to define actual support were obliged to use limited expressions, such as "behaviour that is supportive," or "help that is helpful": which is not only circular but also difficult when we move from the abstract expression, such as "supportive behaviour" to the concrete task in terms of supporting behaviour (Wilcox et al., 1985).

Furthermore, behaviour which might appear to be supportive may in fact be counter-supportive under certain conditions. Sometimes the supporters disrupt the process of coping by promoting dependence, increasing pressure and stress, or denying of stress (Breznitz, 1983; Janis, 1983) diluting self-responsibility and self-efficacy (Coates et al., 1983; Fisher et al., 1981).

Although objective social support refers to the helping behaviours engaged in by others, researchers in this line are also dependent upon their subjects'

perception. The definition of social support which is adopted in this research is therefore limited to the resources appreciated by the subjects. In other words, social support, as used in this study refers to those external resources perceived to be available and valued by the mothers at the time of the study.

(3) The Nature of the social support system

Although extensive research on the social support system has been carried out, and positive effects on human well-being have been found, there is, as of yet, no systematic psychological theory that permits a set of coherent predictions (Stein, 1986). In this thesis we will limit ourselves to discussing the nature of social support in terms of: 1) the structure of social support (size of support network and relationship of the people who belong to the social network to the target person); 2) functional characteristics of social support (emotional, cognitive, or practical help, etc.); and 3) the quality dimension of social support (degree of satisfaction or reciprocity). We will discuss each topic in the following pages.

1) Structure of social support

The structure of the social support system is viewed generally in terms of the size of support network (i.e., number of resource persons), and the relationship of the resource persons to the target person.

a) Size of support network

Social network size has been investigated by many authors who have found that, generally, the network size per se, or number of potential sources of support, is much less of a predictor for the person's well-being than the subjective evaluation of it (Andrews, 1978; Berkman, 1979; Brandt, 1981; Dohrenwend, 1984; Fiore et al., 1986; Henderson, 1978, 1981, 1982; Hobfoll, 1985; Sarason et al., 1983; Schaefer et al., 1981; Stroebe et al., 1985; Turner et al., 1983; Weiner, 1982; Wethington, 1986). Therefore, the quality of the relationships of the target person with his/her supporters is of more importance than the number of supporters.

b) Relationship with supporters

The relationship with the supporting people represents an important support dimension. If social support protects a person against mental disorder, then the

question concerns what constitutes a good support system. As Tedeshi (1972) indicates, the effectiveness of a support system is dependent upon the characteristics of support sources, i.e. the trustworthiness, validity and referent powers. Kobasa (1979) also, states that certain relationships are beneficial in some cases, but not in others.

Brown et al. (1978), for example, found that the marital spouse or partner has a significant supportive function. Similar findings were obtained by Lieberman (1982), Surtees (1980), and Surtees et al. (1983). Likewise, the study by Andrews et al. (1976) on social indicators of well-being in the U.S., reported that mothers who did not have a marital partner and were living with their children had the poorest quality of life.

On the other hand, studies such as Belle (1982), Bernard (1981), Gilbert (1984), and Hobfoll (1987), have cast doubt on the over-all importance of social support from husbands or partners. Miller et al., (1976) found that friends are as important as intimate relatives. Zur-Szpiro et al.(1982) found that women generally do not turn to their husband for help with personal problems, but only for financial support or practical contributions to household maintenance.

Warren's study (1975 quoted in Warren et al., 1983) showed that wives offer twice as much emotional support to their husbands, as husbands offer to them in return. According to Bernard (1981, p.291): "the wife is the man's only confidant, whereas the woman's closest confidant is most likely to be a woman friend." Thus for a woman, an effective support system does not only include the relationship with her spouse or partner, but also with close female friends she can rely on.

In addition to spouses/partners, friends and relatives, collegues at work (Holahan et al., 1981; House, 1981), and neighbours, may offer valuable support. Furthermore, besides the personal sources of support, there are professionals (like social workers, teachers, clergy men, physicians), self-help groups, and other voluntary or government institutions, who offer help and support. Veiel (1985) subdivided these two groups of supporters into "natural support providers" (such as spouse, friends, etc.) and "institutional or professional providers" (doctors, social workers, etc.).

However, when comparing social support systems cross-culturally one has also to be aware that some of these support systems or supporters may play a greater role

in one culture than in another. For example, Argyle (1984) pointed out that in Japan workmates tend to function more as friends and, therefore, as supporters than in western-European countries, where friendships are usually made outwith the workplace.

Cultures also differ in the amount of personal and institutionalised support offered. Marris (1982), for example, thinks that because western-European cultures idealise the nuclear family, less personal support is available in times of crises, but more institutionalised support is offered by professionals.

Whether the replacement of informal personal supporters by paid professionals is helpful in western-cultures is an open question. Various studies on minorities in the U.S.A., for instance, the "black" Americans (Held, 1981; Neighbors et al., 1983; 1984), and the Italian Americans (Johnson, 1982), have shown that these people still tend to rely and use significantly more informal personal help than professional support. Similar findings have been reported by Andrews (1978) for people of low socio-economic status in Australia, and by Yoon (1987) for Chinese in Great Britain. Yoon refers to this as the "under-utilisation of professionals".

The under-utilisation of professionals as potential supporters can also be observed in the Korean society. As stated earlier, Korean culture is based on Confucianism, which emphasizes the blood ties in the family (see chapter II). The family is not seen as a nuclear unit (husband , wife and their children), but also includes the more distantly related blood relatives, horizontally as well as vertically. Inter-generational loyalty and responsibility is of the utmost importance. Thus, in this kind of an extended family system, family members take over the task not only of the material support, but also those of institutional support, by providing emotional, social, and financial help. However, in reality Korean people cannot exclusively depend on members of the extended family for sole assistance. But instead of turning to anonymous professionals, Koreans tend to turn to familiar persons or groups who constitute a second layer of supporters.

We can regard these supporters as some kind of pseudo-family members. Pseudo-family members can be school mates, university alumni, long-standing neighbours, or collegues at work with whom a person has a life-long relationship. This relationship involves mutual loyalty, responsibility, and support. Like blood relatives, members of these pseudo-families are obliged

to help when called upon. In turn they themselves, can rely on this support to further their own aims.

Thus, in general, the "in-group" to which a Korean will mainly turn for help is the extended family and the pseudo-families. Unfamiliar professionals will rarely be made use of, and anonymous institutions, which potentially might be able to offer help, will be strongly avoided, unless one cannot find help from the "in-group" members. Help is, therefore, interpersonal based on life-long mutual obligations.

The main difference between the Korean and the western-European social support system is that the Koreans tend to rely mainly on "in-group" members (the extended family or pseudo-families, which is relatively permanent) whereas west-Europeans have to achieve attachment individually.

Thus the Korean support system is strongly built on life-long mutual obligations within the so-called "in-group", which is relatively permanent. This is in contrast to the patterns of social support in western-European societies, where the obligations to help are less strong within the family. According to Weiss (1982), western-European adults are more free to distance themselves from their families and childhood

relations, and to form new attachments and loyalties to individuals outside their families. These friendships may be permanent or temporary. But they do not (as in the Korean case) necessarily include the mutual obligation to help when called upon. Weiss (1982), therefore, thinks that in western-European cultures a person has to work hard to keep a friendship going, and consequently needs more highly developed social skills to be successful. This idea is supported by Triandis et al. (1988) who found that in individualist cultures, like the western-European ones, people show better developed social skills than those in collectivist cultures, like the Korean one.

In general, it can be said that, the nature of Korean culture supports life-long, intergenerational, and within-family loyalty. This support system is, therefore, more stable, without any fluctuations during the life of a person than the support system in western European cultures. At the same time, Koreans have less need to develop social skills to attract and maintain relationships on an individual basis outside of the ascribed family or pseudo-family.

2) Functional characteristics of social support

The functional characteristics of social support refer to the kind of support received or offered. A number of authors (e.g., Fiore et al., 1986; Hays et al., 1986; Mitchell et al., 1980; Veiel, 1985) have pointed out that the global concept of social support should be divided into sub-categories, each reflecting a different area of support.

Dean et al. (1981) for example classified the support function into emotional "expressive" and practical "instrumental" support. Schaefer et al. (1981) added a further aspect, namely "informational" (appraisal) support to Dean et al.'s two categories. Dean's instrumental support was called "tangible" and the expressive support was termed "emotional" support. Similarly, terms like "socio-emotional aid", "instrumental aid" and "informational aid" were adopted by Thoits (1985). Cohen et al. concentrated on assessing perceived availability of support: they subdivided this into "appraisal support" (confidant and informational), "tangible support" (instrumental), "self-esteem support" (esteem), and "belonging support" (social companionship).

Weiss classified support according to the provisions of social relationships; mainly "attachment", "exchange of services", "guidance", "social integration", "sense of alliance", "reassurance of worth" and "opportunity to provide nurturance" (1974).

Finally, Fiore et al. (1986), reviewing the literature on this topic of the functional areas of social support (e.g., Dean et al., 1981; Henderson et al., 1981; Hirsch, 1981; House, 1981; Weiss, 1974), designed nine functional components of social support for their Global Satisfaction Scale (GSS). These are:

i) "Cognitive guidance", the help to clarify or further one's understanding of problems or possible solutions.

ii) "Emotional support", referring to caring, sympathy, understanding, and reassurance.

iii) "Socialising", being with others in non problem-oriented interactions in whatever manner one finds enjoyable, such as recreation, chatting, or shopping.

iv) "Tangible assistance", concrete behavioural assistance with chores or tasks.

v) "Social reinforcement", receiving feedback from others on how one is doing.

vi) "Physical comfort", being held by someone.

vii) "Opportunity to nurture", being needed for the guidance or support of others.

viii) "Reassurance of one's worth", feelings of being appreciated by others.

ix) "Opportunity for caregiving", being needed for the care of others. (p. 97)

Fiore et al.'s classification seems to be a most comprehensive description of the support system. It not only takes into account the support received from other people (see item 1 through 5) but also the support offered to others (see item 6 through 9). The support received from others has been mentioned by many authors, as already discussed above, yet the support offered to others is a rather new aspect rarely measured by authors. Therefore, the present study adopted Fiore et al.'s classification in order to measure social support as widely as possible.

3) Quality of social support

When we talk of the quality of social support we are really interested in effectiveness of it. This has generally been measured by the satisfaction people received from the support.

Most authors (see the reviews by Broadhead et al., 1983; Leavy, 1983) believe that satisfaction with social support derives from the benefits they receive. For instance, Cohen et al. (1985, 1986) stressed that the benefit could be the protection from the pathogenic effects of stress.

However, some authors (Dunkel-Schetter et al., 1987; Gottlieb, 1981; Rook 1987) believe that the satisfaction with the support system depends not only on what people receive but, at the same time, on what can they offer to other people - thus they stress the reciprocity of the system. The idea of reciprocity is based on the belief that mature adult relationships should be "mutual and reciprocal" (West, 1986). Gottlieb (1981) emphasizes its reward, stating that if the support is reciprocal, then the relationship would be more likely to persist over time. Kahn et al. (1980) consideres support as a convoy for affect, affirmation and aid ("3As"), which people should have, so that during interpersonal give and take transactions, the person would have feelings of fulfillment and avoid social isolation. Similarly, Rook (1987) thinks that people would not find satisfaction merely in one-way social exchanges where they merely receive, but do not give support. Kessler et al. (1985), while believing in the "costs of

caring", states that this also has "rewards". Furthermore, Antonucci (1985) believes that the non-reciprocity of support may be strongly negative and not desirable.

However, Hobfoll (1986) observed that, in real life situations, people who were under stress received support from others, but often could not offer support until they recovered from the impact of the stress. In other words, reciprocation of support was not necessarily immediate and should not be seen as some sort of mechanical or automatic response.

The concept of reciprocity has rarely been studied in much detail, although there has been much speculation about it, as discussed above. Because of this lack of empirical research the role of reciprocity in the social support system has been included in the present study.

(4) Cross-cultural aspects of social support

The social network involves, however, far more than the narrow categories of help between a supporter and a supportee. The help is also dependent on the socio-cultural context in which it is given. Support systems

reflect people's participation in social life, such as how they develop their own "affiliative tendencies" (Brugha, 1984). Therefore, people create their own network, which reflects their own values and choices among other alternatives. Hirsch (1981) referred to this as a "personal community" which not only concerns the individual needs and preferences but also the confines of the socio-cultural environment within which it exists.

The sharing of norms in a wider society makes people greatly dependent upon others for shaping their ideas and choices of the resources (Hobfoll, 1986). Thus, norms shared by any socio-economic class or culture are transmitted to a person through the "significant persons" (Mead, 1934). Significant persons can be parents, other family members, peers, religious or socio-cultural leaders. They may all help to shape "what the support system consists of" and "what to expect from the resources" when they need it in one's own culture.

Thus ideas about social support are, to a certain degree, dependent on the cultural or social environment, yet there has been little research on how social support differs between cultures. Holahan et al. (1983) and Triandis et al. (1985, 1988) have found

that in the United States different subcultures, like the "black vs. white", or "Puerto Rican vs. Caucasian", make different use of the available support system. However less is known about the support system in distinctly un-related cultures that are not housed within one nation. For example, are some aspects universal, are others culture dependent? To investigate these questions in more detail the support system in Korea and Scotland were compared in the present study.

(5) Measuring the Social Support System

The contents of the scale used measure the social support system should be comprehensive and general rather than specific, especially for cross-cultural studies. However, most measurements were not comprehensive. For example, the Interpersonal Support Evaluation List (ISEL, Cohen et al., 1985) covers 40 very specific items in four areas of support: appraisal, belonging, tangible and self-esteem. These appear to be neither evenly specific or general. For example, one item states

> "If I was stranded 10 miles from home, there is someone I could call who would come and get me",

which is very specific (and which can hardly happen to a Korean mother); while another one says

> "In general, people don't have much confidence in me",

which is quite broad and not at all specific. They also used several particular situations such as

> "having someone to bail one out of jail"

through to

> "having someone to go to the movies with".

While these might be applicable for people of one culture, they equally well might be irrelevant for people in another.

Each measure has different points of emphasis: Perceived Support Network Inventory (PSNI, Oritt et al., 1985) classified support system into "emotional", "material", "advice", "physical assitance", and "social participation", which displays more practical aspects of a support system; whereas Cohen et al. had more psychological aspects such as "appraisal", "belonging", "tangible", and "self-esteem" in their ISEL. Parry

(1986) measures social contacts, confidants in Expressive Social Support (ESS) as well as Instrumental Social Support (ISS).

As discussed previous section (pp.158-159) the areas of support function of Fiore et al. (1980) are general and well-balanced for subjects from both the cultures investigated in this thesis.

Format of the measurement should be clear to understand, and effective. It is important to have an easy and convenient scale to administer. The Interview Schedule for Social Interaction (ISSI, Henderson, 1981) needs quite detailed instructions for the interview while PSNI (Oritt et al., 1985) and Social Support Network Inventory (SSNI, Flaherty, 1983) are two measures which have format problems making them difficult to complete.

The range of the support system is one aspect of support we are concerned with measuring. In Perceived Social Support (PSS, Procidano et al, 1983), for instance, only family and friends are included. The two subscales are: PSS from Friends (PSS-Fr) and PSS from family (PSS-Fa). Wider support including that from relatives, neighbours, and community participation were measured by the Social Support Questionnaire of

Andrews et al. (1978) though only in a crisis situation. The ESS by Parry (1986) indicated specifically family members, relatives, friends, neighbours, and work associates.

It has been argued that the subjective appreciation (satisfaction) in the quality and the amount of the support system is significantly correlated with psychological health. Therefore, we tried to measure the subjective perception of the number of supporters (or supportees) and their relationship with the subject as well as the subject's degree of satisfaction with the amount and quality of the support. This was found in the Social Support Questionnaire (SSQ) by Sarason et al. (1983). Therefore, the present study used the format of SSQ and the contents of Fiore et al.'s classification.

4:3 Life Events

This section deals with life events as the causal factor for psychological disorders, in particular depression. The causal effects are reported as rather moderate and, in most disorders, aetiology appears multifactorial. Therefore, life events should be considered as one of several factors, including attributional style and social support system which are discussed in the previous sections. In this section we will briefly examine: (1) studies on life events; (2) their relationship with depression; and (3) the measurement of life events.

(1) Studies of Life events

Numerous studies, starting with the classic study by Holmes et al. (1967), have observed that people who experience adverse life events which demand some change in attitude or behaviour, are at an increased risk of suffering from physical or mental illness in one form or another. Relationships between life stressors and illness have been described in a variety of ways (Brown et al., 1978, 1986; Cohen, 1986; Cooper et al., 1988; Dohrenwend et al., 1980, 1982; Hobfoll, 1986; Kobasa, 1982; Levi, 1978; Rahe, 1974; Sarason, 1978).

However, all explain the "stressful events and health" relationship in terms of causal relationships between the individual and environmental factors. The interaction between the two factors is dynamic rather than mechanistic. This interactional process is a spiralling one rather than a simple linear unidirectional one. Due to the nature of the process which is continuous and active prior to, throughout, and after the events, the prediction of specific behaviour with a high degree of accuracy, seems like an unrealistic goal (Oehman, 1987).

Stress has been comprehended as the outcome of a discrepancy between external events and response capabilities (Doyle et al., 1984). It occurs to the extent that there is some mismatch between the person and one's environment. If the environmental demands exceed the adaptive capacities or resources of the person and constrain the satisfaction of individual needs, then this will lead the person to experience the need for appropriate resources. If the person did not experience the discrepancies at the time of an event, then the person would not perceive the event as a stressful one.

Stressful events can be environmental, social or interpersonal, and should not be viewed in isolation

but rather as part of the whole process. The stressfulness of the event can be determined by the person's past experience and present circumstances. Thus, perceiving stress and the accompanying reaction does not occur in a vacuum devoid of person's socio-cultural experiences, and it is necessary to consider the life transition and role related events that people experience.

Life transition and role related life events

Over time, people continually experience changes and transitions which have the potential to be stressful life-events. Life transition is a constructive dynamic process (Mancuso et al., 1984) with readjustments necessary when any major change occurs. Thus roles can be seen as the sources of stress (Pearlin, 1983).

When life-events result in stress, they do so together with the more structured aspect of social roles. For instance, large numbers of people report that they went through an extensive crisis when they had their first child (83% of subjects reported this in Crawford's study (1985)). Cutrona (1984) also found child-birth and postnatal transition to be stressful life-events. The disruption of their prepartum routine by the demands of the baby care requires parents to

adapt, and may lead to emotional disequilibrium (Leifer, 1977).

It has been observed that women report more life-events and in different patterns to that reported by men (Mulvey, 1984) especially characteristics of homemakers' where events were found to originate from "over-involvement" with others (1979). Henderson et al. (1981) also found that while men reported significantly more work related, life events women reported more events only in the category of childcare related ones. Lee (1977) found significant differences in stress experienced by males and females in Korea, where women complained more about family matters, while men's complaints were more career related.

Menaghan (1982, 1983) found that women reported somewhat more parental distresses than men, especially those mothers who had younger children. As children mature, the character of parental complaints changes (Hoffman et al., 1978), which indicates that transitional adjustment is necessary to carry out parental roles. Brown et al. (1978) suggested that events can create stress adversely by altering or intensifying the enduring aspects of key social roles. Since motherhood is one of the most important roles for a woman, the family can be a major source of a mother's stressful life events.

However, as Pearlin (1983) indicated, there is a lack of research on the impact that children have on their parents. Glenn et al. (1981) found evidence that feelings of distress are generally common in parents, and others such as Morsbach et al. (1987), and Shaver et al. (1973), have studied mothers with infants who experience some health problems or difficulties like crying or colic, while others have studied mothers of different age groups (Bromet et al., 1982; Brown et al., 1975; Moss et al., 1977; Richman, 1974, 1977; Shereshefsky et al., 1973; Uddenberg et al., 1978).

(2) Life events and depression

Stressful life events have been related to mental health as a causal factor for depression. Several studies mentioned the impact of both the number and the types of events.

a) Number of life events

Several previous studies (Brown et al., 1983; Dohrenwend et al., 1974; Rahe, 1974; Steel et al., 1980) found moderate correlations between the number of life events and depression. Eaton (1978) re-evaluated the Myers' data, and found that there were significant

correlations between the number of life events and mental illness.

In the review of published studies on life events among depressed people, Paykel et al. (1988) found twelve out of twenty-five studies recorded that more life events were reported prior to the onset of depression, even though the rest of the studies reviewed found more life events reported by depressives. However it was not clear whether these events were instrumental in causing the depression or whether they were caused by the depression.

b) Type of events

In general, studies concerning the relationship between stressful life events and mental health suggest that we might find a clear effect of differences in the types of life events (Monroe et al., 1983). Brown (1978), for instance, indicates that there are important causal relations with types of event such as "marked" long-term threat, "moderately" long-term threat or "non-severe" event. Brown argues that if the person experiences a "marked" long-term threat he/she would have a higher chance of becoming depressed than the person who experiences "moderate" or "non-severe" events. Goodyer (1985) found that marital and/or

family conflict, accident, or illness, were all associated with mild mood disorders, while permanent separations and terminal exits could cause somatic and severe mood disorders.

(3) Measuring life events

The original measurement of life events, the Social Readjusting Rating Scale (SRRS) by Holmes et al. (1967), was formulated on the basis of American life style. Yet relevant cultures should be considered when a study is carried out in another culture. For example, simply measuring the events which came about due to the individual's loss of ability to control life (such as SRRS) would not be sufficiently comprehensive for measuring events in a "collectivist" culture.

The "cultural expertise" (Ivey, 1977) of motherhood can be very different between cultures. For instance, women's critical life-stage, such as the stage of child-bearing, is dictated more by culture (life-style or religious belief) than by nature. Unlike western mothers, the "empty nest syndrome" (Rubin, 1979) might be an unknown concept for most Korean mothers and, therefore, they may be able to continue considering the child's events as their own. Borland (1982) found that

the "empty nest syndrome" occurred to a greater degree in white middle class Americans than black or Mexican Americans. This was explained as attributable to the unique set of social circumstances in which they live, and the set of family values and social norms concerning women's proper roles.

Brown et al. (1986) rightly recognised the necessity of adopting an appropriately modified methodology for other cultures and to be more sensitive to local values, recognising the differences with non-western cultures. A flexible approach is necessary in order to provide relevant and reliable information from different cultures on aspects of depression.

CHAPTER FIVE

HYPOTHESES AND METHOD

5:1 Hypotheses

It has been argued in the previous chapters that attributional style, social support, and stressful life events, are related to depression. We plan to examine the relationship of these factors to depression and to observe how the relationship between depression and these factors varies with the life stages and cultural background of the mothers.

Hypothesis 1: a) Korean mothers will show higher scores on the depression scale used.

b) Korean mothers will score higher on scales measuring somatic symptoms than cognitive-affective symptoms.

According to the relevant literature, cross-cultural research has indicated that non-westerners (as compared to westerners), record higher scores on depression scales and show more somatic rather than cognitive affective, symptoms. (See p.93 - p.107.)

Hypothesis 2: a) "Old" Korean mothers will be more depressed than "young" Korean mothers,
b) whereas "young" Scottish mothers will be more depressed than "old" Scottish mothers.*

Due to the different socio-cultural traditions in Korea, mothers with a child preparing for the univeristy entrance examination will experience much stress, whereas younger mothers have an easier life as they are taken care of by their extended family. (See Chapter II.)

Hypothesis 3: a) "Internal attributional style" will have a positive relationship with depression.
b) Koreans mothers will attribute more interally about things concerning their children than Scottish mothers.

A person who has an "internal" attributional style rather than "external" attribution, is more likely to become depressed (Abramson et al., 1978; Seligman et al., 1979; Weiner, 1985, 1986). It is a widely held

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* The postnatal group will be referred to in the present study as the "young" mothers; the mothers with a child at the end of seconday education as the "old" mothers.

belief that westerners attribute more internally than do non-westerners. However, all the previous studies have assessed an individual's attribution over their own life, whereas this study measures attributional style over the aspects concerning their children, since collectivistic Korean mothers might attribute internally over the matters of their children.
(See p.123 - p.141.)

Hypothesis 4: a) The Social support system will have a negative relationship with depression;
b) Scottish mothers will appreciate this support more than Korean mothers.

The social support system has been found to be negatively related to depression (Cohen et al., 1985; Sarason et al., 1986). Due to the socio-cultural differences between Scottish and Korean mothers the latter group will not be as appreciative of social support as the former group (Korean mothers have too many tight relationships, so that they take the support for granted, whereas Scottish mothers value it more highly.) (See p.142 - p.167.)

Hypothesis 5: a) Life events will show a positive relationship with depression;
b) Various types of life-events will be differently related to depression.

Several studies (Brown et al., 1983; Dohrenwend et al., 1974; Rahe, 1974) have found moderate correlations between the number of life events and depression. Some authors also suggest that a clear effect of differences in the types of life events may be found (Brown, 1978; Goodyer, 1985). (See p.168 - p.175.)

5:2 METHOD

In this section we discuss the nature and characteristics of our sample, the materials used, the procedure followed, and the pilot study.

1. Subjects

(1) Size of sample and time of testing

362 mothers participated in this study who were subdivided according to their cultural background, and stage in life. The mothers' cultural background was either Korean or British (Scottish), and the life stage was either: postnatal between the 6th to 10th weeks; or six months before the child would finish secondary school education. The postnatal group will be referred to in the present study as the "young" mothers, whereas the group with a child at the end of secondary education will be referred as the "old" mothers. Thus altogether there were 4 subgroups. The number of mothers participating in each subgroup is recorded in Table 5-1.

Table 5-1: Sample sizes

	Korean	Scottish	Total
"YOUNG"	105	52	157
"OLD"	112	93	205
Total	217	145	362

(2) Recruitment of subjects

Young mothers: Korean young mothers were approached at 7 hospitals in 2 Korean cities which were Seoul and Won-ju. Scottish young mothers were approached at 5 clinics in the city of Glasgow, Scotland. Table 5-2 records the hospitals and clinics in Korea and Scotland where interviews took place or were arranged. Most of the interviews were conducted at the mother's home.

Table 5-2: List of Hospitals and clinics

Korean	Scotland
Cha Hospital	Courthill clinic
Won-ju Hospital	Westerton clinic
Gang-nam Catholic Hosp.	Milngavie clinic
Bang-jigoe Hospital	Netherton clinic
Sowha Childrens Hosp.	Sandy Road clinic
Jeil Hospital	
Korea Hospital	

Old mothers: mothers of children in 6 state secondary schools participated in the study. Three of the schools were in Seoul city (Korea), three in Glasgow (Scotland). The six schools are listed in Table 5-3.

Table 5-3: List of schools

Korean	Scotland
Ewha University School	Cleveden Secondary School
Gang-nam High School	Hyndland Secondary School
Shinil High School	Jordanhill College School

Prior to the testing, the headteachers of the 6 schools had approved of the study and had informed every mother whose child was either in the 5th year of secondary education in Scotland or the final year in Korea.

(3) Comparison of mothers' socio-economic and educational level

Information about the subjects' age, marital status, educational level, and employment status, was obtained, as well as information about husbands'/ partners' educational level and employment status. The number of children in the family was also noted. Table 5-4 records the relevant statistics.

Table 5-4: Socio-economic and educational characteristics of the samples

	Korean		Scottish	
	Young	Old	Young	Old
Mean age: (in years)	28.3	46.1	29.9	45.3
Marital status:				
married	100 %	97 %	94 %	87 %
divorced	---	1 %	2 %	5 %
widowed	---	2%	---	4 %
single	---	---	4 %	---
Educational level (in years):				
of subject	14.2	14.4	13.8	13.6
of husband	15.6	16.1	14.4	14.8
Employment status of husband:				
Professional	91 %	97 %	72 %	86 %
Clerical	7 %	3 %	22 %	5 %
Unspecified	---	---	2 %	2 %
Unemployed	3 %	---	4 %	7 %
Employment status of mothers:				
Professional	5 %	14 %	17 %	29 %
Clerical	3 %	1 %	10 %	1 %
Part-time	2 %	1 %	6 %	36 %
Unknown	---	---	2 %	10 %
Homemaker	91 %	85 %	65 %	25 %
Number of children:				
Mean	1.57	2.86	1.57	2.75

As we can see from Table 5-4, most mothers in the four samples are of middle class background i.e. the majority of husbands being professionals and having, on average, a high educational level. The large majority of the families in all four samples consisted of married couples with children.

language, all had to be translated. Rough translations were done by Eun-He Park. These were then checked and modified by bilingual experts at the Institute of Korean Social Sciences.

The English wording of the questionnaires, except for the Beck Depression Inventory, was again checked and corrected by a native English linguist. A further slight modification of the questionnaires was carried out as a result of a pilot study in Britain and in Korea.

The final English and Korean versions of all five questionnaires are recorded in Appendix 2 - 7. The following section will outline a short description of the five questionnaires.

(1). Personal Data Questionnaire

This questionnaire was designed to record information about the subjects and the socio-economic and educational background of the family. The answers obtained by the Personal Data Questionnaire have already been recorded in Table 5-4. The full version of the questionnaire is displayed in Appendix 2.

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(2) Beck Depression Inventory (BDI)

The 1978 version (Beck et al., 1978) of the BDI was used since it has simpler scoring system, and symptom 19 ("loss of weight") is assessed in more detail than the 1961 original version, . The levels of internal reliability and validity of the 1978 version were found to be as high as in the original study.

The 1978 version consists of 21 symptoms. These symptoms can be categorised into 2 subscales according to Steer, Beck and Garrison (1986). The symptoms and the corresponding subscales are recorded in Table 5-6.

Table 5-6: Subscales and symptoms in BDI

Subscales	Symptoms
Cognitive-affective	1. mood
	2. pessimism
	3. sense of failure
	4. lack of satisfaction
	5. guilt feelings
	6. sense of punishment
	7. self-dislike
	8. self-accusation
	9. suicidal wishes
	10. crying
	11. irritability
	12. social withdrawal
	13. indecisiveness

(Continued on next page)

Subscale	Symptoms
Somatic-performance	14. distortion of body image
	15. work inhibition
	16. sleep disturbance
	17. fatigability
	18. loss of appetite
	19. weight loss
	20. somatic preoccupation
	21. loss of libido

Each symptom is assessed by four independent statements. The statements differ from each other by the severity of the respective symptom expressed. The highest degree of severity is assigned a score of 3, and the lowest a score of 0. The degrees of severity in between are assigned the scores of 1 and 2 accordingly (see example below). Subjects had to choose one of the four statements for each symptom. The score for each symptom could therefore vary between 0 and 3.

Example - Symptom: mood

1. (0) I do not feel sad.
   (1) I feel sad.
   (2) I am sad all the time and I can't snap out of it.
   (3) I am so sad or unhappy that I can't stand it.

The total score for the whole BDI could vary between zero and 63. The full version of the questionnaire displayed in Appendix 3.

(3) Mothers' Role Questionnaire

None of the questionnaires available on attributional style were appropriate for the purpose of this study. Therefore, the Mothers' Role Questionnaire was developed by the author based on the format of Heilbrun's (1973) Parent Attitude Research Instrument. The present questionnaire deals with two kinds of attributional style: the "internal attribution" (a mother blames herself or takes credit for matters regarding her child); and "external attribution" (a mother tends to blame or give credit to the environment about matters related to her child). Six items of the questionnaire refer to "internal attribution", and four to "external attribution". The items and the corresponding subscales are recorded in Table 5-7.

Table 5-7: Attributional style subscales and items

Subscale	Items
Internal attribution	1. child's safety - accident 2. child's emotional stability 3. child's health 4. child's personality 5. child's academic achievement 6. general success of child

(continued on next page)

Subscale	Items
External attribution	7. child's safety - accident 8. child's personality 9. child's emotional stability 10. child's academic achievement

The answers to each item were scored on a scale from 1 to 4. (See following example)

Example - (1) "Internal attribution"

A mother never stops blaming herself if her child is injured in an accident.

(1) strongly agree
(2) mildly agree
(3) mildly disagree
(4) strongly disagree

The full version of the questionnaire is shown in Appendix 4.

(4) Social Support Inventory

The Social Support Inventory was developed by the author. It was based on Fiore et al.'s Global Satisfaction Scale (1980) and on Sarason et al.'s Social Support Questionnaire (1983). The content of the Social Support Inventory in the present study followed Fiore et al.'s 9 areas of support. These nine areas can be categorised into two subscales: (1)

support received from others; and (2) support offered to others (see Table 5-8).

Table 5-8: Subscales and areas of support function

Subscales	Areas of support function
Receiving support	1. socialising 2. practical help 3. guidance 4. feedback 5. emotional support 6. comfort
Offering support	7. offer care 8. offer advice 9. appreciated for what is done to others

Superimposed on the nine support areas was Sarason et al.'s format of the Social Support Questionnaire. This permitted the interviewees to respond to each of the nine support areas in 4 different ways:

a) the number of people supporting the subject in each particular area (network size: up to 9 people could be named with an option for "no one");

b) the kind of people who were supporting the subject (eg. friends, relatives, family members, collegue, professionals etc.);

c) the satisfaction about the quality of the support (to be expressed on a scale from 1 to 6, with the lowest degree indicated by 1 and the highest degree indicated by 6);

d) the satisfaction about the amount of the support (again on a scale of 1 to 6) (see the following example)

An example of one of the support areas ("socialising") and the corresponding questions is as follows:

Example - (1) "socialising"

If you spend some time socialising with people (i.e. recreation, shopping, chatting, visiting, etc.):

a) Who are they?

No one	1)_____	4)_____	7)_____
	2)_____	5)_____	8)_____
	3)_____	6)_____	9)_____

b) How satisfied are you with the amount of socialising that you do?

6- very satisfied	3- a little dissatisfied
5- fairly satisfied	2- fairly dissatisfied
4- a little satisfied	1- very dissatisfied

c) How satisfied are you overall with the quality of the time you spend socialising?

6- very satisfied	3- a little dissatisfied
5- fairly satisfied	2- fairly dissatisfied
4- a little satisfied	1- very dissatisfied

The full version of this questionnaire is documented in Appendix 5.

(5) Life Events Questionnaire

The first section of Miller's Questionnaire (1987) on life events and coping strategies was modified for the present study. This was done by adding one more item (i.e. events related to the "mothering role"), and by changing the time reference. For example Miller's questionnaire asked whether the event had taken place during the "last four years", while the present study, asked whether the event had taken place during the "last couple of months". The questionnaire of the present study consists of 9 life events:

1) interpersonal conflict;
2) death of a close person;
3) failure to achieve a desired goal;
4) crisis and disater (excluding death);
5) having been a victim of crime;
6) personal ill health;
7) difficulties experienced in the mother-role;
8) caring responsibility;
9) other events.

For example one item ("interpersonal conflict") in the questionnaire is:

Example - Interpersonal conflict

(1) Interpersonal conflict
including:-

Row or arguments with a boy friend/ husband, parents, brother or sister. Family feuds or quarrels into which you have been drawn. Long lasting bad relationship with somebody important to you.

Mothers were ordered to tick the item, if they have experienced any personal conflict within the last couple of months.

The total number of events could vary between 0 and 9. See Appendix 6 for the full version of this questionnaire.

3. Procedure

The collection of the data was roughly the same in Korea and Scotland. The five questionnaires were presented in the following sequence:

1. Personal Data Questionnaire
2. Mother's Role Questionnaire
3. Social Support Inventory
4. Life Event Questionnaire
5. Beck Depression Inventory

The "young" mothers were either interviewed in the hospitals/clinics or, if they desired so, at their own home. Most of the "old" mothers filled in the questionnaires themselves at their own home. However, some preferred to be interviewed in person by the author.

Thirteen mothers were chosen at random for a more detailed interview to gain further background information. These case studies are reported in Appendix 1.

4. The Pilot Study

The purpose of the pilot study was to find out

a) whether some wording in the questionnaires was still unclear;
b) how mothers felt about participating in such a research study;
c) how long it took to complete the the five questionnaires in one sitting.

The pilot study was carried out in Seoul, Korea and Glasgow, Scotland. About five mothers in each of the four subgroups took part.

Based on these interviews some minor changes were made in the wording of some of the questionnaires. Filling in five questionnaires took about 1 hour.

In general mothers found the questionnaires quite interesting and stimulating, except the Beck Depression Inventory, which they found depressing to read.

CHAPTER SIX

RESULTS AND INTERPRETATION

Introduction

This chapter will deal with the following areas: (1) Depression; (2) Attributional attitudes of mothers on the well-being of their children; (3) Social support; and (4) Stressful experience of life events. For each of these areas we will look closely into:

i) Differences between the two cultural groups;

ii) Differences between the two stages of motherhood;

iii) How the factors (2 to 4) related to the depression of the mothers between the two cultural groups and two stages of motherhood.

6:1 Depression

The depressed mood of the subject was assessed by the Beck Depression Inventory (BDI), and the answers scored according to Beck et al. (1978) for each subject

separately. The analysis of the depression scores of the four subgroups were carried out as follows:

1) Comparison of the distribution width of total scores
2) Comparison of the means of total scores
3) Analysis of levels of depression
4) Subscales
5) Item analysis

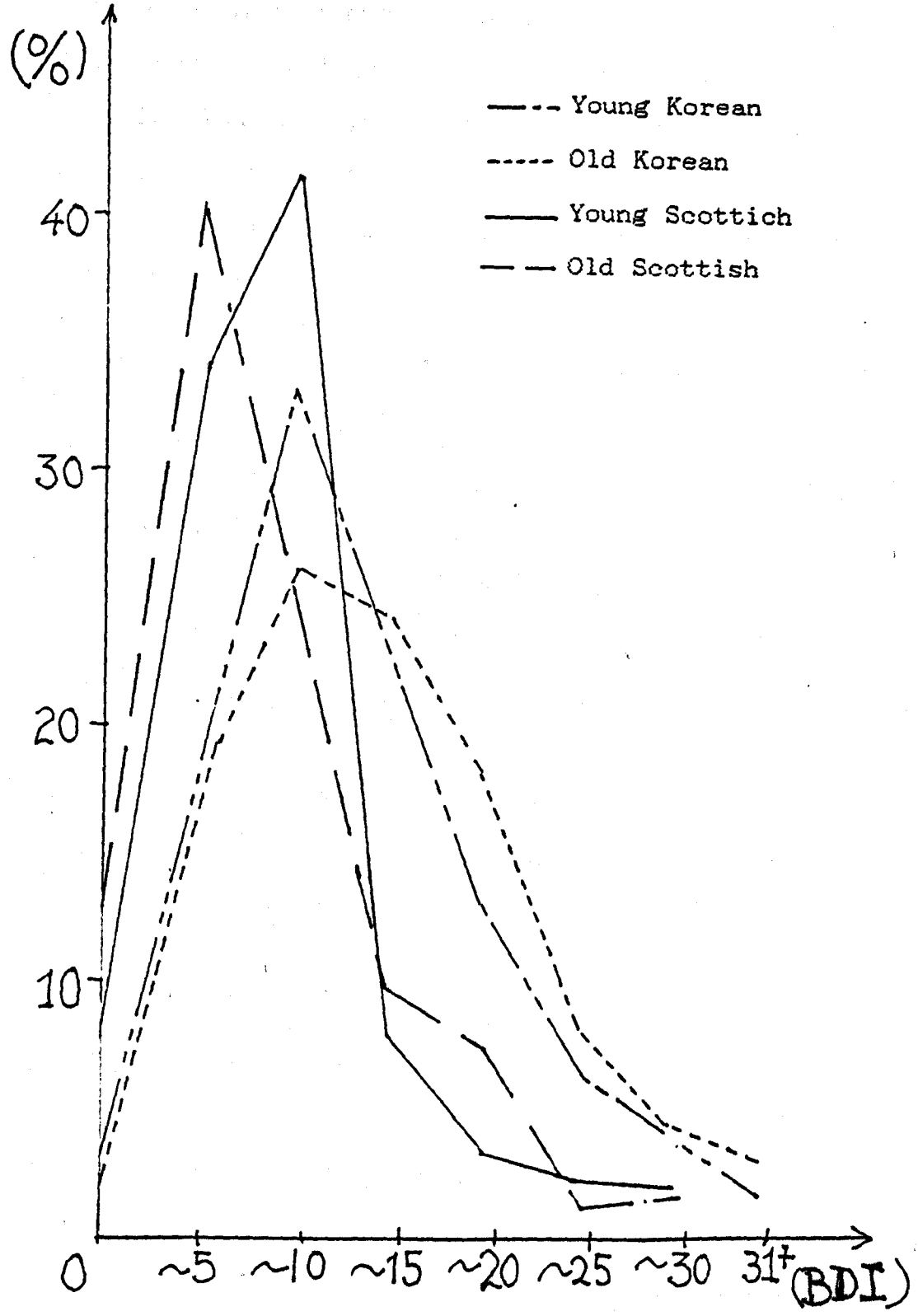
(Hypotheses 1 and 2)

The four subgroups were divided by variables of 'culture' (Korean and Scottish) and 'stage' (young and old).

1) Comparison of the distribution width of total scores between the four subgroups

The distribution of each of the four group is displayed in Fig. 6-1. The vertical axis represents the percentage of subjects having obtained that particular total score, the horizontal axis is the total score on the BDI.

Fig. 6-1: Distribution of total scores on BDI



As can be seen from Fig. 6-1 all four distributions follow a normal curve. In order to see whether the four groups differed in the width of their distribution, F-tests were performed between the variances of the four groups. The average scores and standard deviation for each subgroup is displayed in Table 6-1.

Table 6-1: Average total scores and standard deviation

subgroup	mean	std
Young Korean	11.22	6.80
Old Korean	11.96	7.27
Young Scottish	6.72	5.55
Old Scottish	6.22	6.17

None of the comparisons (F-test) were significant, i.e., the four subgroups obtained a similar spread of total scores on the BDI.

2) Comparison of means between the subgroups

As the four groups did not differ in their width of distributions, the average scores of the four subgroups (see Table 6-1) were compared by using a T-test. The results are displayed in (see Table 6-2).

Table 6-2: Comparison of means (t-test)

subgroups	t-values	significance level (p<)
Young Korean vs. Old Korean	0.77	n.s. *
Old Scottish vs. Young Scottish	0.50	n.s. *
Young Korean vs. Young Scottish	4.43	0.001
Old Korean vs. Old Scottish	6.09	0.001

*n.s.=not significant

As can be seen from Table 6-2, there was no significant difference between the young and the old mothers within either cultural group. However, Korean mothers, both young and old obtained significantly higher average scores on BDI than the Scottish mothers.

3). Analysis of the levels of depression

Steer, Beck, and Garrison (1986) suggest categorising the scores of the BDI into three broad levels of depression according to the severity. The three levels of depressions were: "mild" derpession (including all

total scores from 0 to 13), "moderate" depression (all scores between 14 and 20), and "severe" depression (all scores above 21). The results in terms of levels of severity are recorded in Table 6-3 for the four groups.

Table 6-3: Comparison of levels of depression

	level of depression by BDI total		
	"mild"	"moderate"	"severe"
BDI scores Subgroups	0 - 13	14 - 20	21 - 63
Young Korean	71 %	18 %	11 %
Old Korean	64 %	24 %	12 %
Young Scottish	92 %	4 %	4 %
Old Scottish	87 %	10 %	3 %

The majority of mothers in all four subgroups obtained a "mild" depression scores. Fewer mothers can be found in the "moderate" depression level, and the smallest number of mothers in the "severe" category.

If we look at the "severe" category of depression, we find that both young and old Korean mothers were represented there more than the Scottish mothers. Using the Fisher-Yates Exact Probability Test, the difference in the proportions of "severe" depression

cases was only significant between the old Korean and the old Scottish mothers ($p<0.05$). Significantly more old Korean mothers were "severely" depressed than old Scottish mothers. Although there was also a considerable difference between the young Korean and young Scottish mothers, the difference was not statistically significant. However, within each cultural groups, i.e. between young and old Korean mothers, and young and old Scottish mothers, the percentage of "severe" cases was virtually the same.

At the "moderate" level of depression, both young and old Korean mothers were significantly more often represented ($p<0.01$) than the Scottish young and old mothers using the Chi square test or Fisher-Yates Exact Probability test as appropriate.

At the "mild" level, young and old Korean mothers were significantly less represented than young and old Scottish mothers ($p<.001$).

Between age group, neither culture showed significant differences in distribution in three severity levels of depression (using the Chi square test or Fisher-Yates, as appropriate). However, the differences in the distribution between the two cultures when the age

groups within each culture were collapsed were significant using Chi square test (on the level of $p<.001$).

Overall it was found that within the two cultural groups young and old mothers showed a similar distribution for the three depression levels. However, between the two cultural groups, significant differences were obtained with Korean mothers scoring more frequently on the higher levels of depression.

As can be expected from a study of this kind using subjects from the general population, not clinical samples, the majority of mothers in all four subgroups obtained a "mild" depression score. However, as can be expected, significantly fewer Korean mothers, whether old or young, were represented in the"mild" category as compared to the young and old Scottish mothers.

We will investigate the nature of depression by analyzing subscales and all the items.

5) Depressive Symptoms by Analysis of Subscales:

In one of their recent essays Beck and his collegues (Steer et al., 1988) suggested subdividing the BDI into two separate scales: the "Cognitive - Affective" subscale (including the first 13 items of the BDI), and the "Somatic - Performance" subscale (including the last 8 items). The mean scores were computed by adding the scores and dividing them by the number of items respectively. The scores may therefore vary between 0 and 3 (see Table 6-4).

Table 6-4: Average subscale scores

subgroups	Cognitive-Affective	Somatic-Performance
Young Korean	0.43	0.68
Old Korean	0.49	0.73
Young Scottish	0.45	0.39
Old Scottish	0.26	0.34

The means were compared (using t-tests), and the results are shown in Table 6-5.

Table 6-5: Comparison of subscale means (t-test)

subgroups	t-values	significant level (p<)
COGNITIVE-AFFECTIVE SUBSCALES:		
Young Korean vs. Old Korean	1.08	n.s.
Young Scottish vs. Old Scottish	1.34	n.s.
Young Korean vs. Young Scottish	0.14	n.s.
Old Korean vs. Old Scottish	4.20	.001 (k)
SOMATIC-PERFORMANCE SUBSCALES:		
Young Korean vs. Old Korean	0.85	n.s.
Young Scottish vs. Old Scottish	0.98	n.s.
Young Korean vs. Young Scottish	5.51	.001 (k)
Old Korean vs. Old Scottish	7.04	.001 (k)

n.s.=not significant
(k)=Korean scores significantly higher

In the case of "Cognitive-Affective" subscales, there were no differences between "young" and "old" mothers in both cultures, but "old" Scottish mothers scored significantly lower than the "old" Korean subjects.

On the "Somatic-Performance" subscale, again there was no significant difference between the means of "old" vs. "young" mothers within the Scottish and the Korean group, but both "young" and "old" Koreans obtained significantly higher scores than both Scottish "young" and "old" groups.

The results indicate that within one culture the average depression score as regards the "Cognitive-Affective" or the "Somatic-Performance" aspect is not significantly different between the "young" and the "old" age group. But on the other hand, the Korean mothers whether "old" or "young" obtained on average higher depression scores, particularly on "Somatic-Performance" scale.

4) Symptoms of Depression by Item Analysis

In order to find whether the difference on the 'Cognitive-Affective' and 'Somatic-Performance' scales

were due to only a few symptoms represented in these scales, or due to the majority of these items, all the items of BDI were analysed separately. The results of comparison between the four subgroups on each of the items (using median test) are displayed in Table 6-6.

Table 6-6: BDI Item analysis

Items	Young vs.Old Korean	Young vs.Old Scottish	Korean vs.Scot Old	Korean vs.Scot Young
1. Mood	---	---	---	---
2. Pessimism	---	---	.05(s)	---
3. Sense of failure	---	---	---	.05(k)
4. Lack of satisfaction	---	---	.001(k)	.001(k)
5. Guilt feeling	---	---	---	---
6. Sense of punishment	---	---	.05(k)	.001(k)
7. Self-dislike	---	---	---	.01(k)
8. Self-accusation	---	---	.001(k)	---
9. Suicidal wish	---	---	.01(k)	---
10. Crying	---	---	.05(k)	---
11. Irritability	---	---	---	.001(s)
12. Social withdrawal	---	.01(y)	.001(k)	.01(k)
13. Indecisiveness	---	---	.001(k)	.001(k)
14. Distortion of body image	---	---	.01(k)	.01(k)

(Continued on next page)

Items	Young vs.Old		Korean vs.Scot.	
	Korean	Scottish	Old	Young
15.Work inhibition	.05(o)	---	.001(k)	---
16.Sleep disturbance	---	---	---	.05(k)
17.Fatigability	---	---	.001(k)	.05(k)
18.Loss of appetite	.05(y)	.05(y)	.001(k)	.001(k)
19.Weight loss	---	.01(y)	.01(k)	---
20.Somatic preoccupation	---	---	.01(k)	.01(k)
21.Loss of libido	.01(o)	---	.05(k)	---

---=no significance
The group which showed the higher score is indicated with 'o', 'y', 's', and 'k' within bracket as 'old', 'young', 'Scottish', and 'Korean' groups respectively.

A perusal of Table 6-6 shows that the majority of significant differences were between the two cultures and not between the two age groups.

Within the 21 items there were six significant differences between the young and the old mothers. In the Scottish group the young mothers scored significantly higher on "social withdrawal", "loss of appetite" and "weight loss" than the old Scottish mothers. In the Korean group the old mothers complained more about "work inhibition" and "loss of libido" whereas the young Korean mothers did so more on "loss of appetite". In general the young mothers

obtained higher scores than the old ones in the Scottish samples, whereas the reverse was the true for the Korean mothers where the old mothers scored higher than the younger ones.

Although the young mothers differed somewhat from the old mothers, a much more striking difference was evident between the two cultures. Out of a total of the 42 comparisons, 27 were significant.

These differences covered almost the whole range of depressive symptoms, and not just a few. Furthermore, on almost all items the Korean mothers scored higher than the Scottish mothers (25 of 27). In particular, symptoms like "lack of satisfaction" and "sense of punishment", etc. appeared to have bothered the Korean mothers more than the Scottish group.

On two items the Scottish groups were significantly higher: Scottish old mothers expressed significantly more pessimism than Korean old mothers, and Scottish young mothers felt significantly more irritated than Korean young mothers.

As regards the two subscales discussed in the previous section old Korean mothers scored higher than their

Scottish counterparts on 7 of the first 13 items of the "cognitive-affective" subscale, whereas young Koreans scored higher on 6 of the 13 items than Scottish young ones. For the "somatic-performance" scale old Korean mothers scored higher than Scottish ones on 7 out of 8 items, whereas young Koreans scored higher than Scottish mothers on 5 out of 8 items. Thus the results confirm the difference found in the previous section more or less covering most of the items of the two scales.

The only item among the 'Somatic-Performance' subscale that Korean old mothers scored significantly less than Scottish old mothers was "sleep disturbance".

6:2 Attributional Style and Depression

This section consists of two main parts: (1) the comparison of the attributional style of the mothers between the two cultures as well as two stage groups; and (2) the relationships between the attributional style and the depression scores. (Hypothesis 3)

(1) Attributional Style:

The attributional style of the subject was assessed by the Mothers' Role questionnaire. The answers were scored for each subject separately by giving 1 for "strongly agreed", 2 for "mildly agreed", 3 for "mildly disagreed", and 4 for "strongly disagreed". There were 2 kinds of attributional style: the "Internal" (a mother attributed internally regarding the matters of her child) and "External" attribution (a mother attributed externally).

1) Comparison of total scores

The average scores and standard deviations of internal role attribution and external role attribution of the mother for the four subgroups are displayed in Table 6-7.

The average scores can vary between 1 and 4; the lower the scores the stronger the expression of either "external attributedness", or "internal attributedness".

Table 6-7: Average scores and standard deviation

subgroups	mean	std
INTERNAL ROLE ATTRIBUTION:		
Young Korean	1.70	0.42
Old Korean	1.70	0.42
Young Scottish	2.10	0.46
Old Scottish	2.33	0.48
EXTERNAL ROLE ATTRIBUTION:		
Young Korean	2.11	0.45
Old Korean	2.20	0.49
Young Scottish	1.36	0.37
Old Scottish	1.27	0.30

The result indicated that the Korean mothers attributed more internally than the Scottish ones. The average scores were compared using a t-test and the results are displayed in Table 6-8.

Table 6-8: Comparison of means (t-test)

subgroups	t-values	significant level (p<)
INTERNAL ATTRIBUTION:		
Young Korean vs. Old Korean	0.04	n.s.*
Old Scottish vs. Young Scottish	2.85	.01 (y)*
Young Korean vs. Young Scottish	5.20	.001(k)
Old Korean vs. Old Scottish	9.72	.001(k)
EXTERNAL ATTRIBUTION:		
Young Korean vs. Old Korean	1.60	n.s.
Old Scottish vs. Young Scottish	1.27	n.s.
Young Korean vs. Young Scottish	11.01	.001(s)
Old Korean vs. Old Scottish	16.74	.001(s)

* n.s.= not significant
* (y,o,k,s)= significantly higher 'young', 'old', 'Korean' or 'Scottish' respectively

As indicated in Table 6-8, there were generally no significant differences between the young and old mothers within both cultural groups. However, significant differences between cultural groups were observed for both the young and old age groups.

An exception from this was the difference between subgroups of Scottish mothers on "internal attribution": young Scottish mothers scored higher on internal attribution than the old ones ($p<.01$).

Overall, Scottish old mothers attributed least internally and most externally, followed by the Scottish young ones, and then the Korean young group. The extreme opposite can be seen in the Korean old group, who attributed most internally and least externally.

2) Item analysis

The question can be raised whether the differences between the subgroups on the two attributional scales were reflected by only a few items represented in these scales, or by the majority of items evenly. Therefore the groups were further compared (using a Median Test) on all individual items. The results of

this comparison are displayed in Table 6-9. The group which showed a significantly greater attributional attitude for the item was indicated with 'o', 'y', 's', and 'k' within brackets representing 'old', 'young', 'Scottish', and 'Korean' groups respectively.

Table 6-9: Attribution item analysis

Items	Young vs. Old		Korean vs.Scot	
	Korean	Scottish	Young	Old
INTERNAL ATTRIBUTION				
Safety	.001(y)	---	---	---
Stable emotion	---	---	.001(s)	.001(k)
Health	---	---	.01 (k)	.01 (k)
Personality	---	---	---	.01 (k)
Academic achieve	---	---	.05 (k)	.001(k)
Success	.05 (o)	.01 (o)	.001(k)	.001(k)
EXTERNAL ATTRIBIUTION				
Safety	---	---	.001(s)	.01 (s)
Personality	---	.05 (y)	---	.01 (s)
Stable emotion	---	---	.001(s)	.001(s)
Academic achieve	.05 (o)	---	.001(s)	.001(s)

---=not significant

Results indicated that there were virtually no difference within Korean and Scottish cultures. The Korean young and the old group, showed no differences

except for "Success" ($p<.05$) and for "Academic achievement" ($p<.05$). The old group attributed more strongly internally as regards the child's general success however on "safety" ($p<.05$) the younger ones attributed more strongly internally than the older mothers.

Between the two Scottish subgroups, the significant differences were with the older mothers who attributed more strongly internally than the younger ones on their child's "success" (as was found in Korean cases), and the young ones attributed external influence on the child's personality formation (also found in the young Korean mothers).

In summary we can therefore conclude that the differences within the Scottish young and old mothers, and within the Korean young and old mothers, were negligible in comparison to the differences between the two cultures. The Scottish groups attributed more strongly externally, whereas the Korean groups attributed more strongly internally.

(2) Attributional Style and Depression

This section investigates the relationship between attributional style and the severity of depression. The correlations (Product-Moment Correlation) between the two attributional scales and the depression scores on the BDI are reported in Table 6-10.

Table 6-10: Correlation between attributional style and BDI scores

Attributional Style	Korean		Scottish	
	Young	Old	Young	Old
Internal	---	---	---	-.32***
External	---	---	-.29*	---

* = p<.05
*** = p<.001
--- = not significant

As can be seen from Table 6-10 all of the correlations were non-significant except for Scottish old mothers (R=-.32; "internal" attribution) and the young Scottish mothers (R=-.29; "external" attribution about the children's matter).

In order to find out the specific area of mothers' attribution, the correlation between BDI scores and attribution for each area of the child's life was observed. Results are displayed in Table 6-11.

Table 6-11: Correlations between depression scores with each items

Items	Korean		Scottish	
	Young	Old	Young	Old
INTERNAL ATTRIBUTION				
Safety	---	---	---	-.33***
Emotion	---	---	---	---
Health	---	---	.37**	---
Personality	---	---	---	---
Academic	---	---	---	-.28**
Success	---	---	---	---
EXTERNAL ATTRIBUTION				
Safety	---	---	---	---
Personality	---	---	-.28*	---
Emotion	---	---	---	---
Academic	---	---	---	---

* = p<.05
** = p<.01
*** = p<.001
--- = not significant

As expected few significant correlations were obtained. The exceptions were: Scottish old mothers' depression scores correlated with the safety of their child and academic achievement. The Young Scottish mothers showed inverse correlations with internal attribution on the child's "health" and external attribution on "personality" of the child.

If we take notice of the fact that it was the Scottish old group who were least depressed among the subgroups, it is worthwhile to compare the correlations between depression scores and attributional style among the groups according to their severity (using Pearson Product-Moment). The comparison is shown in Table 6-12.

Table 6-12: Correlation between BDI scores and attributional style among severity groups

Attributional style	"Mild"	"Moderate"	"Severe"
Korean mothers:			
Internal	---	---	---
External	---	---	---
Scottish mothers:			
Internal	-.24**	---	---
External	---	---	---

** = p<.01
--- = not significant

Table 6-13: Correlation between BDI scores and attributional style among "mild" groups

	"Mild"			
Attributional style	Korean		Scottish	
	Young	Old	Young	Old
Internal	---	---	---	-.32**
External	---	---	-.29*	---

As can be seen from Table 6-12 there were no significant correlations within the depression groups and the attributional style, except for the "mildly" depressed Scottish mothers (r=-.24; "internal"). Among "mild" groups Scottish old mothers (r=-0.32; "internal" attribution) and for the "mildly" depressed young Scottish mothers (r=-.29; "external" attribution) showed some significant correlations. Even though, these relationships are weak (sharing only about 10% and 8% of common variances respectively), and it could also have occurred by chance since it was only one out of 18 correlations calculated.

In conclusion, it was found that there were significant differences in attributional style between Korean and Scottish mothers on the matters concerning their children, however, it was not confirmed that there was any interrelationship with depression scores and attributional attitude especially for Korean groups.

6:3 Social Support System and Depression

The support structure of the subject was measured by the Social Support Inventory designed for this study by the author, using the Social Support Questionnaire (SSQ, Sarason, et al., 1983) as a format and the Global Satisfaction Scale (Fiore et al., 1980) for the content. The analysis of the support system was carried out according to two aspects:

(1) A general description of the support system.
(2) The relationship between the support system and the depression. (Hypothesis 4)

(1) A Description of the Support System

The description of the support system is subdivided into three subheadings: 1) the support system in terms of network size, quality, and amount of support; 2) reciprocity, and 3) the primary supporters.

1) Support system

The support system in network size, quality, and amount of support was investigated.

a) Network size

The average number of people giving support to the interviewees on 9 questions (see Appendix 5) are recorded in Table 6-14.

Table 6-14: Average number of supporters

subgroups	mean	std
Young Korean	1.90	1.89
Old Korean	2.54	1.49
Young Scottish	2.58	1.30
Old Scottish	3.62	1.58

Both the young and old group of Scottish mothers reported having more supporters than the respective Korean groups; while older groups reported having more supporters than the young groups in both the Korean and Scottish samples. The differences in four combinations, i.e. by age and by culture (2x2), were all statistically significant (t-test).

The number of supporters mentioned for the 9 areas was compared within and between the young and old

Korean and Scottish groups (using a Mann-whitney U-test). The results are shown in Table 6-15. The group which reported having significantly more support is indicated within brackets as "o", "y", "k" and "s" for "old", "young", "Korean" and "Scottish" group respectively.

Table 6-15: Network size

support items	Young vs. Old		Korean vs. Scottish	
	Korean	Scottish	Young	Old
Socialise	.01 (o)	---	.001(s)	.001(s)
Emotional	---	.05 (o)	.001(s)	.001(s)
Help	---	---	.01 (s)	.001(s)
Feedback	---	---	---	---
Guidance	---	---	.01 (s)	.001(s)
Comfort	---	.01 (o)	.001(k)	---
Appreciated	.05 (o)	.001(o)	---	.001(s)
Offer care	.001(o)	.001(o)	---	---
Offer advice	.01 (o)	.001(o)	---	.001(s)

It can be seen from Table 6-15 that within the Scottish and Korean samples, the old mothers have more people from whom they received support, and also to whom they offered support than the young ones. Furthermore, the last two columns of Table 6-15 show that the Scottish mothers, compared to the Korean ones, mentioned more

people that were willing to help or guide them socially as well as emotionally.

b) Quality and amount of support

The quality and amount of support, received from others and offered to others, were compared within and between the two cultural group (using a Mann-Whitney U-test). The results are recorded in Table 6-16 and 6-17.

Table 6-16: Quality of support.

support items	Young vs. Old		Korean vs. Scottish	
	Korean	Scottish	Young	Old
Socialise	---	---	.01 (s)	.001(s)
Emotional	---	---	.001(s)	.001(s)
Help	---	---	.001(s)	.001(s)
Feedback	---	---	.001(s)	.001(s)
Guidance	---	---	.001(s)	.001(s)
Comfort	---	---	.001(s)	.001(s)
Offer care	---	---	.001(s)	.001(s)
Offer advice	---	---	.01 (s)	.001(s)

Table 6-17: Amount of support:

support items	Young v. Old		Korean vs. Scottish	
	Korean	Scottish	Young	Old
Socialise	---	---	.05 (s)	.001(s)
Emotional	---	---	.001(s)	.001(s)
Help	.05 (y)	---	.001(s)	.001(s)
Feedback	---	---	.01 (s)	.001(s)
Guidance	---	---	.001(s)	.001(s)
Comfort	.01 (y)	---	.001(s)	.001(s)
Appreciated	---	---	.05 (s)	.001(s)
Offer care	.05 (y)	---	---	---
Offer advice	---	---	.05 (s)	---

Table 6-18: Postnatal help at home:

Support items	Korean vs. Scottish Young
Number of helpers	.05 (k)
Time arrangement	.001(s)
Kind of help	.001(s)
Person	.001(s)

A perusal of Tables 6-16 and 6-17 shows that significant differences were much fewer between age

groups, i.e., old vs. young, than between the cultural groups, i.e. Korean vs. Scottish. The Korean mothers reported fewer people with whom they could interact with at ease and whose guidance or help they could rely on rather than the Scottish mothers. They also felt less satisfied with the amount and quality of support they received. Table 6-18 shows that even though Korean young mothers reported having a larger network at the time of the postnatal stage, they were not as satisfied with the support they received as compared to the young Scottish mothers.

2) Reciprocal Support System

Two factors were found by principal components analysis with oblique rotation after 6 to 7 iterations, which were distinctly isolated in both populations (see Table 6-19).

Table 6-19: Factors in Social Supports (Number of support)

	Korean		Scottish	
factor	First	Second	First	Second
Help	.914		.900	
Feedback	.831		.553	
Emotional	.807		.504	
Comfort	.735			.717
Socialise	.597		.807	
Guidance	.553		.745	
Appreciated		.835		.762
Offer care		.787		.806
Offer advice		.692		.698

The first factor can be called "receiving support from others" and the other "offering support to others".

The ratio between offering and receiving support can be calculated by averaging the number of supportees and dividing by the average number of supporters. These ratios were:

	ratio (offer/receive)
Young Korean mothers	0.73
Old Korean mothers	1.30
Young Scottish mothers	0.59
Old Scottish mothers	0.98

The score of 1 reflects a complete reciprocal support

system in terms of support received and given. Therefore, the closer to number 1, the higher the reciprocity. On the other hand, the larger the number of ratio, the more support is offered by the mothers to other people, and the lower the number the more support is received from others.

The young groups tended to receive more support, especially the Scottish young mothers. The old subgroups had a more evenly give-and-take relationships, although Koreans expressed they had more people to whom they offered their support than people from whom they received it, illustrating a responsibility for others.

3) Primary supporters

For the following analysis the first person mentioned by the mothers on 9 questions (see Appendix 5) were taken into account. It was felt that this person represented the most important support relationship for the interviewee. Table 6-20 displays the average number of subjects who gave the husband, other family members (blood tie relationship or the relationship originated by conjugal relationship), and non-family members as the first supporter.

Table 6-20: Average percentages of the first supporter

	Korean		Scottish	
	Young	Old	Young	Old
Receiving support:				
Husband	41 %	22 %	60 %	55 %
Family	34 %	19 %	19 %	12 %
Non-family	25 %	59 %	21 %	33 %
Offering support:				
Husband	20 %	9 %	31 %	34 %
Family	32 %	48 %	38 %	45 %
Non-family	48 %	43 %	31 %	21 %

As can be seen in Table 6-20 husbands, family members and non-family members were not mentioned as the first supporters to the same degree.

A Chi-square test was used to see whether the husbands, family members and non-family members were each mentioned equally often as the first supporters for each area of the support system (see Table 6-21).

Table 6-21: First supporters: Husband, other family members vs. non-family members (percentage & chi square)

	Korean		Scottish	
	Young	Old	Young	Old
Emotional:				
Husband	63 %	27 %	65 %	60 %
Family	15 %	17 %	17 %	13 %
Non-family	22 %	63 %	17 %	27 %
χ^2=	p<.001	p<.01	p<.01	p<.001
Help:				
Husband	36 %	24 %	56 %	46 %
Family	51 %	50 %	21 %	15 %
Non-family	13 %	46 %	23 %	39 %
χ^2=	p<.01	n.s.	n.s.	p<.05
Guidance:				
Husband	19 %	17 %	46 %	50 %
Family	33 %	16 %	15 %	11 %
Non-family	48 %	67 %	39 %	39 %
χ^2=	n.s.	p<.001	n.s.	p<.001
Socialise:				
Husband	49 %	15 %	36 %	31 %
Family	22 %	12 %	35 %	22 %
Non-family	29 %	73 %	29 %	47 %
χ^2=	n.s.	p<.001	n.s.	n.s.

(Continued on next page)

	Korean		Scottish	
	Young	Old	Young	Old
Comfort:				
Husband	40 %	23 %	87 %	75 %
Family	37 %	19 %	13 %	8 %
Non-family	23 %	58 %	0 %	17 %
χ^2 =	n.s.	p<.001	p<.001	p<.001
Feedback:				
Husband	42 %	30 %	67 %	57 %
Family	41 %	23 %	16 %	13 %
Non-family	17 %	46 %	17 %	30 %
χ^2 =	p<.05	n.s.	p<.01	p<.001
Appreciated:				
Husband	36 %	9 %	61 %	57 %
Family	29 %	44 %	16 %	25 %
Non-family	35 %	47 %	23 %	24 %
χ^2 =	n.s.	p<.001	p<.05	p<.05
Offer advice:				
Husband	9 %	2 %	23 %	18 %
Family	20 %	29 %	23 %	53 %
Non-family	71 %	69 %	54 %	29 %
χ^2 =	n.s.	p<.001	n.s.	p<.05
Offer care:				
Husband	15 %	15 %	10 %	33 %
Family	47 %	72 %	75 %	64 %
Non-family	37 %	13 %	15 %	11 %
χ^2 =	p<.01	p<.001	p<.001	p<.001

An examination of the above tables shows that there are differences in the placing of the husband as the first provider among the supporters, and the ratio of the first supporter between the family and non-family members, cross-culturally, as well as intra-culturally. The following will fist discuss the role of the husband, followed by the role of the family members vs. the non-family members.

A. Place of spouse

a) Receiving support from the husband

The two Scottish groups of subjects chose the husband as the most important supporter, 60% and 55% respectively (no significant difference found using a Chi square test). The husband was chosen significantly more often than either family members or non-family members (all differences were significant at .001 level).

The Korean mothers chose their husbands significantly less often as a main supporter (41% and 22% respectively) than did the Scottish mothers. The difference between the respective Korean and Scottish groups was significant at the $p<.001$ level.

For Korean mothers, husbands and relatives appear to offer the same amount of support. In the case of the old Korean mothers, even the support of husbands and relatives combined together is less than that of non-family members (59%) with the difference significant at the $p<.01$ level. This is a rather surprising result and will be discussed in more detail in the discussion section.

b) Offering support to husband

In contrast to the husband's role as a support giver, the results for the husband receiving support from his wife are rather interesting. In all four subgroups the husband is not the person who receives most of the women's support, it is either family or non-family members.

In the case of family members being cared for by the mothers it is mainly their own children who receive this care, especially within the two Scottish groups. (Offering care to their own child is 65% for young Scottish mothers, and 47% for the old Scottish mothers.)

c) The support types:

Generally, the spouses held the important roles, especially in the case of emotional support, on items such as "emotional", "comfort", "feedback", and "appreciated", rather than in the practical side, on items, such as "help" and "socialising" (see Table 6-20).

Investigating the differences in choosing the spouse (including boy friends in those cases of single mothers) as the first supporter, a different set of contrasts between the subgroups was found.

As indicated earlier, the outstanding differences are the fact that the Scottish mothers were dependent on their husbands more, while the young Korean mothers less so, especially in the areas of "help" and "emotional support". The striking differences are shown among the old Korean mothers, who displayed a reverse picture having non-family members in place of husbands among other subgroups of mothers.

Korean mothers' spouses were reported to have lesser roles compared with other family members or non-family members. This was more distinct in the case of old

Korean groups. For instance, they chose non-family member twice as often as their husbands as their first emotional support. Except for "offer care", in all areas, the spouses were chosen less than non-family members as their first supporters.

B. Family versus non-family members

As can be seen in Table 6-20, which contrasts family vs. non-family members as the first supporters, the majority of the Scottish mothers picked one within the family in all categories. The young Korean mothers showed similar preferences to those of the Scottish mothers, except in the areas of receiving and offering guidance.

Generally old Korean mothers seemed to be less dependent upon family and more on non-family members as compared to the other three subgroups. Activities concerning "socialising", "receiving guidance", and "offering guidance", were taking place more definitely with non-family members. The emotional side of support from non-family members was also considerably larger than other subgroups (see "emotional", "comfort", and "appreciated").

(2) Relationship between the support system and depression

The support system in network size (number of supporters), quality, and amount of support, was correlated with the score of depression on the BDI, and discussed in the following sections.

1) Relationship between the number of supporters and depression

The correlations between the BDI scores and the average number of supporters and supportees are shown in Table 6-22.

Table 6-22: The correlation between BDI scores and network size (receiving/ offering)

	Korean		Scottish	
Number of-	Young	Old	Young	Old
Supporters	-.21*	-.09	-.23	-.32***
Suportees	-.21*	-.04	-.05	-.07

* = p<.05
*** = p<.001

A negative correlation indicates that the higher the depression score the fewer the supporters available to the mothers.

All correlations are rather small, obtaining not more than 10% of common variance. Significant correlations were only found for the number of supporters giving assistance to mothers, but not for those receiving help from the mothers.

The correlationships between the BDI scores and the number of supporters in each of the support areas are presented in Table 6-23.

Table 6-23: Correlation between BDI and network size (each area)

	Korean		Scottish	
Support	Young	Old	Young	Old
Socialise	---	---	-.38**	-.33***
Emotional	-.23**	---	---	-.27**
Help	---	---	-.23*	-.22*
Guidance	-.27**	---	---	-.18*
Comfort	---	---	---	---
Feedback	---	---	---	---
Appreciated	-.20*	---	-.27*	-.33***
Offer advice	-.17*	---	---	---
Offer care	---	---	---	---

* = p<.05
** = p<.01
*** = p<.001
--- =no significant correlation

Both young and old Scottish groups showed significant negative correlations between BDI scores with socialising and helping supporters, and appreciators. It can also be seen that only the number of supporters giving help to mothers correlated significantly, not the numbers of people to whom mothers offered support. The number of people who appreciated what the mothers were doing to them ("appreciated") yielded the most significant correlation, as the item itself has a reciprocal quality of support.

The Korean old group had no significant correlations between the depression scores and the number of supporters, whereas young Koreans showed significant negative correlations between the number of supporters who gave emotional support and guidance, with the corresponding BDI socres. One of the things noticeable is that offering adivce is only significant for the young Korean mothers.

2) Quality of support

The degree of appreciation for the quality of support correlated more negatively with depression score than the number of supporters and the results are presented in Table 6-24.

Table 6-24: Correlation between BDI scores and quality of support (receiving/offering)

	Korean		Scottish	
	Young	Old	Young	Old
Receiving sup.	-.39***	-.25**	-.58***	-.65***
Offering sup.	-.34***	-.15	-.49***	-.42***

** = p<.01
*** = p<.001

For Scottish mothers the depression scores correlated significantly with the quality of support, whether given or received compared to Koreans' where the correlations were less strong. Furthermore, for all four groups the quality of support received correlated more highly with BDI scores than the support offered.

Table 6-25: Correlation between BDI scores and quality of support (each area)

	Korean		Scottish	
	Young	Old	Young	Old
Socialise	-.27**	---	-.47***	-.46***
Emotional	-.29**	---	-.47***	-.57***
Help	-.31***	-.16*	-.44***	-.45***
Guidance	-.28**	-.29***	-.31*	-.44***
Comfort	-.20*	-.19*	-.42***	-.54***
Feedback	.17*	-.16*	-.36**	-.49***
Offer advice	-.30***	---	-.32*	-.23*
Offer care	-.27**	-.21*	-.46***	-.50***

* = p<.05
** = p<.01
*** = p<.001
--- = no significant correlation

The most notable difference is with the old Korean subgroup where once again quality of support was not as effective as it was for the other groups. Despite the small size of the correlations the impact of the practical support items, for example, "help" or "guidance" was greater. Korean young mothers, however, showed similar trends to the Scottish mothers with weaker correlation scores being found. They too enjoyed reciprocating support more than the old Korean group.

Both Scottish young and old mothers showed higher correlations in almost all areas, with the exception of the item "offering advice", which showed no significant correlation.

3) Amount of support

Again, the subjective evaluation about the amount of support given to mothers, correlated more significantly with depression scores than the number of supporters they had (see Table 6-26).

Table 6-26: Correlation between BDI scores and amount of support (receiving/offering)

	Korean		Scottish	
	Young	Old	Young	Old
Receiving sup.	-.43***	-.31**	-.56***	-.67***
Offering sup.	.26**	.14	.21	.07

* = p<.05
** = p<.01
*** = p<.001

From the table we see that the Scottish mothers have higher correlations than the Korean mothers. The amount of support received was more highly correlated with BDI scores than the amount of support offered to

others. We will investigate the correlations between BDI scores and the amount of support in each area (see Table 6-27).

Table 6-27: Correlation between BDI scores and amount of support (each area)

	Korean		Scottish	
	Young	Old	Young	Old
Socialise	-.19*	-.21*	-.37**	-.46***
Emotional	-.33***	-.25**	-.50***	-.61***
Help	-.31***	-.23**	-.38**	-.46***
Guidance	-.35***	-.30***	-.31***	-.50***
Comfort	-.24**	-.20*	-.42***	-.54***
Feedback	-.17*	-.19*	-.44***	-.46***
Appreciated	-.27**	---	-.53***	-.50***
Offer advice	.20*	---	---	---
Offer care	.21*	.23**	---	---

* = p<.5
** = p<.01
*** = p<.001
--- = no significant correlation

Generally, the interrelationships between the amount of the support system with the BDI scores were more significant than those between the quality of support. More or less all four groups confirmed the significant interrelationships for the amount of "emotional", "comfort", practical "help" and "guidance" support

categories with BDI scores. Scottish mothers displayed more interrelationships with the amount of support they experienced than the Koreans. A similar phenomenon was found in the case of satisfaction with the quality of the support system.

4) Postnatal help at home and depression scores

The results of the interrelationships between the postnatal help for the young mothers at home and their BDI scores are shown in Table 6-28.

Table 6-28: Correlation between BDI scores and postnatal help

	Korean	Scottish
Number of sup.	---	---
Time arrange	---	---
Kind of sup.	-.17*	-.29*
Person	---	-.25*

* = p<.05
** = p<.01
*** = p<.001
--- = no significant correlation

There was no significant correlations between the number of supporters and time arrangement at home with the BDI scores. The kind of help received was

appreciated by Korean mothers, and the comfortableness with the supporters who provided help correlated significantly in both groups of mothers with the relevant BDI scores. Yet all three correlations were very weak.

5) Correlation between BDI scores and overall evaluation of support

For the Scottish mothers and the young Korean mothers, the depression scores negatively correlated with the overall satisfaction with support (see Table 6-29).

Table 6-29: Correlation between BDI scores and overall evaluation of support

	Korean		Scottish	
	Young	Old	Young	Old
Satisfied	-.30***	---	-.55***	-.73***

* = p<.05
*** = p<.001

Results indicate that mother who were more depressed also reported the dissatisfaction with her overall support system. Again Korean old mothers did not record significant relations.

6) Relationship between the primary supporter and BDI scores

Since the place of husband among the old Korean group was distinct, it was thought worthwhile to investigate the differences in BDI scores between the different supporters who were chosen first using a t-test. The results are shown in Table 6-30.

Table 6-30: Differences in BDI average scores (husband vs. others)

	Korean		Scottish	
	Young	Old	Young	Old
Socialise with:				
husband	9.29	12.24	5.21	5.96
	***			
others	13.04	11.90	7.57	6.33
Emotional support by:				
husband	7.74	9.79	5.65	5.07
	***			*
others	11.36	12.72	8.72	7.95
Feedback by:				
husband	8.02	10.44	6.34	5.15
	***			
others	10.77	12.62	7.47	7.62
Help by:				
husband	8.65	11.23	6.69	5.12
others	10.02	12.18	6.74	7.16
Guide by:				
husband	6.30	7.89*	5.75	4.72
	***			*
others	10.91	12.79	7.54	7.74
Comforted by:				
husband	7.58	10.31	6.38	5.3
	***			*
others	11.48	12.46	8.86	8.87
Appreciated by:				
husband	7.24	10.50	5.52	4.83
	***		*	*
others	10.79	12.10	9.10	7.69
Offer advice to:				
husband	5.72	20.50	4.42	4.5
	***		*	
others	9.97	11.79	7.40	6.59
Offer care to:				
husband	6.91	9.88	5.00	4.06
	***			**
others	10.12	12.33	6.89	7.29

*** = p<.001 ** = p<.01 * = p<.05

Generally all the mothers who selected their husbands as their first choice of supporter scored lower on the BDI than those who chose other people. The young Korean mothers showed significant differences in average depression scores between those who chose their husband first and those who placed others first (except "help"). The old Korean mothers had almost no significant difference between these two groups (except "guidance").

The old Scottish mothers showed more significant differences in their first choice in "emotional support", "guidance", "comfort", "appreciated" and "offering care", than did the young Scottish mothers. The young Scottish group showed significant differences only in "appreciated" by and "offering advice" to their husbands or others.

The husbands were more significant as supporters to the young Korean mothers than the old Koreans, and to a lesser degree to the old Scottish mothers than to the young Scottish mothers.

(3) Comparison between the severity groups

General support patterns between the severity groups (according to the level of depression score) as well as the relationship between the support system and depression scores will be investigated in this section.

1) Comparison of the support structure between subgroups according to the level of depression

The differences in support systems between the severity groups according to the level of depression (Mann Whitney U-test was used) is reported here. The results are shown in Tables 6-31, -32, -33. The group with the higher score was marked within brackets as "mi", "mo" and "se" which stands for "mild", "moderate" and "severe" respectively.

Table 6-31: Support system analysis according to level of depression - Network size

Number of supporters	"Mild vs.Moderate" Korean	"Mild vs.Moderate" Scottish	"Moderate vs.Severe" Korean	"Moderate vs.Severe" Scottish
Socialise	---	---	---	.05 (mo)
Emotional	---	---	.05 (mo)	---
Help	---	---	---	.05 (mo)
Guidance	---	---	---	---
Comfort	---	---	.01 (mo)	---
Feedback	---	---	.01 (mo)	---
Appreciated	---	---	---	.05 (mo)
Offer advice	---	---	.05 (mo)	---
Offer care	---	---	---	---

There were few significant differences in terms of the number of supporters between "mild" and "moderate" groups of mothers in both cultures. In some types of support the "moderate" group reported having more supporters than the "severe" group; for example Scottish mothers showed differences in "socialising", getting "help" and "being appreciated", while Korean mothers scored higher in the number of "emotional" supporters, the "comforters", the number of people who gave "feedback" and the number of people for whom the mothers offered advice.

Table 6-32: Quality of support between severity groups

Quality of support:	"Mild vs.Moderate" Korean	"Mild vs.Moderate" Scottish	"Moderate vs.Severe" Korean	"Moderate vs.Severe" Scottish
Socialise	---	---	.01 (mo)	.01 (mo)
Emotional	---	.05 (mi)	---	.05 (mo)
Help	.05 (mi)	.05 (mi)	---	---
Guidance	.01 (mi)	---	---	.05 (mo)
Comfort	---	.001(mi)	---	---
Feedback	---	---	---	---
Offer advice	---	.001(mi)	---	---
Offer care	---	---	---	---

Table 6-33: Amount of support between severity groups

Amount of support:	"Mild vs.Moderate" Korean	"Mild vs.Moderate" Scottish	"Moderate vs.Severe" Korean	"Moderate vs.Severe" Scottish
Socialise	---	---	.001(mo)	---
Emotional	---	.001(mi)	.05 (mo)	---
Help	.01 (mi)	.05 (mi)	---	---
Guidance	.01 (mi)	.01 (mi)	---	.05 (mo)
Comfort	---	.001(mi)	---	---
Feedback	---	---	---	.05 (mo)
Appreciated	---	.01 (mi)	---	---
Offer advice	---	---	---	---
Offer care	---	.001(mo)	---	---

In reporting the satisfaction in both the quality and amount of support, Scottish mothers scored higher than Korean ones with the greatest differences between the "mild" and "moderate" groups. Korean mothers showed more differences only in practical "help" and "guidance" support; whereas the Scottish mothers showed more differences in "emotional", "comfort" and "appreciated" as well as "help" and "guidance". "Mild" Scottish mothers offered more care to others than the "moderate" group. Between "moderate" and "severe" groups, Korean mothers only showed a difference in the area of "socialising", while Scottish mothers showed differences in receiving "emotional" support, "guidance" and "feedback".

All the significant differences were greater among the "mild" mothers than "moderate" group, and also among the "moderate" than "severe" groups. As far as the number of supporters was concerned, no difference was found between the "mild" and "moderate" groups; whereas the appreciation of quality and amount of support revealed differences between "mild" and "moderate" ones.

2) Correlations among the severity groups

Considering the fact that Scottish mothers were less depressed and appreciated their support system more than Korean mothers, it was thought worthwhile to explain the correlations between the BDI scores and the support system among the severity groups. Since we did not find any significant differences in the distributions of the severity groups, according to the BDI scores, between the young and old groups in either culture, we combined the age groups within each culture.

Table 6-34: Correlations between support system and BDI score between severity groups

KOREAN

Support	"Mild"	"Moderate"	"Severe"
Number-rec.	.02	.16	.01
-off.	-.02	.13	.08
Quality-rec.	-.24**	-.10	-.06
-off.	-.28***	-.29*	-.04
Amount-rec.	-.30***	-.10	.02
-off.	.19**	.04	.02

SCOTTISH

Number-rec.	-.18*	.15	-.39
-off.	-.20*	.01	.97**
Quality-rec.	-.41***	-.59*	.35
-off.	-.24**	-.52	.17
Amount-rec.	-.40***	-.48	-.02
-off.	.16*	.41	-.13

rec. = receiving support from
off. = offering support to
* = p<.05 ** = p<.01 *** = p<.001

From the above table it can be seen that only the mild group showed significant correlations between the support system and depression scores. The number of supporters was less relevant for Korean mothers than for the Scottish mothers, even though the size of the correlations were smaller than those of the quality and amount of support. The Scottish mothers showed higher correlations than the Korean ones, except in the case of quality and amount of "offering support" to others. While all the correlation scores were negative, the amount of offering support was positively correlated, which seemed to reflect the mothers' feeling of being burdened (they have to offer "too much" support to others).

The relations between social support system and depression among severity groups in both cultures for each subscales (using Pearson correlation) are displayed in Table 6-35.

Table 6-35: The correlation between the level of depression and network size

KOREAN

network size	"Mild"	"Moderate"	"Severe"
Socialise	---	---	---
Emotional	---	---	---
Help	---	.25*	---
Guidance	---	---	---
Comfort	---	---	---
Feedback	---	---	---
Appreciated	---	---	---
Offer advice	---	---	---
Offer care	---	---	---

SCOTTISH

network size	"Mild"	"Moderate"	"Severe"
Socialise	-.18*	---	---
Emotional	---	---	---
Help	---	---	---
Guidance	---	---	---
Comfort	---	---	---
Feedback	---	---	---
Appreciated	-.25**	---	---
Offer advice	-.22**	---	.98**
Offer care	---	---	.91*

* = p<.05 ** = p<.01
--- = no significant correlation

As can be seen, there were almost no correlation in any of the severity groups in Korean mothers. The number did not correlate highly in total (see Table 6-33) and seemed even less so when it was observed for each item.

Scottish mothers showed significantly higher correlationships than Korean mothers for some aspects of the support system. For instance, they showed

significant relations between the number of people with whom they "socialise", by whom they were "appreciated", to whom they "offer advice" in their "mild" group. It should also be noted that the number of people they "offer advice and care" to showed significantly positive relations with depression scores among the "severe" group. This means that the more people they have to give advice and offer care to, the more apt they were to be depressed.

The 'severe' category of the Scottish sample in Table 6-35 is inappropriate due to the small number of subjects involved.

Table 6-36: The correlation between the level of depression and quality of support

KOREAN

Quality of support-	"Mild" group	"Moderate" group	"Severe" group
Socialise	-.17*	---	---
Emotional	---	---	---
Help	-.18*	---	---
Guidance	-.25***	---	
Comfort	-.14*	---	---
Feedback	-.21**	---	---
Offer advice	---	---	---
Offer care	-.32***	-.25*	---

SCOTTISH:

Quality of support-	"Mild" group	"Moderate" group	"Severe" group
Socialise	-.20*	---	---
Emotional	-.26**	-.60*	---
Help	-.29***	---	---
Guidance	-.19*	-.57*	---
Comfort	-.28***	---	---
Feedback	-.34***	-.78**	---
Offer advice	---	---	---
Offer care	-.23**	-.55*	---

* = p<.05
** = p<.01
*** = p<.001
--- = no significant correlation

From the above tables it can be seen that the quality of support clearly showed significantly higher correlations with depression scores among "mild" group: more so among the Scottish than Korean mothers. In several areas of support (receiving "emotional" support, "guidance" and "offering care") "moderate" Scottish mothers showed significantly high

correlations. Once again the "severe" group did not respond.

Table 6-37: The correlation between the level of depression and the amount of support

KOREAN

Amount of support-	"Mild" group	"Moderate" group	"Severe" group
Socialise	---	---	---
Emotional	-.19*	---	---
Help	-.20*	-.25*	---
Guidance	-.29***	---	---
Comfort	-.15*	---	---
Feedback	-.23**	---	---
Appreciated	-.21**	---	---
Offer advice	---	---	---
Offer care	.32***	-.25*	---

SCOTTISH

Amount of support-	"Mild" group	"Moderate" group	"Severe" group
Socialise	-.27***	---	---
Emotional	-.25**	-.56*	---
Help	-.26***	---	---
Guidance	-.20*	---	---
Comfort	-.29***	---	---
Feedback	-.34***	-.56*	---
Appreciated	-.40***	---	---
Offer advice	---	---	---
Offer care	.17*	---	---

* = p<.05
** = p<.01
*** = p<.001
--- = no significant correlation

Similarly, the above tables report that "mild" Scottish mothers recorded significantly higher correlations between the amount of support and their

depression scores than did the "mild" Korean mothers. Even among the "moderate" Scottish mothers there were some significant correlations (receiving "emotional" support and "feedback"); while only the "offering care" to others was found significant among "moderate" Koreans. Here, repeatedly, we can see that "severe" groups in both cultures did not show any significant correlations.

6:4 Life Events and Depression

The reported mothers' recent life events were investigated as regards: 1) the number of events, 2) the types of events (see Appendix 6 for full details). (Hypothesis 5)

(1) Nummber of recent life events

The average number of recent life events experienced in the preceeding 2 months by the mothers are shown in Table 6-38.

Table 6-38: Number of recent life events

subgroups	mean
Young Korean	1.73
Old Korean	2.58
Young Scottish	2.07
Old Scottish	1.67

The number of events reported by the old Korean mothers were significantly greater than those by the young Korean mothers or old Scottish ones (both differences were significant at $p<.001$ level, using a t-test). The

difference between the young Scottish and old Scottish mothers and that between the young Scottish and Korean mothers were significant on the 0.05 level.

The correlation between the number of life events and the depression scores are recorded in Table 6-39.

Table 6-39: Correlations between number of life events and BDI scores

subgroups	Correlation coefficient
Young Korean	.22*
Old Korean	.21*
Young Scottish	-.08
Old Scottish	.27**

* = p<.05
** = p<.01

As can be seen from Table 6-39, three out of four of the correlation coefficients were significant although they were not very strong.

Correlation between the number of life events and the depression score among the severity groups is recorded in Table 6-40.

Table 6-40: Correlations between number of events and BDI scores (severity groups)

groups	Mild	Moderate	Severe
Korean	---	---	---
Scottish	---	-.68*	---

* = p<.05

As can be seen in Table 4-3, only moderately depressed Scottish mothers recorded significant negative correlations.

(2) Types of events

The questionnaire included nine types of events. The percentages of mothers who had experienced these events in the two months preceding the interview, or even earlier but which were still troubling the mothers, are recorded in Table 6-41.

Table 6-41: Percentage of mothers in each category of life events

Item	Korean		Scottish	
	Young	Old	Young	Old
Interpersonal conflict	30 %	44 %	52 %	31 %
Death of close people	9 %	30 %	20 %	24 %
Failure	15 %	20 %	4 %	2 %
Crisis & disaster	5 %	12 %	9 %	12 %
Crime victim	4 %	4 %	4 %	6 %
Ill health	18 %	24 %	18 %	6 %
Difficult in mothering	73 %	69 %	73 %	45 %
Caring responsibility	12 %	9 %	9 %	26 %
Other event	11 %	14 %	9 %	11 %

The most frequently mentioned stressful event was the role of being a mother, followed by interpersonal conflict with her husband, in-laws, neighbours, friends or others.

The significant correlations between the types of events and the depression scores are recorded in Table 6-42 (using the point biserial correlation coefficient).

Table 6-42: Correlations between types of life events and depression score

Item	Korean		Scottish	
	Young	Old	Young	Old
Interpersonal conflict	---	---	---	---
Death of close people	.29**	---	---	---
Failure	---	---	---	.21*
Crisis & disaster	---	---	---	---
Crime victim	.21*	---	---	---
Ill health	---	---	---	---
Difficult in mothering	---	---	---	.23*
Caring responsibility	---	---	---	---
Other event	---	---	---	---

* = p<.05
** = p<.01
--- = no significant correlation

As can be seen in Table 6-42, generally the correlations between the specific type of life events with the depression scores were very low. Only 4 out of 36 correlations were significant: "death of close people" and mothers' experience as a "crime victim" showed a significant relationship with the young Korean mothers' mood of depression. The old Scottish group of mothers showed significant correlations for their experience of "failure" and the "difficulty in mothering role" who included the children which are not facing final school examinations.

In conclusion, the number of recent life events showed weak but significant relations with depression, but we did not find that the specific type of events had significant correlation with BDI scores in this study.

6:5 Most Important Variable for Depression

A multiple correlation was carried out with the depression scores as the dependent variable, and the attributional style, social support, and life-events, as the independent variables.

(1) Multiple correlation coefficients for the four subgroups

The following independent variables were entered into the equation:

Table 6-43: Independent variables for the overall multiple correlation coefficient

Attributional style:	1. Internal attribution
	2. External attribution
Social support:	3. Number of supporters- from whom they receive support
	4. Number of supporters- to whom they offer support
	5. Quality of receiving support
	6. Quality of offering support
	7. Amount of receiving support
	8. Amount of offering support
Life-event:	9. Number of life-events

When all the independent variables were entered into the equation, the multiple correlation coefficients were as follows (see Table 6-44).

Table 6-44: Overall multiple correlation coefficient

Korean young:	.53
old :	.41
Scottish young:	.74
old :	.75

As can be seen from the Table there is a clear difference in the size of the multiple correlation coefficients between the Korean and the Scottish groups: both the young and old Scottish mothers had markedly higher multiple correlation coefficients than the Korean ones.

The difference in correlation coefficients between the young Korean and Scottish mothers was significant at $p<.05$ level of significance; and between the old Korean and Scottish mothers at $p<.01$ level of significance (using z-test, see Hinkle et al., 1988, p.276-278).

However, these multiple correlation coefficients in Table 6-44 do not really reflect adequately which of the independent variables contributed most to the common variance. Therefore, the multiple correlation coefficients were calculated again, including only those independent variables which contributed

significantly to the multiple regression. The results for the four groups are recorded in Table 6-45.

Table 6-45: Independent variables which contributed significantly to the regression

	Korean		Scottish	
	Young	Old	Young	Old
step 1:	Amount of rec.-sup. R=.43	Amount of rec.-sup. R=.30	Quality of rec.-sup. R=.58	Amount of rec.-sup. R=.67
step 2:	Number of-off.-sup. R=.47	Number of life-event R=.37	External attribution R=.71	Internal attribution R=.71
step 3:	Number of life-event R=.51	Quality of rec.-sup. R=.40		Number of life-event R=.73
Final R:	R=.51	R=.40	R=.71	R=.73

rec.-sup.: receiving support from others
off.-sup.: offering support to others
Number of-(e.g. off.-sup.): Number of supporters in- (e.g. offering support)

All of the final multiple correlations were significant at the $p<.01$ level of confidence.

Comparing the final multiple correlation coefficient (see the bottom line of Table 6-45) with the corresponding overall multiple correlation coefficient from Table 6-44 it can be seen that they were very similar. The differences were not significant, using

F-test (see Hinkle et al., 1988, p.476) for any of the four comparisons.

Thus for further discussion the multiple correlation coefficients of Table 6-45 are used. The following conclusions can be drawn from Table 6-45:

1) Number of independent variables extracted

In all of the four separate groups only a maximum of 3 of the independent variables were included for predicting the depression scores.

Independent variables which were not included in any of the 4 groups were:

-Number of supporters from whom they receive support
-Quality of the support offered to others
-Amount of the support offered to others

These independent variables either measured specific aspects not relevant to the prediction of the depression, or their common variance with depression was already represented in those independent variables included in the multiple correlation coefficients recorded in Table 6-45.

2) Size of multiple correlation coefficients

The Scottish groups obtained significantly higher multiple correlation coefficients than the Korean ones (significant on $p<.05$ and $p<.01$ level or confidence for the young and old groups of mothers respectively). Thus the independent variables were better predictors of depression within the Scottish samples than within the Korean samples.

3) Cross-cultural similarities

The multiple correlation coefficient of all the four subgroups included at least one aspect of support received from others. The amount of support received from others was particularly relevant for the Korean groups, as well as the old Scottish mothers (supposedly the most important independent variable to correlate with depression). Variables that reflected the subjects support of others, on the other hand, had little in common with the depression scores (except for the young Korean group). Number of life events also contributed to the multiple correlations in both the Korean groups and the Scottish samples, with the exception of the young Scottish group.

It can therefore be concluded that life events and the support received appeared to be related to depression, independently of culture at least to a limited extent.

4) Culture specific variables

There were also similarities within the cultures in the size of the multiple correlation coefficient: neither culture had significant differences between the age groups (using z-test, see Hinkle et al., 1988, p.276-278).

Attributional style variables only contributed significantly to the multiple correlation coefficient within the Scottish samples. They were not extracted for the two Korean groups.

For the Korean groups the best predictors for depression were life event and social support, while for the Scottish groups it was attributional style and social support.

5) Group specific variables

Only in the case of the old Scottish mothers did all three of the areas related to depression reach the

level of significance required ($p<.05$) to be included in the regression equation. As the relevant literature (Cohen et al., 1985; Seligman et al., 1979; Dohrenwend et al., 1980) would suggest these were: social support, attributional style and life-events. In all of the other three groups only two of the three areas were selected for inclusion in the multiple regression.

Unlike the other three groups, the young Scottish groups number of life-events did not add significantly to the size of the common variance, and the quality of support received (rather than the amount of support received) was reported as the most significant contributor to their variance.

(2) Multiple correlation coefficients for the separate severity groups of depression

When all variables were entered into the equation the multiple correlation coefficients for the three severity groups were as follows (see Table 6-46).

Table 6-46: Overall multiple correlation coefficients for the severity groups

	Mild	Moderate	Severe
Korean	.40**	.45	.52
Scottish	.52***	.93	.97

** = $p<.01$ *** = $p<.001$

Although some of the multiple correlations in Table 6-46 appear to be quite high (e.g. for the Scottish "moderate" and "severe" groups) none of them were significantly different from zero except for the Korean and the Scottish "mild" group ($p<.01$). This is mainly due to the small sample size of "moderate" and "severe" Scottish mothers. Therefore, the "mild" group will be discussed only in the following section.

These multiple correlation coefficients do not show which of the independent variables contributed most to the common variance. By using SPSSx (1988) "forward" method, those independent variables were found which contributed to the multiple regressions significantly and the results are recorded in Table 6-47.

Table 6-47: Independent variables which contributed significantly to the regression for the "mild" group

Korean		Scottish	
Young	Old	Young	Old
step 1:			
Quality of off.sup. R=.31	Amount of rec.sup. R=.30	Number of-off.sup. R=.33	Amount of rec.sup. R=.46
step 2:			
Amount of rec.sup. R=.37	Amount of off.sup. R=.35	External attribution R=.43	Internal attribution R=.54
step 3:			
Quality of rec.sup. R=.43	Number of-off.sup. R=.39	Quality of rec.sup. R=.53	Number of events R=.56
step 4:			
Number of-rec.sup. R=.46			
step 5:			
Number of-off.sup. R=.49			
Final R:			
R=.49	R=.39	R=.53	R=.56

In comparison with the results from the whole population (see Table 6-45) the following conclusions for the "mild" groups can be drawn from Table 6-47.

1) Number of independent variables extracted

In three of the four separate "mild" groups three of the independent variables were included for predicting the depression scores, while the young Korean "mild"

group included five of them. All the nine variables were found in the four groups.

2) Size of multiple correlation coefficients

Although the Scottish groups had higher multiple correlation coefficients than the Korean ones, the differences were not large when compared with the total sample which included all levels of severity groups.

3) Culture specific variables

Independent variables concerning social support systems contributed significantly to the multiple correlation coefficients within the Korean groups. Life events and attributional style were not extracted for the two "mild" Korean groups.

Attributional style variables again contributed significantly to the multiple correlation coefficient within the Scottish samples.

4) Group specific variables

Once again, only the regression equation constructed for the group of old Scottish mothers included all of

the three areas related to depression as had been expected. The number of life events were not included in the equations for any of the other three groups.

The young Korean group extracted more variables than any other, though only those of the support system, and are more reciprocal in nature. "Mild" Korean groups had no effect from the number of life-events or attributional style, but did have an effect on reciprocal social support.

In general, the "mild" groups of the Scottish mothers showed similar trends to the total group which included the "moderate" as well as "severe" groups, whereas "mild" Korean groups differed from the respective total population probably because we had more Korean mothers in "moderate" and "severe" categories.

CHAPTER SEVEN

DISCUSSION AND CONCLUSIONS

Introduction

In this chapter the major findings from this study will be discussed and their theoretical implications considered. The discussion is divided into five sections. It begins with discussions of the results in (1) depression of the subjects; (2) attributional style and its relationships with depression of mothers; (3) social support system and depression; (4) recent life events and depression; and 5) the most significant variables related to depression and the main conclusions.

7:1 Depression

Principal findings in this section of the study are: 1) there were no significant differences in depression scores between the two life stages tested within each culture; however, 2) there were cross-cultural differences in depression between the two cultural groups. (Hypothese 1 and 2)

The results will be compared with other studies of depression using BDI.

(1) Distribution width

When we looked at the distribution of total scores for depression on the BDI (Fig. 6-1), we found that all four groups follow a normal distribution curve. In addition we found that the four distributions had similar variances (using F-test), i.e. there were no significant differences between any of the variances of the four groups. Standard deviations varied between 5.55 and 7.27. This result corresponds well with those studies which investigated depression in general populations.

1) Distribution width in normal populations

Gould (1982) tested 185 American college students (42 males and 143 females) and quoted a standard deviation of 7.6 for male and a standard deviation of 4.7 for female subjects, with no significant difference between the two variances. Similar findings were affirmed by Hammen et al. (1977) using 972 male and 1300 female American university students. They reported standard

deviations of 5.74 and 5.58 respectively, and also no significant gender difference.

Rees (1971) used British parents (99 mothers and 77 fathers) and found standard deviations of 5.98 antenatally and 7.41 postnatally among mothers; and 5.66 among antenatal fathers and 4.69 postnatal fathers. 27 nulliparous women acting as the control group had a standard deviation score of 3.81.

Herzberg et al. (1970) using 168 British women who had taken oral contraceptives recorded a standard deviation of 6.01.

As regards people from different ethnic backgrounds, the study by Marsella et al. (1975) using American female students of Caucasian (N=37), Chinese (N=37) and Japanese (N=50) origin, obtained standard deviations of 6.67, 7.36 and 6.81 respectively. However, it should be mentioned that some authors obtained much smaller variances for normal samples on the BDI. Hammen et al. (1976) tested 200 American students, the selected nondepressed group showed standard deviation of 2.42. Vezina et al. (1984) administered BDI to 50 elderly people in Canada. Their results showed that standard deviation of the nondepressed (N=38) was 2.74.

It should be noted, however, that the small variances in the last two studies were obtained from preselected samples: subjects scoring higher than 10 on the BDI were excluded in the calculations. Obviously this had an effect on the variances as decreasing the range of scores results in smaller standard deviations. All in all the variances obtained in the present study for the BDI, correspond well what has been found in many other studies using normal populations.

2) Distribution width in special populations

One of the main aims of the present investigation is to compare the degree of depression between two different cultural groups at a time of life when women are especially vulnerable to stress, such as during the postnatal period, or at the time when a child is preparing for the university entrance qualification. We expected more depression among these mothers even though they are part of the general population. Therefore, it could be of interest whether the range of depression scores among special populations such as psychiatric patients, substance abusers or depressed patients differ considerably from those found in the present study.

The original study was carried out by Beck et al. (1961) with psychiatric patients (N=409), male and female, white and black American, 15 to 55+ years of age, from all socio-economic classes. They found a standard deviation of 8.1 among nondepressed (N=115), 10.2 among mildly depressed (N=127), 9.6 in the moderately depressed group (N=134), and 10.6 among the group of severely depressed (N=33). Beck et al. (1984) administered also both the 1961 and 1978 BDI versions to 598 psychiatric in- and out-patients and 248 psychiatric out-patients in America, and found standard deviations of 10.87 and 9.55 respectively.

Steer et al. (1988) used 174 male and 276 female psychiatric out-patients in America and obtained standard deviations of 10.14 and 10.05 respectively which were not found to be significantly different. The studies mentioned above using psychiatric patients found a limited range of scores as expressed in standard deviation varying between 8 and 11.

Only the two studies by Hammen (1976, 1980) quoted smaller variances than all the other studies, including ours. Hammen et al. (1976), using 200 college students in America, recorded a standard deviation of 5.76 for depressed subjects. Hammen's study (1980) with 400

university students in America categorised people by their severity of depression. Among the 9.2 % of total subjects who scored over 16 the standard deviation score was 2.05 among the major depressed group (N=5); 4.09 among minor depressed group (N=8); 7.00 among mood depression (N=3); and 2.96 among nondepressed group (N=18).

However, certain reservation can be voiced against the Hammen studies. First of all the sample sizes are surprisingly small for some categories. For example, the standard deviation was 2.05 among 5 major depressed people and 4.09 among 8 minor depressed people. Secondly, the small variances in these two studies were obtained from preselected samples. Obviously this had an effect on the variances, by decreasing the range of the scores, and therefore obtaining smaller standard deviations.

It is interesting to note that the studies using substance abusers, such as alcoholics and drug addicts, recorded significantly bigger variances than the studies using psychiatric patients. Steer at al. (1977) tested 103 American black male alcoholics, and recorded a standard deviation of 11.42. Steer et al. (1982) used the BDI self-administered test on 101 male

alcoholics in a metropolitan area in America and found a similar standard deviation of 10.46.
Steer et al. (1985) administered BDI to 105 out-patient alcoholics and 211 methadone maintenance patients. The standard deviation for the alcoholics was 10.60 and for the heroin addicts 9.35.

As regards British subjects, Metcalfe et al. (1965) tested British depressed patients (N=37) on their admission to, and discharge from hospital. They recorded a standard deviation 8.75 and 6.23 respectively. They also compared the groups of "no depression" (N=32), "mild depression" (N=44), "moderate depression" (N=24) and "severe depression" (N=20), and the standard deviations were 5.85, 8.35, 10.84 and 6.51 respectively. The results of this study correspond quite closely with our findings.

In conclusion, the results of the studies of depression which used BDI to general population and special group of people correspond quite well with our findings. Therefore, it is safe to compare the average total scores of present study with other studies which used BDI.

(2) Average scores

As has been shown in the results section the Korean mothers, both young (M=11.22) and old (M=11.96), obtained significantly higher depression scores than the young (M=6.72) and the old (M=6.22) Scottish mothers (see Table 6-1). The question can be raised how the depression scores in the present study compare with depression scores using BDI reported in other studies. As most of the studies using BDI have been carried out with North American or European subjects we will first compare the Scottish samples with those reported. Secondly, we will look at the Korean results with those few available studies using BDI on Asian subjects. This will give us some idea of whether our data confirm the generally known facts of depression.

1) Comparison of Scottish findings with those of European and North American subjects

A perusal of those average scores shows that they are either of the same magnitude, considerably smaller or considerably larger, depending on what sample had been used.

a) In non-preselected samples

The average depression scores vary between 6.1 and 7.8, which are comparable with Scottish mothers' average scores in the present study (i.e. young Scottish mothers: 6.72, old Scottish mothers: 6.22).

For example, Gould (1982) used 185 American students (42 males and 143 females) and recorded no significant sex differences on BDI with a mean for males of 7.83 and for females of 7.51. Similar findings were reported by Hammen et al. (1977) using 972 male students and 1300 female American university students, 5.95 and 6.34 respectively. The difference between the means was not statistically significant.

Brouque et al. (1982, quoted by Lips et al., 1986), using 498 French students, found a mean score of 6.1.

Even Herzberg et al. (1970) using British female group (N=168) taking oral contraceptives reported an average score 8.65.

The results of these four reports correspond rather well with the Scottish mothers' average depression scores.

b) Pre-selected non-depressed samples

Where "depressed" subjects had been excluded from the calculation of the average BDI, the scores are generally lower than those in our samples.

Nondepressed American university students (N=200) obtained 3.0 on average (Hammen et al., 1976). Among a college population, Jacobson et al. (1982) recorded a mean BDI score of 2.25 for nondepressed subjects.

Vezina et al. (1984) studied 50 elderly Canadians who were 60 years old or over. They found that the mean of the non-depressed group 3.82.

Although the average depression scores in these three studies are considerably lower than those of the Scottish mothers, they are not really comparable with our results. Depressed subjects had been excluded from the calculations of the means. It is not surprising therefore that our averages should be higher, where depressed mothers were not excluded in the calculation of the mean scores.

c) Special groups with difficulties

With psychiatric patients and substance abusers the depression scores were found to be higher than the Scottish mothers' average.

In the original study tested on psychiatric patients in America, Beck et al. (1961) recorded mean scores of 10.9 in non-depressed patients (N=115), 18.7 in mildly depressed patients (N=127), 25.4 in moderately depressed (N=134), and 30.0 in severely depressed people (N=33). In a later study, Beck et al. (1984) found means of 19.28 and 23.16 for two different psychiatric populations.

Steer et al. (1988) studied 174 male and 276 female American psychiatric out-patients diagnosed with DSM-III as affective disorder. The mean BDI score for males was 20.31 and females 19.17.

Metcalfe et al. (1965) investigated British depressed patients at admission to and at discharge from hospital. Their mean scores were 26.18 and 7.15 respectively. The difference between admission and discharge scores was significant.

In the same study Metcalfe et al. (1965) also compared doctors' ratings and BDI scores of British patients with those of an American patients from the study of Beck et al. (1961). They found that British patients obtained lower BDI scores than their American counterparts. For example, British subjects diagnosed with "no depression" symptoms showed an average score of 5.37 whereas the corresponding Americans obtained 10.9. For the "mild" depression the British subjects scored 14.27 on average, but the Americans scored 18.7. Also for "moderate" depression, and "severe" depression the American obtained higher score than British ones, which were 25.4 and 30.0 versus 24.21 and 29.5 respectively. Metcalfe et al. suggested that the difference between the British and the American (especially for the "no depression" and "mild depression" categories) might reflect a cultural difference which is more evident in patients who are not very ill.

Comas-Diaz (1981) tested 26 Spanish-speaking depressed Puerto Rican women in American, before and after behaviour and cognitive therapy and compared them with a control group of depressed women, who did not receive any treatment. The control group had an average of 28.00 and 27.79 at the two times of testing. On the other hand, the BDI scores decreased significantly for

the treatment groups after therapy. The behaviour therapy group scored 29.75 before therapy, 14.54 one week after, and 12.36 five weeks after the therapy. The cognitive therapy group scored 30.00 before the treatment, 10.80 one week after, and 16.63 five weeks after the therapy. Although their final scores after the therapy remained somewhat higher than those scores we already discussed for non-depressed people, we have to keep in mind that Comas-Dias' subjects came from low socio-economic background, were single mothers, were relatively uneducated (average length of schooling 6 years), and had been living in the United States for only five years. They had received therapy for depression, but they still had to cope with their difficult life situations.

In addition to the studies on psychiatric patients it is worthwhile looking into the studies on substance abusers. In the studies on alcoholics Steer et al. (1977. 1982) found an average score of 16.42 for black male Americans and 12.80 for a mixed group of black and Caucasian male Americans. In the case of substance abusers Steer et al. (1985) recorded mean scores of 13.88 and 13.18 for 105 alcoholics and 211 heroin addicts respectively.

On the other hand, Reynolds et al. (1981) studied 163 participants in a methadone maintenance program and obtained a mean score of 19.42. Their results also indicated a significant difference between male (M=17.79) and female (M=22.47) patients.

A special group of people who stayed in prison for a period of one month to one year (N=245, male) in the United States, scored an average of 17.7 (Peterson et al., 1982 quoted in Peterson et al., 1984). The average BDI score when they were admitted was 16.8.

However the best study for comparison with our Scottish sample is probably the one carried out by Rees (1971) with British postnatal women. He tested 99 mothers and found average BDI scores of 7.8 antenatally and of 7.7 postnatally. Our results of 6.72 for the postnatal Scottish group correspond well with these findings.

In conclusion we can see that the average scores of Scottish mothers were: a) higher than those from preselected nondepressed groups; b) lower than those of psychiatric patients and substance abusers; and c) about the same found in comparable studies with European and North American subjects.

2) Comparison of Korean findings with other studies using Asian subjects

Before we start this discussion it would be worthwhile to recall our findings: M=11.22 for the young Korean group, and M=11.96 for the old Korean mothers.

To the best of the author's knowledge, no study has yet been reported using the BDI with Korean subjects. There is no official translation of the BDI into the Korean language. As mentioned before, the BDI used in the present study was translated by the author for the purpose of the present study.

However, the BDI has been used by Marsella et al. (1975) with other Asian groups. For example, Chinese and Japanese second generation immigrant female students were compared with Caucasian female students in the United States, and their average scores were 8.08, 8.12, and 6.49 respectively. The difference between the Caucasian American students on the one hand, and the Chinese and Japanese American students on the other was significant. Thus subjects of Asian ancestry appear to score higher on a depression scale than their Caucasian peer group. However, the difference was not as big as the difference found in our study between Korean mothers and Scottish mothers.

The fact that the students in the study by Marsella et al. were all living in the same country, even though they had different ethno-cultural backgrounds, may have contributed to this result. We may assume that these second generation Asian students were already acculturated to a considerable degree to the North American culture.

On the other hand, all of our Korean mothers lived in Korea. Thus if Asian females in general tend to show higher scores in a depression scale (as indicated by the study of Marsella et al.) than females of European descents, then we might expect our Korean mothers to score higher on BDI than the Scottish mothers. The fact that the subjects in our study lived in their respective countries at the time of research, where cultural differences are greater in life, might be one of the factors contributing to the bigger difference than the result we see from Marsella et al.

Our study shows the same trend, namely, that people of Asian origins show higher depression scores. The average scores on BDI of Korean mothers in our study were significantly higher than all the above mentioned pre-selected European and North American normal groups.

Korean average depression scores are placed at the lower end of scores of some of the special groups we reviewed above.

(3) Level of depression

As reported previously, the categorisation of the levels of depression followed Steer et al. (1986); their subdivisions into "mild", "moderate" and "severe" level. The large majority of mothers in all four groups fell into the "mild" category. But between the Korean and the Scottish mothers there were significant differences: more Korean mothers were "moderately" or "severely" depressed than Scottish mothers, both in the young and the old samples. The question may be raised how these differences in the present study compare with distributions in the levels of depression using BDI reported in other studies.

Firstly, we will compare the results of our study with those found in studies using a normal population. Then compare these with those using special subjects.

1) Level of depression in normal populations

Hammen et al. (1976) tested American university students (N=200) and found 15% depressed (M=14.5, SD=5.78). Hammen (1980) administered BDI to 400 university students, and found 9.2% scored above 16. In our study, the mothers who had scores higher than 16 were 23% among young Korean, 28% among old Korean, 10% among old Scottish, and 8% among young Scottish subgroups. Hammen's results are similar to our Scottish subjects and much lower than Korean mothers (see Table 6-3).

Oliver et al. (1979) tested and retested 222 American university students and found 17% of them showed higher scores than 10 on BDI. Our study shows that 46% of young Korean, 66% of old Korean, 20% of old Scottish, and 16% of young Scottish scored higher than 10 on BDI. Again Oliver's findings correspond better with our Scottish mothers, whereas Korean mothers show many more depressed cases.

Herzberg et al. (1970) found some differences in the level of intensity on BDI scores between group of British women (N=168) who had taken oral contraceptives as compared to a control group (N=93). What they

found in their control group were: 78% in "mild" (BDI score 0-12), 17% in "moderate" (BDI score 13-20), and 5% in "severe" (BDI 21-63). If we consider the difference of the one point both for "mild" and "moderate" categories from the cut off points used in the study, then Herzberg's results are similar to those of our Scottish subjects. In the case of subjects who had taken oral contraceptives Herzberg found 76% in mild group, 14% in moderate group, and 10% in severe group. We can see differences here, especially in the "severe" level, when compared to the oral contraceptive group. The results of Herzberg's et al. contraceptive group are similar to our Korean mothers results.

Rees et al. (1971) compared British mothers in prenatal and postnatal stages (N=99). Results prenatally were 83% in the "mild" condition (BDI score 0-13), 11% were "moderate" (BDI score 14-17), and 5% in the "severe" condition(BDI score 18-36) prenatally. Their results correspond rather well again with our results for Scottish subjects. They recorded the postnatal results 78%, 11%, and 10% respectively. The percentage of the "severe" group matched more closely with that of Korean mothers from our study.

Overall we may say that both young and old Scottish

mothers from our study showed similar percentages in the level of depression to British and American normal populations. Whereas Korean mothers, regardless of their life stages, showed a higher percentage in their depressed level both for the moderate and severe categories, and they correspond better with the contraceptive group or postnatal group which were mentioned above.

2) Level of depression in special populations

Most of the authors who tested BDI on a special population were not interested in the percentage of the level of severity in depression. Nielson et al. (1980) using 526 ambulatory patients found 6% of them were depressed.

The original study of Beck (1961) showed that only 8% of officilaly classified non-depressed people would make the cut off score 21 or higher, i.e. for "severe" depression. Our study obtained fewer than 8% of "severe" cases among our Scottish population and more than 8% of "severe" cases among our Korean population.

(4) Depressive symptom character: subscales/ item analysis

The discussion so far has concentrated on the total depression scores, ignoring the different aspects of symptoms which may be contributing to the overall score. Therefore, the scale was divided into two subscales, 'Affective-cognitive' and 'Somatic-performance'. Each item of the whole scale was studied. The results (pp. 202 - 208) have shown that a clearer picture emerges to uncover the characteristics of depression of the mothers in four subgroups.

There seems to be no significant differences between age groups in both the Korean and Scottish mothers in either subscales and all throughout the whole BDI items. Thus only the differences between the cultures are observed to be distinctive.

The following points will be discussed on the results analysed in this section: 1) Somatisation of non-westerners; 2) Affective-cognitive depression of westerners; 3) Affective-cognitive depression of old Korean mothers; 4) Gender-free depression of Korean mothers.

1) Somatisation of non-westerners

It is a well known fact that symptoms of depression

found among non-westerners were characteristically the complaints about the body rather than those of emotion. Studies on depression symptoms done by Morsbach et al. (1983) on Japanese postnatal mothers; Cox (1983) on Ugandan postnatal women; Kleinman (1982), Lin et al. (1981), Marsella et al. (1973), and Tseng (1975) on Chinese; Ebigno (1982) on Nigerian; El-Eslam (1975) on Qatari women; Racy (1980) on women in Arab; Rubel (1977) and Uzzell (1977) on Hispanic people, showed that all those non-western people tend to complain more about body symptoms of one kind or another than about internal mood symptoms.

The review papers (Marsella, 1980; Pfeiffer, 1968; Racy, 1970) summarised the literature on the manifestation of depression across cultures, especially non-European cultures, and shared the opinion that somatic disfunctions are always found as the core of the symptomatology.

The results from present study support these characteristics of non-westerners' depression by showing the significant differences in the 'Somatic-Performance' subscale both the young and the old mothers (see Table 6-5) and all through the somatic scale items (see Table 6-6) such as 'sleep

disturbance', 'fatigability' (tiredness), 'loss of appetite', 'weight loss', 'somatic preoccupation' and 'loss of libido'. The Korean mothers scored signficantly higher than the Scottish mothers. This is especially so for old mothers, who showed no significant difference except on 'sleep disturbance' which is easily understandable. For example, mothers who have children preparing for university entrance qualifications do not sleep while their children are awake and have to get up earlier to wake them up again, not to mention the time needed for preparation of breakfast, which is not as simple as in the west (toast or cereals), and packed luches which are not again as simple as sandwiches. Naturally they are physically tired and at least free from sleep disturbances.

Some of the authors (El-Islam, 1975; Kleinman, 1982; Leff, 1981; Lin et al., 1981; Marsella, 1980; Rack, 1982; Rubel, 1977; Tseng, 1975; Uzzell, 1977) tried to offer some explanation of the somatisation of depression in non-western people. They assume that depressive disorders are filtered through ethnocultural experience, and this produces variations in the way the dysfuctions are presented. For example Kleinman argued that Chinese people generally believe that it is only natural for everyone to have his or her own worry and

(emotional) problems, therefore, one should not consider emotional matters as any special problem to complain about. It is more acceptible for the Chinese to perceive and present psychiatric problems or any emotional experience in body-oriented expression. By drawing the attention to physical symptoms help is more forthcoming. Therefore he believes that somatisation is more prevalent. A somatic illness is a more effective and, perhaps the only legitimate excuse to request attention and care from others, while psychological strain is not.

This interpretation is quite relevant in explaining the Korean attitude about somatisation. However there is also one more basic idea about life in Korean culture. This is the Korean attitude toward the life: "Life is bitterly difficult" (人生苦海: bitter ocean of life), therefore one cannot expect life to be sweet and happy. One has to survive without awareness of emotional matters. In this atmosphere one cannot conceive any emotional matter as a problem, rather one tends to conceive and presents one's problems in visible practical somatic terms based on one's own medical knowledge and orientation.

Now we will look into the affective-cognitive side of

the symptoms which were generally considered as prevalent symptoms of westerners than non-westerners.

2) Affective-cognitive depression of westerners

Most authors who have done the cross-cultural studies (Benedict, 1947; Cox, 1983; Kleinman, 1982; Marsella et al., 1973; Tanaka-Matsumi et al., 1976; Morsbach et al., 1983; Pfeiffer, 1968; Racy, 1970) indicated that westerners show more existential complaints, or internal mood states, or guilt, which belong to the 'Cognitive-Affective' subscale symptoms. However Teja et al. (1971) compared two studies in Britain with two studies in India and found that the incidence of guilt feeling to be similar in both countries.

It appears that in our study Scottish mothers are the exception to these most of the previously done cross-cultural studies, since they did not show any significantly higher scores on the cognitive-affective side of the symptoms.

The phenomena of internal mood or existential complaints, including guilt, were explained in terms of cultural differences in self concept (Marsella et

al., 1980; Tanaka-Matsumi et al. 1976). The self in the west has been based on an individual-centered model of the person, whereas the non-westerner's individual is a part of an entire social nexus which acts as a behaviour unit. Therefore, westerner's subjective experience of depression is inner-directed.

However, in this study, it is the Korean old mothers group which scored significantly higher than their Scottish counterpart (see Table 6-5). This unexpected result will be discussed in the next section.

"Pessimism" was the only scale among 13 scales in which Scottish old mothers scored significantly higher ($p<0.05$ level). The impression gathered during the interview was that Scottish old mothers showed more pessimistic concern about the socio-cultural change in the future. It should be interpreted as an intellectual pessimism rather than a personal one.

The only affective symptom which scored significantly higher among Scottish young mothers than Korean ones was "irritability" ($p<0.001$). Young mothers with a new baby isolated from their family in comparison with Korean young ones, may be naturally more upset.

3) The cognitive-affective symptoms among Korean mothers

The Korean old mothers scored significantly higher on the 'Cognitive-Affective' subscale, which is a striking difference from all the previous cross-cultural studies. They scored higher in all 13 items (excepting "pessimism") including "guilt feeling", "sense of punishment" ($p<0.05$), "self-accusation" ($p<0.001$), and "suicidal wish" ($p<0.05$), which have been generally regarded as typical westerner's symptoms.

Marsella (1980) indicated some implication in explaining that the so called "typical" symptoms of depression (by which he meant internal existential moods including guilt etc., rather than somatic symptoms) found in non-westerners were due to the westernisation of the non-western cultures. There was a related study (Johnson et al., 1987) on "guilt" and "shame", using Hawaiian, Japanese and Korean University students, which found that there was a high degree of consistency across national groups upon the socially disapproved conducts. It might be an explanation for the case with our Korean mothers who had experienced westernised higher education in urban situations, and who showed all-round symptoms of depression.

However it does not explain why the Korean old group scored significantly higher than Scottish old mothers while young mothers did not score significantly higher than their Scottish counterpart in the 'Cognitive-Affective' subscale, even though they were as westernised as the old ones, if not more so. It is more convincing to explain this in terms of them having the inclusive self concept, which shows a tendency to attribute internally about matters concerning their children (this will be dealt with in the section 7:2). In a similar vein, several authors tried to explain the absence of existential inner feeling or guilt in non-westerners by using the diffused self concept (Hsu, 1975), or dependency (Doi, 1971), reciprocal obligation (which Benedict thought only led them to experience shame rather than guilt feeling, 1947) of group consciousness. What they fail to argue was that the sense of responsibility for the group can lead to the same existential guilt feelings as can individual attribution for the individual. Korean mothers' (especially old ones), heavy burden of responsibility should be seen as the cause of their depression symptoms. The old mothers in Korea not only have much more to worry about than the young ones, but also are more freely express complaints.

4) Gender-free depression among Korean mothers

There are several authors who have investigated the gender differences of depression and concluded that there were no differences in severity between sexes, but there were differences in the domain of expressions. Steer et al. (1988) used psychiatric patients (174 male and 276 female) and found that women combined affective and cognitive symptoms in describing their depressions, whereas men combined affective and performance symptoms. They postulated that such differences may arise from the negative pressure upon men that depressed states be considered as weakness, while women may admit such symptom without fearing any social sanctions.

Using 972 male and 1300 female college students Hammen et al. (1977) also recorded similar findings of gender differences in the expression of depression. In their study depressed men were more likely to report an inability to cry, loss of social interest, a sense of failure, and somatic complaints, while women were characterised by indecisiveness and self dislike.

It is interesting to note that Korean mothers seem to show characteristics of both gender related symptoms.

According to our personal experiences of Korean culture compared to western culture, Korean women have a more independent responsibility in a separate domain of life from men than western counterpart. They are living with less expectations of western style gender specific roles. They live in a more task-oriented way than Scottish mothers. That might provide a cultural reason for Korean women expressing gender free symptoms of depression, more so than the Scottish mothers.

7:2 Attributional Style and Depression

The attributional style of the mothers and it's interrelationships with depression scores will be discussed in this section. General conclusions to be drawn from this section are: (1) notable differences in attributional styles between the two cultural groups; (2) no clear relationship of attributional style with depression scores, especially for the Korean mothers. (Hypothesis 3)

(1) Differences in attributional style

1) Average scores in attributional style

The average scores in attributional style showed that there were significant differences between Korean and Scottish mothers' role perception on the matters concerning their children. The Korean mothers showed significantly higher levels of internal attributing than did Scottish mothers ($p<.001$ level): Scottish mothers displayed significantly higer levels of external attributing than Korean mothers ($p<.001$ level). This means Korean mothers accepted more responsibility for whatever happened to their children, whereas Scottish mothers tended to blame others or the social environment more than themselves for whatever happened to their children.

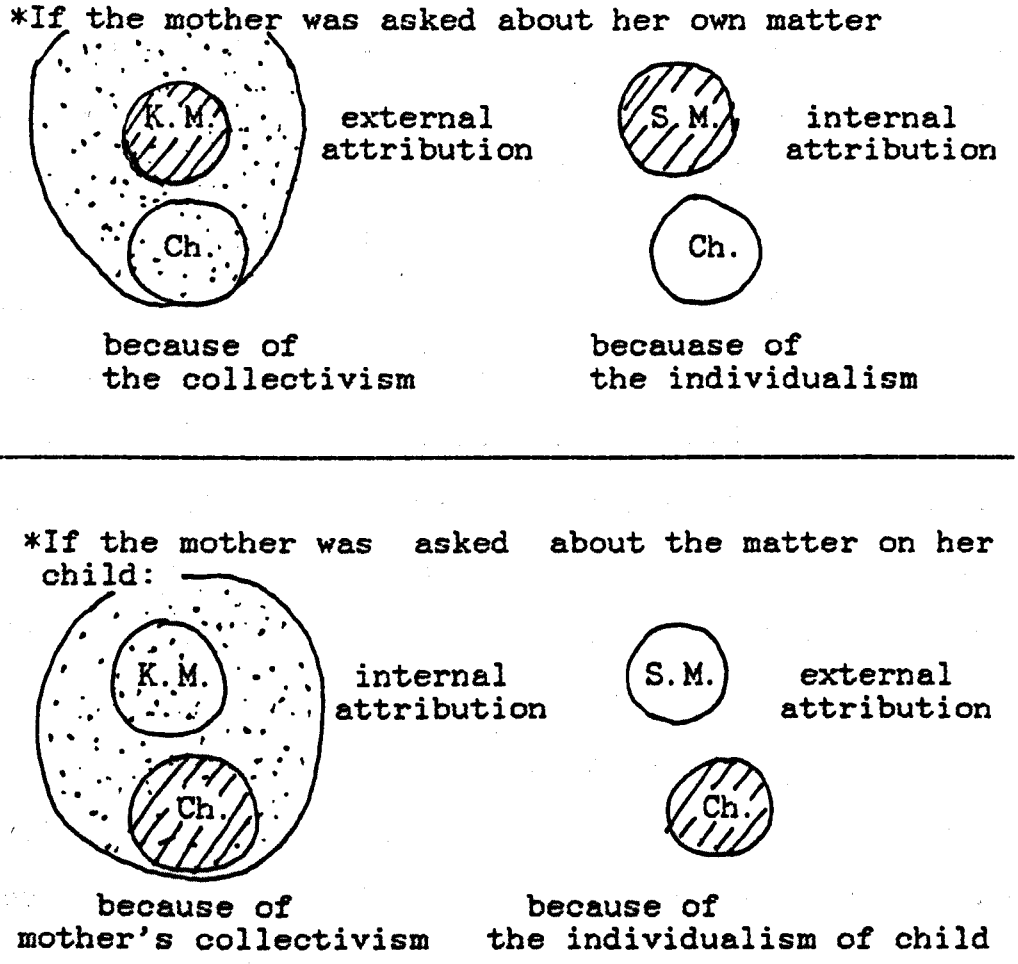
These findings are somewhat surprising as they seem to contradict the general view that Europeans attribute more internally than non-Europeans. In other words, it was generally believed that Europeans tend to feel more personally responsible for what happens to them, whereas non-Europeans see themselves as being more passive in their social environment (Benedict, 1947; Graves, 1961).

Before turning to a more detailed discussion of these apparently contradictory findings, it should be remembered that we employed different content viewed from different perspectives than did previous studies, namely, we questioned the mothers' attribution over what happens to their child. This study concentrated on inclusive as opposed to individualistic modes of attributional style with respect to matters concerning children. The perspective of this study was different from previous studies which have focussed on the individual's attributional style over the actions of the individual. This study questioned the issue of whether mothers' attributed internally or externally on matters concerning their children. From the point of view of the "individualist" such matters should be viewed as the matters of others (external) but, from the "collectivist" viewpoint these matters should be viewed as matters of the mothers' own - they become internalised (Hofstede, 1980; Trandis et al., 1988). If we investigated the attributional style of the subjects in this study in the same manner as in previous studies we may or may not have observed the same tendency. For instance in questioning attribution over matters concerning the mother herself, a Scottish mother might show evidence of more internal attributing than her Korean counterpart thus confirming previous studies. However, since we asked

mothers for their attributional tendency on the matters concerning their children, we expect to find evidence in their attitudes as to whether they included their children within themselves (internal) or not (external).

If we think in terms of the Confucian idea of the self as an "open system" (which included others in oneself especially one's children), it is understandable that Korean mothers displayed an internal attributional style over the matters concerning their children. A Scottish mother, on the other hand, would not include her child within her attributional unit of self but, rather, would keep herself and her child independent from one another. This is in keeping with their culture of the "individualist" (Triandis et al., 1988). Naturally, they would attribute more externally on our scale.

Fig.7-1: Diagram of the difference in the attributional style between Korean and Scottish mothers



K.M.: Korean mother S.M.: Scottish mother
Ch.: Child

An examination of the above diagrams indicates that the findings of this study are not as much at odds with the views on cross-cultural differences in attributional style found in previous studies.

Another, but related factor which may be associated

with this tendency of the Korean mothers to attribute more internally is the role which the mother occupies within the family. The Korean mother accepts total responsibility for all family matters which is a very different role from that of the Scottish mother. Some studies have suggested that role-taking by women can be changed by cultural factors which in turn influence the locus of control - the basic factor of internal attribution. Doherty et al. (1985) studied locus of control in a female population from 1968 to 1976, and found a shift to external tendency during the mid-to-late 1970's in the U.S.A. She gave the "cultural shift" under the influence of the women's liberation movement, in that part of the world, as an explanation of the change in women's role concept: women came to attribute more externally so that they could blame socio-environmental factors rather than themselves, for their situation.

The socio-cultural characteristics of the group or country can impose roles on the mother and help shape the attributional style rather than individual personality characteristics. For instance, in Britain the parents bear less responsibility for their own children's actions in law than Korean parents do. Korean mothers are supposed to be responsible for their children for an indefinite period of time: virtually as

long as they live. Hewstone et al. (1985) suggested that the socio-cultural characteristics of groups and countries on attribution more influential than individual personality differences even within the non-western societies. They observed Chinese in Malaysia and Singapore, and they found that the Chinese in Malaysia attributed favourably to out-groups whereas the Chinese in Singapore attributed favourably to in-group. Graves (1961) undertook a study using Ute Indian, Spanish and white American children and found Indians had the most "external" attribution, Spanish American were in the middle, and the white Americans were more "internal". The implications being that there is direct cultural teaching of an "internal-external" attitude.

Therefore, we can accept, as suggested by Snyder et al. (1981), that the social millieu is one of the sources of attribution. This accounts for the observed differences in attributional style, on the matters of their children, between Korean ("internal") and Scottish mothers ("external") in terms of socio-cultural explanations.

The exception to this general description - the difference between the subgroups in Scottish mothers on "internal" - can be discussed from the socio-

contextual perspective. The Scottish mother accepts more personal responsibility for the child at the infant stage than at later ones. It is only to be expected, therefore, to find that the young mothers attributed internally more than the old ones, because the infants are totally dependent upon them.

2) Areas of attribution

As has been shown in the results section the Korean mothers (both young and old) attributed "internally", whereas the Scottish young and old mothers, with little exception, attributed "externally".

Since academic achievement has been very important throughout Korean history, both young and old Korean mothers did not show any difference in internal attributedness on this issue. Concerning the child's general "success", the old mothers attributed this to themselves having long supported the child they felt the success to be a joint effort. It would seem natural too, to find a stronger internal attribution on the safety of the baby among the young Korean mothers as this is the immediate problem which they face at this moment. Furthermore, the Korean tradition emphasises the more feasible, practical matters like physical safety or health ($p<.001$).

On the other hand, the old Scottish mothers exhibited more internal attribution on the success of their children than the young mothers. The young mothers attribute externally on the personality of their child. Throughout the interviews with Scottish mothers, the researcher had the impression that these mothers could not do much about the children except worry for their safety. In all aspects of the child's life, they said they had to cooperate with their husbands and other resource persons, such as teachers, clergies, doctors, friends and others. They seemed to believe that by the time the child reached the stage of leaving the secondary school he/she should be an independent and responsible human being.

The differences between the young mothers in the two cultures are less distinct than the ones between the old groups. Most of the Korean mothers experienced the western style education, and were introduced to western psychology, emphasising the environmental impact on personality formation. They, at the very least, expect the cooperation with their spouse in performing the educative function of the modern family - parents are expected to guide, encourage, and support the child. The popularised modern psychology adds a new dimension, whereby the parent should foster a healthy personality in the child. Young mothers

with this educational background, prior to the real tough mothering role required in Korean society might hold a more naive western idealised attitude to the role of mother. This is displayed in their attitude by not attributing solely to themselves over the child's personality formation.

The more distinct differences between the two old subgroups can be explained by the rationale that the longer one experiences the role in the respective culture the more one would adapt to or be steeped in the characteristics of the culture. If the old Korean mothers were reminded of the external environmental influence on children's well-beings, their heads would readily accept and acknowledge this fact, but at an instinctive emotive level, in their hearts, there would be no such recognition.*

We can draw the conclusion in this section that there are differences in the attributional style between Korean (more internal) and Scottish mothers (more external) on the matters concerning their children.

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* Korean old mothers would say that "it is ideal to have children with good personalities, but in reality they have to get in to university, after all. I used to believe the same way as the young mothers do when I was young."

Considering the different results in depression between Korean (more depressed) and Scottish mothers (less depressed), it would be interesting to observe the relationships between the two variables in both cultures.

(2) Relationship of attributional style with depression scores

1) Correlationships among the cultural subgroups

One of the main findings of this study was that the Korean groups, who made more internal attributions than did the Scottish groups, did not show any significant relationship between attributional style and depression scores. It is only in the case of Scottish mothers that the attributional model of depression is in any way confirmed. For Scottish mothers there is evidence of depression being correlated with both "internal attribution" (the old group r=-.32) and "external attribution" (the young group r=-.29) on their child's affairs.

Several psychologists have displayed interest in this issue: the correlation between depression and

attributional style. Weiner (1974; 1978; 1981) suggests that there are some causal connections between the attribution, which is the causal explanation weighting the incentive value and goal attainment, and the affective reaction which is the consequence of the attribution. Raps et al. (1982) suggest that attributional processes may be of central importance in the individual's capacity to establish and maintain a state of mental health - specifically depression following a failure.

Both Weiner and Raps seem to agree with Beck's emphasis on cognitive elements of depression as central to emotional factors. However, they feel that the causal connection between attribution and affective reaction needs refinements to the dimensions of attribution (Krantz, 1984). One such attempt was by Seligman et al. (1978), who developed the learned helplessness model of depression based on the theories of Heider (1958), Rotter (1966) and Weiner (1974). This explains depression by employing the three factors of "internal", "stable" and "global" attributional style.

There is, as of yet, no consensus among the researchers in this field as to whether attributional style and depression are related. For instance, using postnatal mothers, one study found significant associations

between the attributional style of the mother and their experience of postnatal depression (Cutrona, 1983), while another found no such correlation (O'Hara, 1984). Hayworth (1980), trying to predict the occurrence of post-partum depression, found that people who felt less in control of their lives had higher depression scores than those who felt in charge of their lives.

Several studies have observed that from among the three factors, either "internal or external" mode of attribution had been observed in association with depression. Peterson et al. (1985) reviews the published literature on the subject and draws the tentative conclusion that "internal" factors have not been consistently found by empirical researchers. Coyne et al. (1983) tries to explain this inconsistency by suggesting that the critical factor was whether studies asked about attributions on the basis of hypothetical as opposed to real events. People can, they state, impose their habitual style of attribution more readily on hypothetical events than on actual events. Or alternately they may be less likely to display "self-serving defensive biases" when making causal attributions that are hypothetical. On the other hand, Peterson et al. (1984; 1985) argues that the critical factor is whether a study asks for attributions about many events versus a few.

In this study, Korean mothers, regardless of the degree of their depressed mood, claim responsibility for their children's affairs. On the other hand, Scottish mothers partly (weakly) confirm the cognitive model of depression in that the old group distortedly attribute internally on matters concerning their children while the young mothers, realistically, tended to attribute externally (Abramson, 1981; Alloy, 1979; Brewin, 1984; Golin, 1977, 1979; McClure. 1985; Martin, 1984).

2) Interrelation among the severity subgroups according to the level of depression

Our results did not show differences in correlationships among the severity subgroups. However, it is notable that Scottish mothers' internal attributional style showed significant correlations with depression even though it was quite low ($r=-.24$, $p<.05$). In general, though, there is no clear support for the idea that the reformulated learned helplessness theory works better in a group of people who are only "mildy" depressed.

Some people have turned their attention to areas other than the methodological to seek the answer to the problems of inconsistency. Blatt et al. (1982); Coyne

et al. (1983); Depue et al. (1978) have raised the question of continuity in the degree of depression. They asked whether mildly depressed and severely depressed people share common characteristics and aetiology.

It is generally accepted that the learned helplessness model may better account for symptoms of mild depression among normal populations - usually university students - than it does major depression disorders among psychiatric patients. According to Peterson et al. (1985), 52% of studies which used undergraduates support the helplessness reformulation while only 20% of the studies which tested psychiatric patients supported the helplessness reformulation.

When Cutrona (1983) found evidence for a direct relationship between attributional style and depression, she used mothers who scored lower than 9 on BDI (N=64). She suggested that it was not possible to test whether more serious cases of depression were predicted by attributional variables. Cutrona also mentioned that any generalisation from instances of mild depression to cases of clinical depression be made with caution.

The results of this study do not support the learned helplessness model of depression, especially in the case of Korean mothers who attributed internally over their child's affairs.

7:3 Social Support and Depression

The term "social support" used in this study, refers to those external resources available and valued by people at the time of the study. The positive function of support from the social network which can bring about emotional well-being is generally measured by how satisfied people are with the support they have received or they have offered to others. Therefore, the terms "support received" or "support offered" do not mean how much the subjects received in actual fact from others or offered to others, but how much they felt they have received or have offered and how satisfied they were.

The following discussion will concentrate on two major findings of social support in relation to depression in this study: (1) cross-cultural similarities; and (2) cultural and age group differences. (Hypothesis 4)

(1) Cross-cultural similarities

1) Satisfaction vs. network size

One of the major findings in this study is that the amount and quality of support received or offered appears to be more important than the actual number of people giving or receiving that support, i.e. the size of network. The depression scores of all the four subgroups of mothers were related more to the degree of satisfaction with the support than the number of people who were supporters. All the correlations between the number of supporters and depression scores were rather small, obtaining generally less than 10% of common variance, and only 12 out of 36 calculations of the correlations were significant.

This result is in line with many other studies on the social support system. It has generally been found that the network size per se, or number of potential sources of support, is much less of a predictor for the person's well-being than the subjective evaluation of it (Andrews, 1978; Berkman, 1979; Brandt, 1981; Dohrenwend, 1984; Fiore, 1986; Henderson, 1978; 1981; 1982; Hobfoll, 1985; Sarason et al., 1983; Schaefer et al., 1981; Stroebe, 1985; Turner et al., 1983; Weiner, 1982; Wethington et al., 1986). In other words, it is

not the actual structural feature (i.e., size of support network) which seems to influence how effective a support system is but the subjective awareness that one is loved, cared for or esteemed by others, and that one loves, cares for and respects others.

2) "Receiving" vs. "offering" support

Secondly, "receiving support from others" correlated higher with depression than "offering support to others". The scores of correlations ranged in the number of supporters, "receiving", r=-.09 to -.32, "offering", r=-.04 to -.21; in quality, "receiving", r=-.25 to -.65, "offering", r=-.15 to -.49; in amount, "receiving", r=-.31 to -.67, "offering", r=.04 to .26. This means mothers who have received more support from others were less depressed and mothers who have received less were more depressed. Whereas mothers who have offered more support to others or less, did not show any particular trend in their depression scores.

Most authors who have done empirical research in this area concentrated on the "receiving" side of support. Almost all scales, which have been developed in the past for measuring social support, have in actual fact only measured the support "received" and not the support "offered: for instance, Inventory of Social

Support Behaviors by Barrera et al. (ISSB; 1981), Social Relations Scale by MacFarlane et al. (SRS; 1984), Social Support Network Inventory by Flaherty et al. (SSNI; 1983), Social Support Scales by Dean et al. (SSS; 1981), Interview Schedule for Social Interaction by Henderson et al. (ISSI; 1980), Personal Resource Questionnaire by Weinert (PRQ; 1981, 1984); Instrumental Social Support and Expressive Social Support by Parry et al. (ISS & ESS; 1982, 1986); Perceived Social Support by Procidano et al. (PSS; 1983), Interpersonal Support Evaluation List by Cohen et al. (ISEL; 1985) and Social Support Questionnaire by Sarason et al. (SSQ; 1983).

The results found from applying one or the other of these scales showed some positive effects of support, either as "direct effect" or as "buffering one" on physical or mental health (for more information see the comprehensive reviews of this literature by Berkman (1986), Cohen et al. (1985), Hammer (1981), Hobfoll et al. (1986), House (1981), Leary (1983), Mitchell (1982), Sarason et al. (1985; 1987), Shaver (1984) and Veiel (1985)).

Although those studies used different methods to analyse their findings, they all found that in general the more social support people receive, the less likely

these people tend to suffer from physical or mental symptoms.

Some of the studies dealt mainly with the relationship between the support function and physical symptoms (Berkman et al., 1979; Miller et al., 1979; Sarason et al., 1984; Schaefer et al., 1981 and many others); others between social support and psychological symptoms, including depression (Brown et al., 1978; Henderson, 1980; MacFarlane et al., 1983; Thoits et al., 1982 and many others).

Their methods of analysing the data varied from one study to the other. For example Andrews (1978), Barrera et al. (1981), Flaherty et al. (1983; 1986), MacFarlane et al. (1981; 1984), and Miller et al. (1978) used average scores for comparison. The percentages were used by Berkeman et al. (1979), Brown et al. (1985; 1986), Fischer et al. (1982), and Panzarine (1986). A frequency test was employed by Eisenman (1984); and variance analysis was used by Parry et al. (1986) and Sarason et al. (1985), while Cohen et al. (1985), Flaherty et al. (1983), and Sarason et al. (1987) used correlations.

The correlational studies are of particular interest for the present discussion, as we used the same

statistical analysis. The correlations for the two Scottish samples between the BDI and the measures of social support were for the young and the old group respectively: "amount", r=-.56, r=-.67; "quality", r=-.58, r=.-65. The correlations for the Korean mothers were for the young and the old group respectively: "amount", r=-.43, r=-.31; "quality", r=-.39, r=-.25. All were significant at the $p<.01$ level of confidence.

Sarason and his team (1987) reported the following correlations between the BDI and three social support scales for female university students in North America: for PSS "friend" r=-.36, "family" r=-.45; for ISEL r=-.67; for SSQ r=-.58.

Cohen et al. (1985) reported a significant correlation between the BDI and their scale (ISEL) using also university students: r=-.51 for the total score but r=-.10 for a subscale which they called "tangible help".

Flaherty et al. (1983), using unipolar depression patients (N=44), correlated the support scale (SSNI) with the Hamilton Rating Scale for Depression. They reported a significant correlation of r=-.57.

It is interesting to note that the correlations for the two Scottish samples correspond well with the results reported by these three studies. On the other hand, the correlation coefficients obtained for the Korean samples, although significant, were somewhat lower in general than those found for Western European cultures. This point will be discussed in more detail later on.

In conclusion it can be said that, especially for western European groups, depression and the "received" social support appear to correlate inversely - the greater the amount and the better the quality of social support, the less likely it is that these people will suffer from depression.

The same conclusion cannot be drawn so clearly for the social support which is offered to others. The quality of "offered" social support correlated lower than the quality of "receiving" support with the depression scores for the Scottish and the Korean samples. The correlations for the young and the old Scottish samples were respectively: for quality $r=-.49$ ($p<.001$), $r=-.42$ ($p<.001$); the correlations for the young and the old Korean mothers were respectively: $r=-.34$ ($p<.001$), $r=-.15$ (not significant).

The correlations in amount of "offering" social support were insignificant: for the young Scottish (r=.21), old Scottish (r=.07), and old Korean (r=.14), except for the young Korean mothers correlation of r=.26 (p<.01). As can be seen, all the correlations were positive, which indicates that if there was a relationship between depression and the "amount" of social support offered, then the more social support offered to others the more likely the person appears to be depressed. Which means people find it a "burden" or as Vanfossen (1986) stated "role overload", which can be seen as the attitude of "too much to offer to others". This finding is actually opposite to that which was found for "receiving" support from others.

As mentioned before, in empirical research very little attention has been paid to the relationship between a person's mental state and his desire or ability to "offer" support to others. The study by Fiore et al. (1986) is an exception. They studied both support "received" as well as "offered" by the care-givers to a spouse with Alzheimer's disease. The correlations for the "received quality of support" with the depression scores were all significant and were as follows: socialise, r=-.40; help, r=-.37; emotional, r=-.41; feedback, r=-.30; comfort, r=-.39; guidance, r=-.23. In general these correlations were somewhat higher than

those they obtained for "offered support": offer care, r=-.27; offer advice, r=-.29 ($p<.05$).

Thus similar to the present study, Fiore et al. (1986) obtained generally higher correlations between depression and "received" support, than between depression and "offered" support. Although Fiore et al. used a very special sample, namely care-givers to spouses with Alzheimer's disease, even in such extreme cases, the feeling to be needed and valued by someone (the support "offered") was linked less to depression than "received" support from others.

As Fiore's study and our findings showed there was only a weak, or no, relationship between depression scores and support offered to others (especially for the amount of support), it appears to be that for a depressed person the help he/ she can offer to others is less important than the assistance given by others.

3) Characteristics in "mild" depression groups

Thirdly, the "mild" depression group obtained higher correlations between the support system and depression than the "moderately" and the "severely" depressed groups. As would be expected from the discussion of

satisfaction vs. network size these significant correlations were only found for the "amount" and "quality" of support, and not for the network size. Only six out of fifty-four possible correlations were significant for the relationship between the number of supporters and depression scores (see Table 6-35). Thus the numbers of people involved in the support does not apparently play any significant part in whether a person is depressed or not. Therefore, the correlations of "amount" and "quality" of support with depression will be discussed here.

In the "mild" groups, fifteen out of eighteen correlations for the "amount" (range from r=-.19 to -.40) and for the "quality" (range from r=-.17 to -.34) of support were significant. In contrast, for the "moderate" and the "severe" groups together only five out of the thirty-six correlations were significant in respect to the "quality" of support and only four out of thirty-six in respect to the "amount" of support. These were more or less the same for the Scottish and the Korean mothers.

In other words, in mildly depressed groups, which include all mothers scoring between 0 and 13 on BDI, there was a significant, though weak inverse relationship between the "amount" and "quality" of

support on the one hand and depression on the other; i.e., the more depressed a person is then the less support was effective.

In contrast, there was virtually no relationship between social support and "moderate" or "severe" depression. The amount of support received or offered did not appear to alleviate the depression in the subjects.

In other words, social support was only related to those women (Korean and Scottish alike) who experienced very little depression (the "mild" groups); for the subjects who suffered from more severe depression, social support did not appear to alleviate the depression. At first glance these results appear to be surprising, but it can be interpreted in corroboration with some studies done by other authors on this topic.

These phenomena which were found in "mild" depression group has already been implied by several authors. Theoretically, as Weiner et al. (1975) said, depressed people are less efficient in cognitive tasks, such as recall of their past experiences. In other words, depressed people might not recall accurately the support they had. Similarly Nelson et al. (1977) found that the depressed were more likely to underestimate

the receiving reinforcement. Studies done by Teasdale et al. (1979) and Clark et al.(1982) found that the depressed were able to recall more unpleasant memories.

Coyne (1981) found non-depressed people showed more satisfaction with the support they had received than did depressed people. More severely depressed individuals are likely to experience less support and greater distress (Mitchell et al., 1984). Mitchell et al. studied depressed patients and found little evidence of an effect of social support on strain and changes in life. Thoits (1982) suggested that the pre-existing psychological disturbances may determine social support and experience of events. For example individuals who are relatively free from psychological disturbances may possess a strong social support systems and be able to diminish undesirable events.

This evidence supports the idea of depression as suggested by Beck, which described depression as a negative frame of mind concerning the "self", the "world" and the "future" ("triad"). Therefore, theoretically depressed people have an ineffective association between external self-relevant events (such as support experience) and the awareness of the events. Generally it can be said that social support is

perceived as relevant and effective only for the people who are not depressed ("mild" group in this study).

(2) Cross-cultural and Life-stage Differences

1) Relationship of support system with depression scores

Firstly, the Scottish mothers showed more significant relationships between BDI scores and social support than Korean mothers.

The differences in correlations of the "number of supporters" between Scottish mothers and Korean mothers were not as big as the "amount" of support or the "quality" of support. For the "number" of supporters, the correlations ranged between r=-.17 and -.27 for Korean mothers (only four out of eighteen correlations were significant); and between r=-.18 and -.38 for the Scottish mothers (seven out of eighteen correlations were significant).

On the other hand the "amount" and "quality" of social support appeared to be more effective for the Scottish samples. In the "amount" of support, sixteen out of eighteen correlations were significant for the Korean

mothers (ranging between r=-.17 and -.35), and fourteen out of eighteen correlations were significant for the Scottish mothers (ranging r=-.31 and -.61). In the "quality" of support, the correlations ranged between r=-.16 and -.30 for the Korean mothers (thirteen out of sixteen were significant), and between r=-.31 and -.57 for the Scottish mothers (all sixteen were significant).

Thus, in general, social support seemed to be more effective for the Scottish mothers than the Korean ones.

There are few cross-cultural studies that compare social support systems between culturally different groups and none which specifically compare Korean and Scottish subjects.

A cross-cultural study which compared "black and white" subjects in the United States (Holahan et al., 1983) found that "blacks" who were low in social integration exhibited more symptoms compared to white; and a study comparing "Puerto Rican American and Caucasian American" (Triandis et al., 1985) recorded that Puerto Rican Americans perceived that they receive more and a better quality of social support (Triandis et al., 1985). What we can see from those studies is that

"black" or "Hispanic" people were helped more by the support system.

However, those results should be considered in the light of the special minority position in America, because the "black", or "Puerto Rican" subjects are "minorities" in the "white" or "Caucasian" "majority culture". According to Holahan et al. (1983) members of these minorities tend to encounter more social prejudices which in turn makes them more sensitive and perceptive to social support. Another determining factor of this perceptivity can be the degree of their acculturation: the impact of acculturation of the minority groups which Triandis et al. (1986) found from "Hispanic" population in the U.S. was that the greater the level of acculturation, the less observed cultural differences between them.

However, these cross-cultural studies are not comparable with the findings in the present study. The present study dealt with two distinctly different cultures which were not in a "minority and majority" relationships. Therefore, the following discussion will be based on the two different life styles of Korean and Scottish societies, as detailed in depth.

Considering the Korean mothers who have much tighter extended family systems and abundant pseudo-familial relations, (see chapter II on the life of Korean mothers), it was expected that the size of network would be greater for the Korean mothers than for the Scottish mothers.

However our results were contrary to this prediction, as well as the effectiveness of the support system being lower than for the Scottish mothers. It appears to be the case that the social structure per se of a culture is not the exact picture of how people evaluate their social support system. It might be better explained in terms of how people in a particular culture interact between the members of the community and what motivates their interaction.

Triandis et al. (1988) distinguishes between "individualist" and "collectivist" cultures. The relationships between the members in the "individualist" culture are based more on "detachment", "distance" and "self reliance", which were observed in European (Scottish) cultures. In a "collectivist" culture, which was found in Asian (Korean) cultures, the relationships with ingroup members are "intensive", "interdependent", "involuntary" and more "enduring.

Having more characteristics of the "collectivist" culture, Koreans might have less effective social relationships by: a) being more insensitive about the relationships; b) making the relationship more stressful; and c) being less motivated in having social skills. We will now discuss these three areas in more detail.

a) One reason for this surprising result (i.e. the fact that less support for the Korean mothers than for the Scottish mothers) could be the fact that any tight relationship is not taken automatically as the appreciative support system. Korean mothers might not be fully aware of what they have habitually taken for granted, and yearn for relationships which are different from what they already have. Therefore, they might not consider the existing relationships as the ones with high support quality.

The lower correlations between overall satisfaction with the support system and depression found in Korean mothers can be understood in terms of their lower awareness of support caused by their involuntary life situation. For instance, postnatal Korean mothers in our study definitely reported having more support than the Scottish counterparts, but they did not seem to recognise what they had received. This showed in some

of the cases of young Korean mothers, where some mothers identified the people who have provided them with help, but still indicated that they had "no one" in the questionnaire.

In contrast to the Korean mothers' insensitivity, Scottish mothers may be more appreciative of whatever support they received. As Oehman (1987) suggested value more the scarcer or rarer social relationships.

b) Another reason for this phenomenon might be that frequent and intensive interactions with people can lead to greater stress and depression (Belle et al., 1979). Some interactions can be negative and unhelpful, overprotective or non-sympathetic.

Korean mothers were practically never left alone to feel lonely, but "time-alone" can be desirable for them as providing a time of reflection, rest and self-renewal (Larson, 1982). Suedfeld (1982) had similar opinions on this and valued it as a "solitary quest" for concentration by reducing external stimulation which is opposite to the "fear of isolation". "Too much isolation" might be bad for the Scottish autonomous and independent mind, but "too much involvement" might be bad for the Korean inclusive collectivistic mind.

c) As the lack of social skills is one of the barriers against the effective use of support systems (Hansson, et al., 1984), the emphasis of winning friendships or the importance of social skills found among western middle-class people as compared to Korean people, can be relevant in explaining the results of this study. Sarason et al. (1985, 1986) found that subjects who scored higher in perceived social support rated themselves as more socially skilled than those who scored less.

Several authors reported that middle-class people in the west, especially women as opposed to men, keep more relationships by using their better skill or capacity at "making friends" (Liem, 1981; Sarason et al., 1985; Willmott, 1961). This phenomenon was also found in the study by Triandis et al. (1988) where female subjects from individualist cultures displayed more highly developed social skills than subjects from collectivist cultures. Hofstede's comprehensive study (1980) showed that in more "individualist" countries, there is more of a stress on affiliation, which involves establishing, maintaining, or restoring a positive affective relationship with another person. Thus in such countries affective relationships must be acquired personally by each individual. In less individualist (collectivist) countries where

traditional social ties, like those with extended family members, continue to exist, people have less need to make friendships.

As Henderson said (1984), social support is obtainable only through social relationships. This can only be achieved by having competence in establishing and maintaining good relationships in the individualist culture. In other words, a person can be active in their social environment as well as a recipient. On the other hand, as was mentioned in chapter II describing the life of Korean mothers, the life in an extended family-oriented society, i.e., the inclusive and "collectivist" culture, could make the Korean mothers less well equipped with social skills as they have no urgent need to mobilise the support of others.

Sarason et al. (1985) cautiously suggested that the difference between men and women in terms of social skills, may present culturally conditioned differences between the genders. It might be the case with our study that the cultural differences between Korea and Scotland influenced the support system through social skills.

The Scottish mothers showed higher correlations than Korean mothers in their perceived satisfaction

with social support. This can be interpreted in two ways. Either that the subjective perception of satisfaction with the support was more effective for the Scottish mothers and less effective for the Korean mothers; or that less depressed and more socially skillful Scottish mothers mobilised more satisfactory support resources than the Korean mothers.

2) The areas of support function

There were also differences in the support areas between the two cultural groups. Generally, the Scottish mothers showed more significant correlations of BDI scores with the support for areas covering the affect, affirmation and aid, whereas the Korean mothers had significant correlations with practical help or guidance, especially for the old Korean group. As can be seen in Table 6-25, only the old Korean mothers did not obtain significant correlations in "socialise" and "emotional" support subscales in "quality". For the old Korean group, the correlations of receiving practical "help", "guidance", "feedback" and "comfort" were significant (ranged between r=-.16 and -.29).

It has been consistently emphasised and studied that emotional support and the feeling provided by a network would be more significant than tangible aid or

practical services (Cohen, 1986; Henderson, 1978; Lin, 1979; Stone, 1981; Wilcox, 1985). Stone (1981) found that support for emotion was more effective than practical help, and general support was more appreciated than specific support in the case of Los Angeles area residents (N=1003). Cohen (1986) found there was no effect at all of tangible help (r=-.10 according to ISEL), only emotional help was effective (r=-.51 for total score of ISEL).

Neighbors et al. (1984) found that "black" Americans were less likely to seek any help when they had emotional problems. However they did not investigate the effectiveness of emotional support for the "black" population in America.

Some authors (Fiore et al., 1986; Lin, 1985; Schaefer et al., 1981) suggested that there might be different areas of need for support including instrumental and tangible support. The results found by Fiore et al. were similar but to a lesser degree to those of the Scottish and the young Korean mothers' responses in quality of support in this study.

It is predictable that the old Korean mothers show significant correlations in practical help or guidance rather than with the emotional side of the support.

This may be because they were in the position of carrying out practical matters for the whole family, and were doing so in a cultural environment which emphasizes the practical and suppresses the emotional. That everything should be in their hands is the obvious end result in a "task oriented" culture (Kim, 1986).

In conclusion, we can say that people ask for what they need. The support areas can vary from one group to another due to their differences in needs. For instance, while the old Korean mothers need practical support, the two Scottish groups of mothers and the young Korean ones require emotional support as well as assurances from others, which was exemplified by the three groups' common results on the subscale of "being appreciated by others". During interviews several young Scottish mothers said they had support from their husband or their mother through their "understanding of my feelings" or by being told that "I am doing all right"; whereas Korean mothers would like to be viewed in practical terms by family members.

3) The important supporter

Thirdly, there were differences in choosing the first supporters between the Korean mothers and the Scottish ones, and between the young Koreans and the old

Koreans. We would find the person who is closest to the target person among the "convoy" (Antonucci, 1985) of supporters. It has been suggested that the first choice can be as important as that support received from significantly close relationships from the inner core of the network which matters more than all of the other relationships (Kelley, 1983, 1984; MacFarlane et al., 1984).

Excepting the old Korean mothers, all of the subgroups showed significantly lower BDI scores for those who put their husband as the first choice of support than those who selected others. The young Korean mothers who had their husband as their first supporter showed significant difference in more areas of support (8 out of 9) than the young and old groups of Scottish mothers who also chose their spouse (2 out of 9 and 5 out of 9 respectively); even though the young Koreans chose their husbands significantly less often as someone offering them support (41%) than Scottish mothers (60% and 55%).

The types of relationship between the person and network members (e.g. friend, family members) has been measured as a relevant point (Procidano et al., 1983). A number of studies which dealt with people who constitute the support network, especially for female

subjects, emphasised the spouse as the most intimate and key confidant or who had the strongest and most effective ties. Therefore, they consider the spouse as the most important one on top of any other relationships.

American "black" populations were found to seek help from their informal supporters than professional people (Neighbors, 1983; Neighbors et al., 1984) or from the target person's mother (Held, 1981); and Italian Americans had more help from kinship relations such as siblings.

Lin et al. (1979) studied Chinese Americans, and found that they looked for non-kin supporters. However, it should be noted that, unlike ours, the subjects studied were immigrants who were away from their kin, and needed more support to adjust into a new situation. They therefore needed indigenous people, native American, who were familiar with the way of life.

The question of the effectiveness of the support given by the spouse, or by others, is dealt with by several authors, and has not as yet been clearly defined. Lieberman (1982) studied well-educated, middle-class, young mothers who recently had a baby, and found that 75% of them chose friends as their intimate confidants.

However, Lieberman also found that the "best-offs" were enjoying the marital confiding relationships.

Monroe et al. (1986)found that other people can be effective when one already had a marital relationships with no conflict. D'Arcy (1984) studied mothers with young children for their marital support versus community support, and suggested that community support can have preventive function against the well-being of mothers, but it varied depending on their children's age. Miller et al. (1976) studied the general population in Scotland, and found that having a good confidant as well as several acquaintances were associated significantly with lower levels of depression. In explaining their differences in results from those of Brown et al. (1978), Miller et al. implied that their subjects were probably a good deal less disturbed than the subjects of Brown et al.

There remain two questions to be answered: one is whether it is universal to say that a husband is the key support person; the other is whether close relationships are the only effective support or whether diffused relationship are as effective as close ones.

Even in the studies which dealt with the Europeans who had couple-centered family ideologies, the authors

found that women had more support from other women than their spouse (Belle, 1982; Bernard, 1981; Duck, 1984; Gilbert, 1984; Hobfoll, 1985; Kessler, 1985; Miller et al., 1976). On the other hand, some found the spouse was the most important person for a woman's well-being (Brown et al., 1978; Lieberman, 1982; Lin et al., 1985).

The issue of whether the spouse is the key confidant or whether others can be substituted remains in dispute. The results from this study suggest that cultural differences may play a key role. In Korean culture, the husband can be one of the family members, whilst the Scottish mothers depend heavily upon their spouses.

The results of the effectiveness of the spouse as a supporter for the Scottish mothers and the young Korean mothers were supported by the above studies.

When the simple distributions were tested the Scottish mothers revealed having more support from their husband, whereas Koreans had more support from other family members (for the young) or from friends (for the old). We can thus safely report that there are differences in choosing people as the inner core of the network.

The differences between Korean and Scottish cultures are prominant as can be seen by the differences in the tendency to mobilise non-husband supporters (within or outwith the family members) and the husband. The difference in the family system and the attitudes derived from the respective family system might cause the resultant pattern of mobilising the supporters.

Korean mothers who have been tightly surrounded by family members would not differentiate the familial support, and would consider it natural thing to have. Compared to the Scottish mothers, Korean ones (especially the old mothers) were less aware of the support from the family members. In this respect, it is understandable to obtain results that indicate reciprocal action between non-family members such as "offering advice to them" and "receiving guidance from them" is more prevalent among Korean mothers than the Scottish ones.

On the other hand, the Scottish mothers were more aware of the support provided from the family members, including their spouse. The impression gathered during the interviews with the Scottish mothers was that their attitudes toward their family members were strongly based on the respect of one another as separate individuals. The mothers respect their children as

autonomous people. Husband and wife share the respect for each other as a separate person. Therefore, they appreciate the support within the family more readily.

The old Korean mothers chose their husband as the first supporters even less than non-family members in almost all the support areas and showed no difference in depression scores between the two. This means that for them, non-family members are perceived to be the key supporter. This may be due to the Korean mothers' independent way of life being engaged for a long periods in activities "inside of home", separate from their husband whose activities lie "outside of home". Or it might be better understood as a failure in spouse support mobilisation similar to that found by McFarlane et al. (1984). They found that people who feel the least helped by their social networks (least satisfied with the support) tend to experience a lack of success in their help seeking efforts with the inner core of their network, their close relationships and have no mutuality in their relationship with their spouse.

Although it was less so with the Scottish mothers, the young Korean mothers were more attached to their husband than the old Korean ones. Those who had chose the husband as the first supporter showed significant

differences in BDI scores. Newly imported couple-centered life patterns have apparently had an impact on young mothers, and as young family members they still do not have total responsibility for the family matters which have to be carried out by themselves. It remains to be seen if they would keep the husbands as their effective supporters when they reach the same life-stage of the old mothers.

In conclusion, spouses were generally effective for the two Scottish groups and the young Korean mothers. This was, however, not so evident in the differences shown on that depression scores for the Scottish mothers considering the fact that the Scottish mothers were heavily dependent upon their husband compared with the young Korean ones. It can be said that for the young Korean mothers the husband was not chosen as often as in the Scottish mothers' cases, because of their current life-stage in which they can be pampered and surrounded by all the supporters. However, as far as the effectiveness was concerned, the spouse was the key supporter. Hobfoll's believes that "peer support" has many advantages over spouse support (1986, p.253) however this has not been supported in this study.

It was not at all clear who provided the most effective support for the old Korean mothers, who had diffused

relationships. This should be investigated in more depth in any further studies.

In conclusion, the similarities between the cultures are well supported by previous research based on theories, while the differences are explained by the differences in the cultures.

7:4 Life Events and Depression

The main findings in this section are: (1) there are significant correlations of depression scores with the number of recent life events; and (2) there are few significant relations with specific types of events. (Hypothesis 5)

In this study, we chose relatively homogenous subjects who were going through similar life events: one group of mothers who were at 6 to 10 weeks after child-birth; and the other group of mothers who had a child about to finish secondary school education. In order not to overlook the effects of other events as possible indices of stress related to depression, we asked mothers about their recent experiences of special events. These were mainly adverse ones, such as

interpersonal conflict; death of close people; failure to achieve a desired goal; crisis and disaster; being a crime victim; personal ill health; caring responsibility; and unspecified other events; as well as the difficulties experienced in the mothering role when having a new born baby or a child finishing secondary school education.

In this section, we will discuss the general trend of events both in terms of the number of incidences as well as the types of events. The relationship between these factors and depression scores on the BDI will be discussed with reference to the findings of this study.

(1) Number of recent life events

The number of events reported by the old Korean mothers was significanly higher than the young Korean mothers and the old Scottish mothers ($p<.001$ level). It seems in Korea, the older a mother becomes the more she experiences such events ($M=2.58$ vs. young mothers $M=1.73$). Although the difference between the two groups of Scottish mothers was not significant, it looked like the reverse in of the Korean case.

Since most of the life events originated from interpersonal and social relationships, such as social roles, ties to others or community ties (Antonowsky, 1974; Oatley, 1984), and characteristic women's roles in Korea required more involvement with others, the old Korean mothers would typically have more events. This occurs because of the tighter family system including the custom of keeping close ties with relatives and their continuing long and accumulated friendships throughout their lives. The Korean mother occupies many roles and finds it impossible to have a simple life, free from events which arise from this web of relationships (see chapter II on Korean mother's life). As Mulvey (1984) indicates women (mothers) tend to include some of the life events that happen to their children or husband, obscuring the distinctiveness of their own experiences. For instance, in this study, some of the old Korean mothers responded that their children's failure to secure an admission to university was their own failure.

Relationship between number of life events and depression scores

When we look at the comparison on BDI scores between the young and old mothers in both cultures the

differences were not significant. However the old Korean mothers did score higher than the young mothers; and the young Scottish mothers scored higher than their "old" counterparts. The level of depression and number of events seemed to show the reverse trend between the two age groups in both cultures. The old Korean mothers reported having more life events and experienced more depressed moods than the young ones; while the old Scottish mothers reported having fewer life events and experienced less depressed moods than the young Scottish ones.

Even though the correlations were all very weak, the old and young Korean mothers and old Scottish ones showed some significant correlations ranging between r=.21 and .27. This would indicate that the higher the number of stressful life events which had recently occurred the more likely it is that the mothers will be depressed.

Several previous studies (Brown et al., 1983; Dohrenwend et al., 1974; Rahe, 1974; Steel et al., 1980) support these results. A re-examination of Myers' data from the New Haven area (Eaton, 1978) reported that there were significant correlations between the number of recent life events and mental illness symptomatology.

Paykel et al. (1988) reviewed 25 published studies on life events in depressed people, and found twelve studies recorded that more events were reported prior to the onset of depression. Some studies have found that more life events are reported by depressed people, but such differences are not clearly attributable to cause rather than to the effects of depression. This study does not claim to establish causal relationships nor resolve the issue of effect, but it is interesting that correlations between depression and the number of life events were found even though the correlations were low.

All the studies Paykel et al. reviewed were of people who suffered from clinically diagnosed disorders, thus they might not be comparable with our study. Subjects in the present study were generally stable middle class mothers, who either had not experienced any recent severe events, or who were taking the events very well and calmly. For instance, some young Scottish mothers (see "cases" in Appendix 1) did not show any sign of depression after their parents death ("terminal exits" in Goodyer's term, 1985). One of them even had several life events occurring in the space of a month, such as the father's death; mother moving in; husband's car accident and brother's wedding, all on top of her own physical problems and having a baby after many years

of trying, yet she managed everything herself remarkably well. These mothers commented that having a baby was a lot of work but that they could set aside other emotional problems and this allowed them get on with the day to day business of living.

Generally, studies concerning the relations between stressful life events and mental health suggest that we should look into the effect of the different types of events on depression. This will be discussed in the next section.

(2) Types of events

In this study, the most important event chosen by our subjects was the one concerning the mother's role: "recently had a baby" or "having a child who was preparing for an important examination" (such as university entrance qualification or the final school examinations). Secondly, events concerning "inter personal conflict" were chosen. Although our subjects were selected on the basis of events relating to the mothering role, not all of them considered this item most important. This is especially true in the case of the old Scottish mothers. (Whereas 45% vs. 73% of both of the young groups and 69% of the old Korean mothers

chose this item.) This would seem to suggest that the old Scottish mothers did not feel stressed by their mothering role. This tendency can be observed even more clearly if we take account of the fact that among this comparatively small number of the old Scottish mothers (45%) who were concerned about their children more than a third were worried about children other than the one who was preparing for the final school examination. This leaves only a small proportion (less than two third among those 45%) of the old Scottish mothers who were worried about the child or children who were preparing for the examinations.

In conclusion, child-birth was weighted comparably in both cultures (73% of both Korean and Scottish young mothers chose it). As Rand (1986) commented, "pregnancy and childbirth occupy unique positions among the common stressors in the lives of women" (p.173). However, the preparation for the university entrance qualification was weighted differently by the mothers in the two cultures. Considering the importance of academic achievement and the inclusive role attitude of mothers in Korea, it seems natural for them to choose the child's preparation for university entrance qualification exams as a life event of their own in contrast to the case of old Scottish mothers.

We should point out that any specific life event cannot be measured for its weight equally. Life events were measured initially by the Social Readjusting Rating Scale (Holmes et al., 1967), which was formulated on the basis of the American way of living.

Fairbank (1981) suggested the "hierarchy of needs" can be employed to explain the differences between the socio-economic classes in terms of cultural difference and choice of life event. For instance, economically deprived people would be more concerned with meeting the basic material necessities of life, whereas other more prosperous people seek different things. For example self-actualisation becomes one of the basic necessities. In the case of less industrialised cultures Holmes et al. (1974) observed a general tendency to rank items dealing with bodily necessities more highly than items dealing with personal and interpersonal dynamics.

Yamamoto et al. (1987) investigated stressful events in the lives of children (3rd to 9th grade) in six countries which were Australia, Canada, Egypt, Japan, Philippines and United States, and found no difference between the countries. The simple life which children tend to lead may satisfy universally found needs of children.

However, Baratta et al. (1987) found some transcultural difference in the perception of life events by using English and Italian adults (17 to 70 years old) - Italian subjects tended to rate any life event as less disturbing than the English.

It can be concluded that the perception of stress arising from a particular life event differs not only from individual to individual but from group to group. That is it differs from one culture to another.

Relationships between the types of events and depression scores

In this study, the correlations between specific life events with depression scores were found to be very low. There was virtually no significant relationship between depression scores and specific events alone. For example, only four out of thirty-six calculations were significant but still low (range between r=.21 and .29).

Several authors suggest that there are consequential differences between different types of event. Brown (1978) indicates the importance of causal periods as well as the types of event, such as marked "long-term

threat", "moderately long-term threat" or "non-severe event". He found the ratio of "markedly long-term threat", "moderately long-term threat" and "no-severe event" between depressed patients and normal women were 4.83, 3.50 and 0.92 respectively. What he suggested was that if one experiences a marked long-term threat then there would be a higher chance of becoming depressed than if one experienced a moderate or non-severe event.

Goodyer (1985) found that marital and/ or family conflict, accident or illness can all be associated with mild mood disorders, while permanent separations and deaths lead to somatic illness and severe mood disorders.

On the other hand, Henderson (1981) found that magnitude estimation scaling among different life events did not provide a significantly higher correlation than did a simple count of life events with symptoms (p.61).

It does not seem, therefore, that any specific life event - including the events related to the mothering role - has a clear relationship with depression scores. No specific causal relationship between depression and the type of event examined in this study was observed.

7:5 Most Important Variable for Depression

So far we have discussed the results of depression, and have examined the relatedness of attributional style, the social support system and life events to depression of our subjects. We will now examine the results regarding the most relevant factors among these variables to depression in our four subgroups of mothers. For this purpose we turn to the results of the multiple regression analysis.

(1) The most important independent variable to correlate with depression was "amount" of support "received" from others. All the four subgroups showed at least one aspect of support "received" from others. The importance of "receiving" support was discussed in section on the relevant topic of support (see pp.320 - 326).

(2) Secondly, the number of life events was extracted in both Korean subgroups and the "old" Scottish group. Significant relationship of number of life events to depression was discussed in previous section (see pp. 350 - 352).

(3) Thirdly, attributional style variables only contributed significantly to the multiple correlation

coefficient of the Scottish subgroups. Korean mothers, regardless of their degree of depression, blame themselves and claim the responsibilities for their children's matters. For Korean mothers, it seems natural to take the blame or claim responsibility for their children's matters whether or not they are depressed. Whereas, if a Scottish mother had the attitude of claiming responsibility or blaming herself for her child, she would be seen as unreasonablly involved with her child. Therefore, in an individualistic culture "internal attribution" of a mother over her child's matter can be identical with a symptom of depression i.e. "excessive and inappropriate guilt" (DSM-III-R, 1989).

CONCLUSIONS

The main conclusions of this study are as follows.

Depression

1. It was found that within each culture there was no significant difference in depression scores between the two life stages tested. No postnatal depression was detected in Scottish mothers, and motherhood at the end of a child's secondary education did not relate significantly to depression in Korean mothers. This is consistent with the life event section, that no specific kind of life event showed a significant correlation with depression.
   (The Hypotheses 2:a and 2:b were rejected.)

2. Cross-cultural differences in depression scores were found between Korean and Scottish samples:
   a) Korean mothers in both stages scored significantly higher than their Scottish counterparts. (Accepted the Hypothesis 1:a.)
   b) Korean mothers recorded significantly higher scores on overall depression symptoms and not just on somatic ones.
   (Partly rejected the Hypothesis 1:b.)

On related variables to depression

1. a) In both cultural groups it was found that the social support system is the most important variable which correlates with depression, especially "receiving" support from other people. (Generally accepted the Hypothesis 4:a.)

   b) However, there was significant differences in the support system between the cross-cultural subgroups. Scottish mothers showed a higher appreciation of the support system they had than Korean mothers in terms of network size and satisfaction with both "amount" and "quality" of support. (The Hypothesis 4:b was accepted.)

2. The number of life events showed significant correlations with depression scores, but the specific types of event did not show significant relationships. (The Hypothesis 5:a was accepted.)

3. a) Attributional style did not show clear correlations with depression, especially for the Korean mothers. (The Hypothesis 3-a was partially accepted.)

   b) However, there were significant differences in attributional style between Korean and Scottish mothers. i.e. Korean mothers attributed more internally over the child's matters, whereas Scottish mothers attributed more externally. (The Hypothesis 3:b was accepted.)

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APPENDICES

Appendix 1 **CASES**

Introduction

A glimpse of the real life situation of mothers in both cultural groups is outlined here.

Scottish Old Mothers

Case 1

This mother was from the South of Glasgow where her own mother still lives (her father died the previous year). She is the eldest of three children having two younger brothers - the youngest being 13 years younger than herself. As a teenager she had to help her mother with both the care of her baby brother and the housework which she did not like. She desperately wanted to leave her parents' home. She decided that when she had her own children there would not be such large age gaps between them as that between her brothers and herself.

She was working as a secretary at the time she met her husband, and has not had to go out to work since she married. Her husband is an architect and has been a sufficient provider so that she has been able to be a full time homemaker - a role she finds more fulfilling

than her secretarial work. However, she commented that she has been busier than anyone she has known who does have a job, because people ask her to do more things and she finds it difficult to say "no". She dislikes disagreeing with people and wants to be liked by everyone. She sits on several charity committees, sings in the church choir (where she met her husband), socialises with friends and neighbours from the surrounding area (where she and her husband have lived for the past 17 years), and pursues the hobby of flower arrangement. She has "hundreds" of friends all of whom are "willing to help" if she requires them.

She and her husband have two sons and one daughter, all of whom live at home. The eldest son was, at the time of interviewing, 21 years old, a recent graduate of Edinburgh University presently working as a photographer. The youngest boy was 16 years of age and studying for his Highers. He was interested in art. The daughter was 19 years old, and had been trying to enter Drama School but had been unsuccessful in obtaining a place. The mother thought that her children were more artistic than academic.

This mother believes that discipline of children should start when they begin to say and understand "no" which is, she thinks, at about 10 months of age. She did

smack her children when they were young, and of the opinion that children should learn how to behave before they went to nursery school. (This was an opinion that I found to be upheld by most of the Scottish mothers in the study.)

The main worry experienced by the mother was concern for the safety of the children. When, for instance, the older son started to drive a car it became the overriding concern in her life. Now, the youngest son goes out to discos at the weekends and she finds she cannot stop worrying until he has returned home safely. At the time of the interview, she was most concerned with the travel arrangements for her mother who is visiting the United States where one of her brothers lives. She has found that her mother is coming to rely on her more and more.

Overall, the mother is quite happy with her children and enjoys an easy relationship with them at an adult level. Part of this can be attributed to the fact that she no longer feels tied down to the home. Now that the children are older she is free to pursue her own interests - to do things for herself. In agreement with most Scottish mothers, she considers the "success" of her children to be the "living of happy life" and "doing what they want to do". The only thing that

makes her sad about her children is the fact that they are not committed to the church. She is a committed member of the church that her parents attended. She feels there is little she can do about the matter as her children have a more relaxed attitude to religion.

This mother felt herself to be surrounded by lots of friends and family but that she did not use these social resources. Rather she contributed to help others out of a sense of duty. She seems to be benevolent to others but unable to accept the position of being a beneficiary. Her BDI score was 0.

Case 2

This mother was a full time homemaker, doing voluntary work and participating in personal recreational activities. She held a strong belief that housewives should stay at home. She did not feel it was right for married women to employ nannies for their children in order that they could work. She commented that intelligent people often lack common sense and that they did not seem to know the real world or, more exactly, the difficulties that it held.

She and her husband have two daughters, one of whom wants to be a shoe designer and the other wishes to enter into the catering profession. Contrary to her husband's idea that the achievements of girl's are not important, she believes that a girl's career is, nowadays, as important as a boy's.

In common with many fulltime homemakers, she seems to be experiencing pressure to find herself a job outside the home. So far she has not secured herself one and does not seem to have any urgent need, in the economic sense, to do so. Some mothers were open enough to talk about this "trendy" pressure to take up paid employment. Others observed that it is a "luxury" for women to be able to choose whether to work or to stay at home - a choice which is not afforded to men.
Her BDI score was 2.

Case_3

This mother was a special education teacher for blind and mentally handicapped children. She had started her job for economic reasons, but is now thoroughly enjoying both her work and her family life. She has one 15 year old daughter. Her priorities between her career and motherhood are clear - "definitely

motherhood!", she emphatically states. When she returned to take the special education teacher course her daughter was 9 years old. She did not start her studying until after the girl had gone to bed - sometimes this meant she had to stay awake until three o'clock in the morning to keep up with her work.

The mother believes in the extended family. Despite her parents having died when she was relatively young (her mother died 24 years ago in a road traffic accident while out shopping with her; her father had died a year earlier) she is part of a pseudo-extended family. This extended family includes friends from childhood and their parents, friends of her parents, in-laws and relatives. This arrangement has been beneficial to her daughter by helping to overcome the possible shortcomings of being an only child.

Though originally from a working-class family, this mother considers herself to be middle-class. She said that some of the "better people" are produced from supportive working class families and that some of the problem children were the product of middle-class liberal families which lack both "discipline and interest" in their own children. For her own daughter she has set quite firm boundaries. For instance, the daughter is not allowed to go out alone at night; she

has to inform her mother where she intends to go when out with her friends or boyfriend; and so on. The daughter seems to have been a sensible child from an early age - for example she wants to be a medical doctor and does well at school. Mother and daughter have a good relationship and are able to talk freely with each other. They can, for instance discuss contraception and sexual relationships.

At the time of the interview, the hardest thing for this woman to cope with was the death, a year previously, of two children of a friend: she had found no coping strategy for the sadness which she was experiencing. Even talking with her husband was of no help. Apart from the sadness, everthing was very smooth in her life. She seemed to be bright, active and joyful, living in warm family surroundings with a loving and helpful husband (he was decorating their daughter's room on the day of the interview) and friendly daughter.

As most of the mothers in this study did, she too managed her life very well. Even though they seemed to have difficulties of one sort or another. For example one mother had a very bright daughter suddenly struck by an incurable viral infection; others had to cope with their husband's being unemployed; one has been a

widow with no proper income for 15 years. Yet others have older children who have failed examinations at university or have developed attitudes unacceptable to the mother. Most of these mothers seemed to make effective use of the social resources available to them and some depended upon their belief in God for support. Her BDI score was 2.

Case 4

This mother and her husband were university lecturers with four children. The eldest one was their 16 years old daughter, studying for her Highers and interested in art. The other three children were all sons aged from 10 to 14. The children caused her some concern - mainly in terms of their behaviour, especially the eldest one does not seem willing to accomodate to her wishes. However, her children, especially the younger boys, offered her more comfort than they caused her concern or worry.

The up-bringing of the children was a joint effort with both her and her husband being actively involved. She is a strong believer in the effect of the environment on the rearing of children and emphasized the importance of the "right" environment. Similar to most

of the mothers in the study, she too believed that children know what parents wish of them quite early in their life. Children should learn their manners when they are young and an effort should be made to teach them to have good communication skills. She thought that as children reach their late teens they make their own decisions, which effectively places them outwith parental control.

Her main source of stress came from the pressure to be successful in her career, which seemed to be causing her to feel depressed. She was under the pressure of publishing a book and had been experiencing difficulties with her publisher. Her BDI score was 17.

Scottish Young Mothers

Case 1

Until about five years before the time of the interview, this mother had been working as a language teacher -teaching French, German and Russian and had to give up her work due to health problems (blood pressure). Her experience of different cultures is wide and includes those of Europe, Africa and North America.

After 13 years of marriage without children, she and her husband decided to try for adoption. Just as they were about to apply, she found herself pregnanat. Both before and after the birth of a daughter, she had health problems. There were a number of other major events that occurred around the same time. When her baby was two weeks old her father died suddenly. (He had led a full life.) Two weeks after the death her brother was married. A further two weeks later her husband was involved in a car accident. Not in the best of health herself, she had to care for her family as well as her widowed mother who had come to live with her after the father's death.

As with most of the professional mothers she claimed that "she is not a typical middle class mother." She held strong opinions on middle-class culture. For example she thought middle-class people are ambitious, more polite but shallower in their relationships than working-class people. She said too, that, middle-class people are more inhibited and that their inter-generational problems generally resulted in more acute conflicts. In her role as a mother, she would not push her child to be competitive at school. Her own teaching experience - in a middle class residential area - had shown her that such "pushing" could cause the child to become anxious. She hoped that her child

would become a "well rounded person", and felt that as she and her husband were mature enough (both in mid 30s) and had sufficient resources (her husband is a well established accountant) to both enjoy and cope well with their baby this should not be a problem.

Despite her expression of negative feelings towards "so-called middle-class" attitudes, she herself seemed to hold some such attitudes. She had sufficient self-confidence to be able to cope with the many events which were happening to her at that moment. Her coping strategy was to keep herself busy and to satisfy the needs of her baby. She seemed able to rationalise the events which happened to her quite well: she felt happy for her father that he had an easy death after leading a full life.

She described herself as a "private person". For example when she was hurt she would only confide in her husband. She was, however, able to express her emotions within the close family circle and could cry when feeling sad, such as after the death of her father. Even though she had a close family network and close friends, all of whom she knows are willing to help her, she said she would not seek help from them. She felt able to offer help to others but found it difficult to accept help herself. When asked about

post-natal assistance at home she said that, at the moment, her mother needed more help than her.

On the BDI she scored 1 for 2 items. However, she gave legitimate reasons for both cases: she said she had "good reason" for answering positively to the question (item 20) which asks whether "she was worried about physical problems; and she gave hormonal change as a reason for feeling "slightly more irritated now than usual" (item 11). Her BDI score was 2.

Case 2

Both she and her husband were solicitors in their late twenties. They had been married for six years and had been planning to have the baby for more than three. The infant was aged eight weeks at the time of the interview. This mother, too, emphasized her working-class background by stressing that her mother had been a midwife. She and her husband had been very close to her parents - both very recently deceased. Her mother had died only five weeks before the interview; her father nine months previously in a car accident. She thus had to take care of her parents estate while caring for a very young baby.

At the time of the interview, her sister-in-law, a health visitor and a home help were there. During the interview, a minister from the local church stopped by to say a friendly "hello". The mother held the baby throughout the interview session (this was also true of the Case 1 mother; c.f. to young Korean mothers who usually let other people, such as family members or a house-maid, hold the baby while they greet visitors.) Having the infant was not causing her stress but, rather, giving her the motivation to keep going and to hold on at this time of bereavement. Another source of comfort was her Christian faith: this was especially comforting when she had to watch her mother going through the pain of having her leg amputated, and she felt powerless to help (during the interview, she cried when talking of her mother's illness and death). She said that she would, normally, try to control whole situations by herself without asking or receiving any help from anyone unless she experienced a severe event. At this particular stage in her life, even though she had not sought help she had been offered practical help from various sources: friends brought in food; a cousin who had recently had a baby herself took care of the infant to let her have some sleep; a sister-in-law who lived nearby dropped in and gave her help from time to time; her husband helped her more over the weekends; and a home-help came in twice a week for two hours.

During the interview, the mother emphasized the care of the infant's emotional well-being with support from her husband and other family members. She did not think that future academic achievement or success were important for her child, rather it was the future happiness of the child that she stressed. She stated that working at a job was easier than being a mother. She thought the "mothering role" deserved more appreciation.

Her BDI score was 7. This is not high and most of the score arises from physical complaints which had reasonable explanations.

Case 3

This mother is a working journalist, married to another journalist. She had one previous miscarriage before having this first baby. She said she would not mind staying at home full-time with the baby for at least the first year. However, she had to return to work in order not to lose her job. She felt guilty about this. When she had to be absent overnight on a business trip to London she missed the baby terribly and experienced a great deal of guilt. She found that the baby did not, in fact, seem to be disturbed by her staying away

from home, and that hurt her too. She had never thought that she would be so maternal and it was a surprise to find herself like this.

Her mother resided in Edinburgh and was unable to offer her much help. However, she felt it was better that way, as her mother would try to impose on her a mothering role which she would dislike. She would rather seek her help from professional people, such as the health visitor or the G.P. Otherwise she would try to cope with the situation by herself.

She did not have any special event in her life except the birth of an infant of her own. She does not seem to have mobilised a lot of social resources - she is somewhat of a loner - and seems dissatisfied with her position. Overall, she found professional advice and help, praying alone and getting on with something else, to be effective coping strategies.
Her score on the BDI was 26 which is a high score. It should also be noted that she showed some distress evenly thoughout the scale.

Case 4

This mother is a civil servant in her mid thirties. Her husband is a postman. She had just had their second child - a girl - following a gap of 13 years since the birth of her first son. In general, she is more concerned with her older child. She feels a sense of responsibility for her child's affairs and, at the same time, she realizes the importance of the environmental influences which he is exposed to.

She has not had any other special events recently other than the birth of the child. She feels rather bored at home and, therefore, wants to go back to work full-time. However, the arrangement for the care of the infant is posing a problem because this baby happens to be slow in every way. For example the baby feeds very slowly.

The mother does not seem to have a good social support system - it is unsatisfactory in terms of quantity of helpers available and in terms of the quality of support offered. She has few friends with whom she can spend time socialising and her husband seems to offer her little support.
She had a high score on the BDI on all items and her score was 24.

Korean Old Mother

Case 1.

This mother is a 48 year old married school teacher with four children aged from 12 to 21 and carries out a typical role of housewife in Korea. As a teacher, she is active in managing money matters for her husband's small buisiness. She complains that she has been working hard to manage the family's economy because her husband's business has not prospered recently. She tried to arrange money to supply the business as well as for a new house which she planned to have, however, the plans were stopped through the betrayal of a trusted friend. She even got involved in a law case because of the matter. Since then, she suffers with heart palpitations, her hands and feet become numb, and she has fainting spells when she gets anxious.

At the moment, all she talks and cares about appears to be matters concerning practical economy in one way or another and the concern with her children's future career, academic achievements and health.

The eldest 21 year old son causes her worry over his health, his studies at university, his future career

and his girl friend. She can still have a say about his girl friend. Of course, she said, her daughter who would soon sit the university entrance examination causes her the most concern of all of her four children. Even though she maintains that she has kept her teaching post all the time for her own satisfaction, she still suffers from the feelings of guilt that she had not accomplished the mother's role properly because of her career. She has not resolved her ambivalence between her own satisfaction and the mothering role for the children.

She does not have enough time to socialise with her friends because of the job and family. She misses the life with friends from secondary school and university. One or two close friends at the (Catholic) church and the priest are the only source of support she has. Reaching the present stage, she finds her children are quite selfish as they do not show her much care but are concentrating on their own lives, her husband does not seem to be able to manage his finances, and only people at work and church were appreciative and provided mutual support.

Since she cares most for her family's well-being in practical terms and she does not appreciate the interaction within the family, she feels she has failed

in her life. Her depression score was as high as 32 on BDI.

Case 2.

This mother was in her mid forties and a full-time homemaker. The wife of a university lecturer with three children aged from 12 through to 18 years old (two boys and a girl in between). She has kept tight control over her children in terms of studying and social behaviour. She has managed everything for the whole family from her husband's income, because she had not found a job suitable for her academic qualifications and her interests (research or teaching at any institution of tertiary education). She has been dedicated to improving family life in every way. For instance, she goes early in the morning to a whole sale market to buy fresh food at more reasonable prices. (It requires quite an effort using public transportation without a family car in her case.) She has been tutoring her children in mathematics and science subjects while she managed her home without any form of service from a domestic helper, which is quite commonly practised in Korea. Since the family has been living in university accommodation, she has been saving for a private house (which is quite difficult to get

because in most cases it requires big sums of money to pay the whole price of the house) in several ways. The most important revenue is the system of 'gue' (a kind of private bank among a close group of people), therefore she has managed to organise and joined with another group through relations.

Her husband is the first son of the head (main) family so that she is responsible for the matters concerning their (husband's) extended family. Her aphasic mother-in-law has been confined to bed for several years through a stroke. Her grandmother-in-law had a stroke and was bed ridden for over seven years until her death before the case of her mother-in-law. She feels it is her fate too, married to a family with this kind of bad luck. She is afraid she will be the same, wonders whether her future son's wife would carry out the duty as her mother-in-law had done to the previous generation.

Fortunately, her father-in-law is still living an active life, and earning his own income, they are not therefore totally dependent upon her husband. However, she should visit her mother-in-law as often as possible. As she feels she should be responsible for caring for (nursing) her mother-in-law she and her other sisters-in-law donate some money regularly to pay

for the live-in nurse and a house-keeper who do things in place of her.

Her senile widowed mother lives with her older sister, because her brother's wife did not get along well with the mother. She feels sad about her mother's situation - for the loss of her proper place to live which should be her brother's home. She has to squeeze out some money and time for her, too.

All these matters are carried out without any support from her husband, except that his total salary is put into her hands every month. She has to divide it for all the items required for her to carry out. She has nothing left (actually she seems to be short of money, time and stamina every month but she manages to find ways round this).

She always wanted to study horticultural, however, she never managed to do it, because of lack of finance and time. She said she envied me getting away from the tie of full-time homemaking. She is ambivalent in a way as she cannot do what she wants for herself because of her role in the family.
However, there is no doubt that if she has to choose between family and herself, her family comes first. It is believed in Korea that it is not right to do

anything for oneself if it is against the family welfare. There was a case of a mother who wanted to finish her final degree in music at a university in the U.S.A., where she started her family and raised them for a while before returning to Korea. She had earned the permission to go back there with her two children from her husband's parents by telling them it was good for the children's education if they go back to America without mentioning her own ambition. Her BDI score was 5.

Young Korean mother

Case 1.

She had just had her third child and was in her early thirties. She had not finished her university education to get married to a high school teacher who had a postgraduate degree. After having two daughters, she was experiencing pressure from people around her to have a son this time. She had to fight against her husband who kept requesting her to get an amniotic test or ultrasonic test to identify the gender of the foetus. (These tests have been practised for some time among people who can afford them, and if they find it is a girl they would be willing to have an abortion.)

As a Christian, she did not accept it, therefore, she had a difficult time from her husband during the pregnanacy. She did have a boy, but "if it was a girl...," she said she would not like to imagine the consequences. She was brave and confident in herself. She seemed to have good female support in the family; her mother, mother-in-law, sister-in-law and grandmother were all behind her. She has had the heavy responsibility of caring for a big family of four generations, but in return this has provided her with power and position in the family. She was confident enough to offer advice to her family and friends including her husband. Generally in Korea, the people who have higher academic credential or who are senior are supposedly in the position of offering advice to their juniors. She showed the reverse case. She did not have a big group of friends, and would go to her church minister for advice if she felt the need to go outwith the family.

The first week after her child's birth she had domestic help from a paid assistant for more than seven hours daily. She did not consider the help of other family members' as being real substantial help. This is in contrast to the case of the Scottish mothers' who felt that just talking with their own mothers and receiving the assurance they needed were helpful.

At the time of interviewing she expressed concern for her first daughter who had started school and was experiencing her first term examination. She felt she could not assist sufficiently in the preparation of school work, because she has been busy with the new baby and her homemaking role. She also showed concern for the second daughter, who may be missing out on the attention she needed being in between the big sister and the baby brother.

She did not score high on depression scale with a score of 5.

Case 2.

This mother worked as a civil servant after completing her seconday school education. Her husband was also a civil servant educated to the same level. At the age of 27 years she had just given birth to her second son. Both boys are growing up well without any notable problems. She had also had to care for an elderly bedridden relative who had died recently.

She had a deep feeling of failure, because she did not have a university education. Her husband too experienced limitations in his promotion prospects at

work due to not having a university education. In comparison to people who have a higher educational background they experienced economic difficulties. This woman was not content with what she possessed. She thought of herself as belonging to the middle class and became dissatisfied when she compared her living standards to those of other middle class families.

She kept herself at home and limited herself to activities with family members only. Her husband was the only one with whom she socialised, or from whom she receives help and emotional support. However, she was not satisfied with this life style.

Her mother came to help her by staying for the first week after the childbirth. She would have liked her mother to stay longer - at least for three weeks which is considered to be a normal period for the mothers' recovery from the childbirth.

When interviewed, she said she would feel responsible for any problems with the children's health or behaviour. Despite not having any practical problems, except the expressed discontent with the economic situation, she felt very pessimistic and down.
Her BDI score was 27.

Case 3.

This subject was a Korean language teacher for foreigners. She had just had her first baby boy at the age of 29 years. She was married and living with her husband's parents. She had to return to her work, after two months maternity leave, and her mother-in-law took care of the baby while she stayed away during the week. In that sense, she had no difficulty in getting practical help (she also had assistance from a domestic helper for more than seven hours each day), but she missed her baby when she was away at work.

At the time of the interview she was in good health and had experinced no health problems during the pregnancy or delivery. She had no recollection of any stressful events. She had a good relationship with her parents-in-law, kept in close contact with her friends and juniors in her alma mater, as well as maintaining good relationships with her collegues at work. She has a close relationship with her husband. It seems, therefore, that not only has she a good number of supporters from various sources, but she also has a relaxed attitude to asking and receiving support from those people.

She lives a life which is a typical postnatal Korean mothers' one; all the house chores are carried out by someone else, she does not worry about anything including her infant as he is looked after by the experienced grand-mother. On top of this she is not confined to the family in isolation but can enjoy outside life as well.

During the interview she said she might feel responsible if her child had problems in health, emotion, or academic achievement in the future, but she was not anxious or depressed in anyway. Her BDI score was 5.

GENERAL OBSERVATIONS

The role of homemaker is more highly valued by Scottish mothers than Korean mothers. Scottish mother would rather stay home with their children if they can afford to do so, while Korean mothers would prefer to work outside if possible, even if they can afford to stay at home. For the Scottish mothers, raising their children should be carried out by the couple-centered nuclear family with the support from the social service system, whereas Korean mothers expect support from the extended family unit with no state intervention.

Scottish mothers seem to think that their children should be regarded as independent individuals and, therefore, the children are to an extent, outwith their control. They accept that their influence is only one of several which come from the surrounding environment of the children. Korean mothers, on the other hand, seem unable to give up the desire to control their children; even if it is not effective control. This tends to lead to disappointment because the effort put into this is greater than the reward they receive, thus, they complain more about their heavy responsibility.

In general, Korean mothers consider their family welfare in terms of practical and economic life, while Scottish mothers consider in more non-material entities. Scottish mothers are more active in socio-emotional ways such as volunteer work, while their Korean counterparts are more active in practical ways, for instance in the economic affairs of the family.

For Korean mothers, the support system is based on trust and loyalty which is considered as natural, but can be betrayed unexpectedly (e.g., Old Korean case 1). Scottish mothers' support system is based on good-will and can be an extra thing to the normal relationship. Therefore, the gap between mothers who have the support

(young Scottish case 1 and 2) and who do not have (young Scottish case 3 and 4) can be shown in their depression scores.

Appendix 2 **Personal Data Questionnaire**

Please fill in or tick for each item.

Your age:_____years old

Marital state:(married, single, divorcee, widow)

Your job:_____(part time or, full time)
Your husband's job:_____(or, unemployed)

Educational background of yourself:_____years of formal education
Educational background of husband:_____years of formal education

How many children do you have? _____

Appendix 3 **Beck Depression Inventory**

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY! Tick the the statement you picked. If several statements in the group seem to apply equally well, tick each one. Be sure to read the statements in each group before making your choice.

1. ( ) I do not feel sad.
   ( ) I feel sad.
   ( ) I am sad all the time and I can't snap out of it.
   ( ) I am so sad or unhappy that I can't stand it.

2. ( ) I am not particularly discouraged about the future.
   ( ) I feel discouraged about the future.
   ( ) I feel I have nothing to look forward to.
   ( ) I feel that the future is hopeless and that things cannot improve.

3. ( ) I do not feel like a failure.
   ( ) I feel I have failed more than the average person.
   ( ) As I look back on my life, all I can see is a lot of failure.
   ( ) I feel I am a complete failure.

4. ( ) I get as much satisfaction out of things as I used to.
   ( ) I don't enjoy things the way I used to.
   ( ) I don't get real satisfaction out of anything anymore.
   ( ) I am dissatisfied or bored with everything.

5. ( ) I don't feel particularly guilty.
   ( ) I feel guilty a good part of the time.
   ( ) I feel quite guilty most of the time.
   ( ) I feel guilty all of the time.

6. ( ) I don't feel I am being punished.
   ( ) I feel I may be punished.
   ( ) I expect to be punished.
   ( ) I feel I am being punished.

7. ( ) I don't feel disappointed in myself.
   ( ) I am disappointed in myself.
   ( ) I am disgusted with myself
   ( ) I hate myself.

8. ( ) I don't feel I am any worse than anybody else.
   ( ) I am critical of myself for my weakness or mistakes.
   ( ) I blame myself all the time for my faults.
   ( ) I blame myself for everthing bad that happens.

9. ( ) I don't have any thoughts of killing myself.
   ( ) I have thoughts of killing myself, but I would not carry them out.
   ( ) I would like to kill myself.
   ( ) I would kill myself if I had the chance.

10. ( ) I don't cry any more than usual.
    ( ) I cry more now than I used to.
    ( ) I cry all the time now.
    ( ) I used to be able to cry, but now I can't cry even though I want to.

11. ( ) I am no more irritated by things than I ever am.
    ( ) I am slightly more irritated now than usual.
    ( ) I am quite annoyed or irritated a good deal of the time.
    ( ) I feel irritated all the time now.

12. ( ) I have not lost interest in other people.
    ( ) I am less interested in other people than I used to be.
    ( ) I have lost most of my interest in other people.
    ( ) I have lost all of my interest in other people.

13. ( ) I make decisions about as well as I ever could.
    ( ) I put off making decisions more than I used to.
    ( ) I have greater difficulty in making decisions than before.
    ( ) I can't make decisions at all anymore.

14. ( ) I don't feel that I look any worse than I used to.
    ( ) I am worried that I am looking old or unattractive.
    ( ) I feel that there are permanent changes in my appearance that make me look unattractive.
    ( ) I believe that I look ugly.

15. ( ) I can work about as well as before.
    ( ) It takes an extra effort to get started at doing something.
    ( ) I have to push myself very hard to do anything.
    ( ) I can't do any work at all.

16. ( ) I can sleep as well as usual.
    ( ) I don't sleep as well I used to.
    ( ) I wake up one-two hours earlier than usual and find it hard to get back to sleep.
    ( ) I wake up several hours earlier than I used to and cannot get to sleep.

17. ( ) I don't get more tired than usual.
    ( ) I get tired more easily than I used to.
    ( ) I get tired from doing almost anything.
    ( ) I am too tired to do anything.

18. ( ) My appetite is no worse than usual.
    ( ) My appetite is not as good as it used to be.
    ( ) My appetite is much worse now.
    ( ) I have no appetite at all anymore.

19. ( ) I haven't lost much weight, if any, lately.
    ( ) I have lost more than five pounds.
    ( ) I have lost more than 10 pounds.
    ( ) I have lost more than 15 pounds.

    * I am purposely trying to lose weight by eating less.
    Yes_____ No_____

20. ( ) I am no more worried about my health than usual.
    ( ) I am worried about physical problems such as aches and pains, or upset stomach, or constipation.
    ( ) I am very worried about physical problems and it's hard to think of much else.
    ( ) I am so worried about my physical problems that I cannot think about anything else.

21. ( ) I have not noticed any recent change in my interest in sex.
    ( ) I am less interested in sex than I used to be.
    ( ) I am much less interested in sex now.
    ( ) I have lost interest in sex completely.

Appendix 4 **Mother's Role Questionnaire**

Read each of the statements below and then rate them as you think of yourself as a mother as follows:

A: strongly agree	D: strongly disagree
a: mildly agree	d: mildly disagree

Indicate your opinion by drawing a circle around the "A" if you strongly agree, around "a" if you mildly agree, around "d" if you mildly disagree, and around "D" if you strongly disagree.
There are no right or wrong answers, so answer according to what you think. It is very important to the study that all questions be answered.

	agree		disagree	
	A	a	d	D
1. A mother never stops blaming herself if her child is injured in accident.	A	a	d	D
2. A mother will feel responsible if her child turns out to be emotionally unstable.	A	a	d	D
3. A child's good health is due to mother's effort.	A	a	d	D
4. If her child has well rounded personality, that is because the mother raises the child well.	A	a	d	D
5. A mother will feel guilty if her child is an under-achiever at school.	A	a	d	D
6. If her child became very successful whatever one did, the mother can consider the success as one of her own as a mother.	A	a	d	D
7. There are a lot of other factors concerning the physical safety and health of child a mother cannot control.	A	a	d	D
8. Other people contributed to the formation of a child's good personality.	A	a	d	D
9. Circumstances around a child can give him/her emotional problems.	A	a	d	D
10. People around a child other than the mother can help the child to do well at school.	A	a	d	D

Appendix 5 **Social Support Inventory**

The following questions ask about people in your environment who provide you with help or support. Each question has two parts. For the first part, list all the people you know, excluding yourself, whom you can count on for help or support in the manner described. Give the person's initials and their relationship to you (see example). Do not list more than one person next to each of the numbers beneath the question.
For the second part, circle how satisfied you are with the overall support you have.
If you have no support for a question, check the words "No one".
Do not list more than nine persons per question.
Please answer all quesitons as best you can. All your responses will be kept confidential.

Example

Who do you know whom you can trust with information that could get you in trouble?

No one	1) T.N. (older brother)	4) T.N. (father)	7)_____
	2) L.M. (girl friend)	5) L.M. (employer)	8)_____
	3) R.S. (boy friend)	6) G.H. (physician)	9)_____

How satisfied?

6- very satisfied	3- a little dissatisfied
(5)- fairly satisfied	2- fairly dissatisfied
4- a little satisfied	1- very dissatisfied

This response indicates fairly satisfied state.

Now please proceed through the questions, answering all of them for how you generally feel at this time in your life.

==========

1. a) If you spend some time socialising with people (i.e. recreation, shopping, chatting, visiting, etc.), who are they?

No one 1)_____ 4)_____ 7)_____
2)_____ 5)_____ 8)_____
3)_____ 6)_____ 9)_____

b) How satisfied are you with the amount of socialising that you do?

6- very satisfied
5- fairly satisfied
4- a little satisfied
3- a little dissatisfied
2- fairly dissatisfied
1- very dissatisfied

c) How satisfied are you overall with the quality of the time you spend socialising?

6- very satisfied
5- fairly satisfied
4- a little satisfied
3- a little dissatisfied
2- fairly dissatisfied
1- very dissatisfied

==========

2. a) If you talk about getting practical assistance or services from other people (i.e. with chores, tasks, finances, etc.) from whom do you get it?

No one 1)_____ 4)_____ 7)_____
2)_____ 5)_____ 8)_____
3)_____ 6)_____ 9)_____

b) How satisfied are you overall with the amount of assistance you are receiving?

6- very satisfied
5- fairly satisfied
4- a little satisfied
3- a little dissatisfied
2- fairly dissatisfied
1- very dissatisfied

c) How satisfied are you with the kinds of assistance you receive?

6- very satisfied
5- fairly satisfied
4- a little satisfied
3- a little dissatisfied
2- fairly dissatisfied
1- very dissatisfied

3. a) Sometimes you get guidance from people (i.e. advice, informations, clarification of problems, or possible solutions, etc.). To whom do you go for this?

No one 1)_____ 4)_____ 7)_____
2)_____ 5)_____ 8)_____
3)_____ 6)_____ 9)_____

b) How satisfied are you overall with the amount of guidance you are receiving?

6- very satisfied
5- fairly satisfied
4- a little satisfied
3- a little dissatisfied
2- fairly dissatisfied
1- very dissatisfied

c) Overall, how satisfied are you with the quality or kinds of guidance you receive?

6- very satisfied
5- fairly satisfied
4- a little satisfied
3- a little dissatisfied
2- fairly dissatisfied
1- very dissatisfied

==========

4. a) At this point you are getting some feedback on how you are doing (i.e. praise, compliments, criticism, blame, etc.).From whom you get the feedback?

No one 1)_____ 4)_____ 7)_____
2)_____ 5)_____ 8)_____
3)_____ 6)_____ 9)_____

b) How satisfied are you with the amount of feedback you are getting?

6- very satisfied
5- fairly satisfied
4- a little satisfied
3- a little dissatisfied
2- fairly dissatisfied
1- very dissatisfied

c) How satisfied are you with the kinds of feedback you are getting?

6- very satisfied
5- fairly satisfied
4- a little satisfied
3- a little dissatisfied
2- fairly dissatisfied
1- very dissatisfied

5. a) Sometimes you get <u>emotional support</u> from others (i.e. sympathy, understanding, caring, reassurance, etc.). Who are the others?

<u>No one</u>	<u>1)</u>_____	<u>4)</u>_____	<u>7)</u>_____
	<u>2)</u>_____	<u>5)</u>_____	<u>8)</u>_____
	<u>3)</u>_____	<u>6)</u>_____	<u>9)</u>_____

b) How satisfied are you with the <u>amount</u> of emotional support you receive?

6- very satisfied
5- fairly satisfied
4- a little satisfied
3- a little dissatisfied
2- fairly dissatisfied
1- very dissatisfied

c) How satisfied are you with the <u>quality</u> of emotional support you receive?

6- very satisfied
5- fairly satisfied
4- a little satisfied
3- a little dissatisfied
2- fairly dissatisfied
1- very dissatisfied

==========

6. a) Are there ever times when you are comforted by being held in someone's arms? Who are they?

<u>No one</u>	<u>1)</u>_____	<u>4)</u>_____	<u>7)</u>_____
	<u>2)</u>_____	<u>5)</u>_____	<u>8)</u>_____
	<u>3)</u>_____	<u>6)</u>_____	<u>9)</u>_____

b) How satisfied are you with <u>amount</u> of comfort you receive in this way?

6- very satisfied
5- fairly satisfied
4- a little satisfied
3- a little dissatisfied
2- fairly dissatisfied
1- very dissatisfied

c) How satisfied are you with the <u>way</u> of comfort you receice?

6- very satisfied
5- fairly satisfied
4- a little satisfied
3- a little dissatisfied
2- fairly dissatisfied
1- very dissatisfied

7. a) Are there people for who are dependent on you in their day-to-day life, who need your care?

No one 1)_____ 4)_____ 7)_____
2)_____ 5)_____ 8)_____
3)_____ 6)_____ 9)_____

b) How satisfied are you with the amount of care required of you at this time?

6- very satisfied
5- fairly satisfied
4- a little satisfied
3- a little dissatisfied
2- fairly dissatisfied
1- very dissatisfied

c) Would you like to have more or less of this in your life or is it about right? (tick one)

_____ more ____ about right ____ less

==========

8. a) Are there people who depend on you in particular for guidance or advice in day-to-day life?

No one 1)_____ 4)_____ 7)_____
2)_____ 5)_____ 8)_____
3)_____ 6)_____ 9)_____

b) How satisfied are you with the number of people who come to you particularly for this type of support and help?

6- very satisfied
5- fairly satisfed
4- a little satisfied
3- a little dissatisfied
2- fairly dissatisfied
1- very dissatisfied

c) Would you like to have more or less of this in your life or is it about right? (tick one)

____ more ____ about right ____ less

9. a) Are there people in your life who really appreciate what you are doing for them?

No one	1)_____	4)_____	7)_____
	2)_____	5)_____	8)_____
	3)_____	6)_____	9)_____

b) How satisfied are you with the amount of appreciation you receive?

6- very satisfied
5- fairly satisfied
4- a little saitsfied
3- a little dissatisfied
2- fairly dissatisfied
1- very dissatisfied

==========

10. Overall, how satisfied are you with the help and support you are receiving at this time?

6- very satisfied
5- fairly satisfied
4- a little satisfied
3- a little dissatisfied
2- fairly dissatisfied
1- very dissatisfied

Appendix 6 **Life Event Qeustionnaire**

This questionnaire is aimed at finding out how you deal with life's problems. So we would like you to specify some of the nasty things that may have happened to you during last couple of months, or something has happened before then which is still troubling you.
So please examine the brief list below and tick any that you think have happened to you personally within the last two months.

(1) Interpersonal conflict
including:- ( )
Rows or arguments with a boy friend/husband, parents, brother or sister. Family feuds or quarrels into which you have been drawn. Long lasting bad relationship with somebody important to you.

(2) Death
including:- ( )
the death of anybody to whom you were close. Tick this one only if either it was your mother, father, brother, sister, own child or very close friend or you had at least some involvement, e.g. found the dead person, were there at the death, went to the funeral or consoled somebody closely involved.

(3) Failure to achieve a desired goal
including:- ( )
Failure of an important examination, or to be accepted for the career of your choice, or to achieve something which really mattered.

(4) Crisis and disaster
including:- ( )
Emergency other than death. E.g. flood, fire, accident and/or injury to you or someone close, and unexpected loss of job which affected you, unexpected problems of all kinds.

(5) Crime in which you personally were a victim
including:- ( )
Theft of your property, physical assault, and any other crime in which you were a victim.

(6) Personal health
including:- ( )
Any operation to you personally where a general anaesthetic was required; any illness to you personally which either was life threatening, or might have meant serious deformity or incapacity or which kept you at home for four weeks or more.

(7) Mothering role
including:- ( )
Having a baby recently, or having a child who is preparing for an important examination.

(8) Caring responsibility
including:- ( )
Nursing and attending to an elderly or sick relative over a long period, or doing extra chores over a long period because somebody is incapacitated.

(9) Other ( )
If you have not already ticked any of the categories above, can you think of anything else which you found particularly distressing or inconvenient or irritating?

Now please enter brief details about things which you have ticked in the appropriate spaces below. If you did not tick any particular box leave the space corresponding to it blank. If you had more than one happening in a particular category (*e.g.* there were two crisis which you can remember) give details of all of them.

(1) Interpersonal conflicts
Details when?(approximately)

(2) Death
Details when?(approximately)

(3) Failure to achieve a desired goal
Details when?(approximately)

(4) Crisis and disaster
Detail when?(approximately)

(5) Crimes in which you personally were a victim
Details when?(approximately)

(6) Personal health
Details when?(approximately)

(7) Mothering role
Details when?(approximately)

(8) Caring responsibility
Details when?(approximately)

(9) Other
Details when?(approximately)

Appendix 7

우리나라 "어머니"의 심리태도 조사

안녕하십니까.

이 연구는 어머니의 역할과 생활에 대하여 심리적 태도를 비교하기 위한 것입니다. 다행히 이번에 영국의 글라스고 대학교 비교심리 연구계획의 일환으로 우선 우리나라와 영국의 "어머니"를 조사하게 되었읍니다.

이 연구가 출발점이 되어 어머님들이 좀더 활기있고, 즐겁고 건강한 생활을 하시는데 도움이 되었으면 하는 것이 유일한 바램입니다.

솔직하게 알려주실수록 상황판단이 정확할수 있기 때문에 있는대로, 느끼신대로 표시해 주시면 감사하겠읍니다.

연구 이외에는 이 자료를 쓰지 않을 것이고, 모든 비밀을 지켜드릴 것을 약속 드립니다.

감사합니다.

•연구 계획 책임자: 문 은 희
(영국 글라스고 대학·심리학)
•한국사회학연구소 협조

귀하에 대한 것들

1. 나이 : _____
2. 결혼관계 : (기혼, 이혼,사별)
3. 귀하의 직업 : (현재) _____
   (과거) _____
4. (1) 남편의 직업 : _____
   (2) 가장의 직업 (남편이 가장이 아닌경우)
   : _____
5. 귀하의 학력 : (국졸, 중졸, 고졸, 대중퇴, 대졸, 그 이상)
6. (1) 남편의 학력:(국졸, 중졸, 고졸, 대중퇴, 대졸, 그 이상)
   (2) 가장의 학력(남편이 가장이 아닌 경우) : (국졸, 중졸, 고졸, 대중퇴, 대졸, 그 이상)
7. (1) 귀하가 현재 직업이 없다면, 그것은 본인의 의사에 따른 것입니까? (예, 아니오)
   (2) 귀하가 현재 직업을 가졌거나 가지길 원하는 경우, 그것은 귀하 자신을 위한 것입니까,
   또는 가족을 위한 것입니까? (본인, 가족)
8. 귀하의 가정을 우리 사회의 어느 계층으로 보십니까? (상류, 중류, 하류)
9. 귀하께서는 어머니로서의 자신의 위치를 어떻게 보고 계십니까?
   (아주 나쁨, 나쁨, 보통, 좋음, 아주 좋음)
10. 귀하께서는 자녀를 몇명이나 두셨읍니까? _____ 명
11. 어느 자녀에게 가장 마음이 쓰이는지, 걱정되는 순서대로 써주십시오.

	나이	성별	걱정되는 이유 (보기 : 건강, 학업, 성격···)
1.			
2.			
3.			
4.			

12. 귀하의 경우, 다음의 각 시기에 따른 어머니로서의 경험은 어떠하리라고 생각하십니까?

	아주 좋음	어느정도 좋음	별로 좋지 않음	아주 좋지 않음
1.임신부				
2.출산모				
3.갓난아이를 가진 어머니				
4.취학전 어린이를 가진 어머니				
5.학교(고등학교 까지)에 다니는 자녀를 둔 어머니				
6.다 장성한 자녀를 둔 어머니				

어머니의 역할을 어떻게 보십니까?

어머니로서 다음의 의견들을 어떻게 생각하시는지, 알맞은 곳에 (V)표를 해 주십시오.

	(강하게 동의함)	(약간 동의함)	(약간 부정함)	(강하게 부정함)
1. 아이가 사고로 부상당하면 어머니는 자기 잘못 때문이라고 질책하게 된다.	( )	( )	( )	( )
2. 아이에게 정서적인 문제가 나타나면 어머니는 책임을 느낀다.	( )	( )	( )	( )
3. 아이의 건강문제는 어머니의 노력여하에 좌우된다.	( )	( )	( )	( )
4. 아이가 원만한 성격을 지니게 되는 것은 어머니가 잘 기른 탓이다.	( )	( )	( )	( )
5. 아이가 학업에 뒤진 경우에 어머니가 죄책감을 느낀다.	( )	( )	( )	( )
6. 아이가 성공적이면 어머니로써 성공한 것이라고 여길수있다.	( )	( )	( )	( )
7. 아이의 건강과 안전에는 어머니가 어떻게 할수 없는 것이 있다.	( )	( )	( )	( )
8. 어머니 이외에 다른 사람들이 아이의 성격형성에 영향을 줄수 있다.	( )	( )	( )	( )
9. 아이가 학업에 실패하는 것은 아이의 의지와 능력 탓이다.	( )	( )	( )	( )
10. 어머니와는 전혀 관련이 없는 주변 사람들이 아이의 학업성취를 좌우한다.	( )	( )	( )	( )
11. 어머니와 관련이 있는 주변 사람들이 아이의 학업성취를 좌우한다.	( )	( )	( )	( )
12. 아이의 타고난 조심성과 신체조건이 사고를 막을수 있다.	( )	( )	( )	( )
13. 갓난아이일때 어머니가 가장 주의해야할 것은 아이의 건강이다.	( )	( )	( )	( )
14. 어머니의 역할에서 제일 좋은 점은 아이가 주는 즐거움이다.	( )	( )	( )	( )
15. 어머니의 가장 우선되는 책임은 아이로 하여금 장래 성공하게 하는 것이다.	( )	( )	( )	( )
16. "자녀가 다른 사람을 사랑하고 아끼는 사람으로 자라는것" 이 양육의 첫 원칙이어야 한다.	( )	( )	( )	( )
17. 아이와 어머니는 분리될수 없는 존재이므로 어머니는 아이의 생활에서 일어나는 모든 일을 다 알고, 간섭해야한다.	( )	( )	( )	( )
18. 아이가 16살 이상된 경우에는 아이의 문제에 개입하지 말아야 한다.	( )	( )	( )	( )
19. 갓난아이는 어머니 혼자 돌보게 해서는 안된다.	( )	( )	( )	( )
20. 주변에서 어머니의 노고를 더욱 알아주어야 한다.	( )	( )	( )	( )

귀하는 지금 어떻게 느끼시고 있읍니까?

다음은 우리들의 느낌에 대해서 말하고 있읍니다. 여기서는 1에서 20까지 20묶음으로 되어 있읍니다. 지금 이 순간에 귀하의 느낌을 가장 잘 나타내는 말 앞에 있는 번호에 동그라미를 치십시오. 반드시 한 묶음씩을 다 읽은 뒤에 고르셔야 합니다. 만일 한 묶음속에 귀하께 맞는 것이 하나 이상이면 모두를 표시해도 되겠읍니다.

1. 0 나는 슬프지 않다.
   1 나는 울적하고 슬프다.
   2 나는 언제나 울적하고 슬퍼서, 거기서 벗어날 수가 없다.
   3 나는 너무나 슬프고 불행하게 느껴져서 참을수가 없다.
2. 0 나는 앞날에 대해 별다르게 비관하지 않는다.
   1 나는 앞날에 대해 비관적이다.
   2 나는 앞날에 기대할 것이 아무것도 없는것 같다.
   3 나는 앞날에 희망이 하나도 없고, 또 더 나아지리라고 생각되지 않는다.
3. 0 나는 실패자라고 느끼지 않는다.
   1 나는 보통 사람들에 비해 실패했다고 느낀다.
   2 내가 이제까지 지내온 것을 되돌아 볼때, 수많은 실패만을 거듭해 왔다.
   3 나는 완전히 실패한 사람이라고 느낀다.
4. 0 내가 이전에 느꼈던 만큼의 만족을 지금도 느끼고 있다.
   1 이전 만큼 모든 일을 즐기지 못한다.
   2 이제는 무엇에서나 참으로 만족을 얻지 못한다.
   3 모든 일이 불만스럽고 지루하다.
5. 0 별다른 죄책감을 갖지 않는다.
   1 꽤 많은 시간을 죄책감에 젖는다.
   2 요즘은 거의 언제나 죄책감에 사로잡힌다.
   3 언제나 죄책감에서 벗어날수가 없다.
6. 0 나는 벌 받고 있다고 느끼지 않는다.
   1 나는 벌을 받을지도 모른다고 느낀다.
   2 나는 벌을 받을 것이다.
   3 나는 이미 벌을 받고 있다고 느낀다.
7. 0 나는 나 스스로에 대해 실망하지 않는다.
   1 나는 나 스스로에 대해 실망한다.
   2 나는 나를 역겹게 여긴다.
   3 나는 나를 증오한다.
8. 0 나는 자신을 다른 누구보다 못하다고는 생각지 않는다.
   1 나는 자신의 약점과 실수에 대해 비판적이다.
   2 나는 나의 실수를 가지고 언제나 나를 질책한다.
   3 나는 무슨 나쁜 일이 일어날 때마다 나 자신을 질책한다.

9. 0 나는 자살할 생각이 전혀 없다.
1 나는 자살할 생각은 있으나, 실행하지는 않겠다.
2 나는 자살할수 있으면 좋겠다.
3 나는 기회만 되면 자살하겠다.

10. 0 전보다 더 우는건 아니다.
1 요즘은 전보다 더 많이 운다.
2 요즘은 언제나 운다.
3 전에는 울수가 있었는데 요즘은 울고 싶어도 울수조차 없다.

11. 0 전과 같은 정도로 요즘도 속상해할 뿐이다.
1 전보다 조금은 더 쉽게 속상해 한다.
2 요즘은 상당히 많은 시간을 속상해 한다.
3 요즘은 언제나 속상해 한다.

12. 0 다른 사람에 대한 관심과 배려를 잃지 않고 있다.
1 전보다 다른 사람들에 대한 관심과 배려가 줄었다.
2 다른 사람에 대해 거의 관심과 배려를 가질수 없다.
3 다른 사람에 대한 관심을 완전히 잃어 버렸다.

13. 0 이전과 마찬가지로 결정해야할 일에 결단을 내릴수가 있다.
1 이전보다 결정을 미루는 경우가 많다.
2 전보다 결정하는 것이 더욱 어렵게 느껴진다.
3 전혀 아무런 결정도 할수 없게 되었다.

14. 0 전보다 내 외모가 못나 보인다고는 생각지 않는다.
1 전보다 더 늙어 보이고, 내 외모가 못나 보인다고 걱정한다.
2 이제는 영영 고칠수 없게, 아주 내 외모가 못나 보인다는 느낌이다.
3 누가 뭐라고 해도 나는 밉게 되어버렸다고 생각한다.

15. 0 전만큼 일을 잘 해낼수 있다.
1 요즘은 무슨 일을 시작하려면 이전보다 힘이 더 든다.
2 무슨 일을 하려면 무리를 해서라도 나를 힘껏 밀어붙여야만 하게 되었다.
3 아무것도 해낼수가 없다.

16. 0 전만큼 잠을 잘 잔다.
1 전만큼 잠을 잘 못잔다.
2 전보다 한두 시간 일찍 깨게 되고, 다시 잠들기가 어렵다.
3 전보다 더 여러 시간 일찍 깨게 되고 전혀 다시 잠들수가 없다.

17. 0 전보다 쉽게 피곤해지는 것은 아니다.
1 전보다 쉽게 피곤해진다.
2 무엇을 하던지 거의 언제나 피곤해진다.
3 너무 피곤해서 아무것도 할수가 없다.

18. 0 전보다 식욕이 나빠진건 아니다.

1 전만큼 식욕이 좋지 않다.

2 전보다는 식욕이 아주 좋지 않다.

3 식욕이 아주 없어졌다.

19. 0 전과 비교해서 최근에 체중이 줄지 않았다.

1 체중이 5파운드(2-3 킬로그람) 이상 줄었다.

2 체중이 10파운드(4-5 킬로그람) 이상 줄었다.

3 체중이 15파운드(6-8 킬로그람) 이상 줄었다.

*체중을 줄이려고 적게 먹는다. (예, 아니오)

20. 0 내 건강에 대해서 전보다 더 걱정하는 것은 아니다.

1 통증, 소화불량, 변비 같은 신체적인 증상에 대해서 걱정된다.

2 내 건강 문제에 대해서 걱정이 많아서 다른 생각을 하기 어렵다.

3 내 건강 문제에 대해서 너무나 걱정이 되어 다른 생각은 전혀 할수가 없다.

21. 0 나의 기력에 대한 변화는 별로 없는것 같다.

1 기력의 부족을 좀 느낀다.

2 기력이 아주 줄었다.

3 기력이 아주 없어졌다.

도움을 받을수 있는 귀하의 주변 사람들

다음 문항들은 귀하 주변에서 도움을 주거나 지원해 주는 사람들에 대한 것입니다. 아래의 보기에서와 같이 다음 항목들에 대해 빠짐없이 대답하여 주십시오. 문항 내용에 대해 도움 주시는 분이 없으면 "아무도 없다"에 표시해 주십시오. 각 문항에 9명 이상은 쓰지 말아 주십시오.

(보기)

다른 사람이 알면 안되는 일을 믿고 말할수 있는 사람은 누구입니까?

"아무도 없다"	1) 친구 A	4) 시어머니	7) 의사
( )	2) 친구 B	5) 고용주	8) 언니
	3) 친정 어머니	6) 상담원	9) 고모

만족도:

6	(5)	4	3	2	1
대단히 만족	꽤 만족	약간 만족	약간 불만	꽤 불만	아주 불만

*이 대답은 "꽤 만족한 상태"를 나타내는 것입니다.

이제 일반적으로 현재 당신의 위치에서 어떻게 느끼고 있는지를 대답해 주시기 바랍니다.

(1) 가) 오락, 쇼핑, 대화, 방문 같은 일들은 주로 누구와 함께 하십니까?

"아무도 없다"	1)	4)	7)
( )	2)	5)	8)
	3)	6)	9)

나) 그와같은 사귐에 있어서 시간의 길이에 대해 얼마나 만족하십니까?

6	5	4	3	2	1
대단히 만족	꽤 만족	약간 만족	약간 불만	꽤 불만	아주 불만

다) 그러한 사귐에 있어서 사귐의 내용과 질 면에 있어서는 얼마나 만족하십니까?

6	5	4	3	2	1
대단히 만족	꽤 만족	약간 만족	약간 불만	꽤 불만	아주 불만

(2) 가) 실제적인 도움(집안일, 경제적인 도움 같은것)이 필요할때 누구에게서 받을수 있읍니까?

"아무도 없다" ( )	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

나) 이런 도움을 받는 그 횟수와 정도에 어느만큼 만족하십니까?

6	5	4	3	2	1
대단히 만족	꽤 만족	약간 만족	약간 불만	꽤 불만	아주 불만

다) 이런 도움의 내용과 질면에서는 어느 만큼 만족하십니까?

6	5	4	3	2	1
대단히 만족	꽤 만족	약간 만족	약간 불만	꽤 불만	아주 불만

(3) 가) 때때로 사람들은 다른 이의 지도(충고,정보제공,문제를 분별해 해결해 주는 일 같은)를 받곤 합니다. 이런 지원을 받을때 어떤 사람들을 찾게 됩니까?

"아무도 없다"	1)	4)	7)
( )	2)	5)	8)
	3)	6)	9)

나) 이런 지도를 받는 양적인 정도에 대해 어느 만큼 만족하십니까?

6	5	4	3	2	1
대단히 만족	꽤 만족	약간 만족	약간 불만	꽤 불만	아주 불만

다) 이런 지도의 내용과 질면에서는 어느 만큼 만족하십니까?

6	5	4	3	2	1
대단히 만족	꽤 만족	약간 만족	약간 불만	꽤 불만	아주 불만

(4) 가) 귀하의 역할에 대한 반응(칭찬,고마운 표시,비판,질책···)은 주로 어떤 사람들에게서 받으십니까?

"아무도 없다"	1)	4)	7)
( )	2)	5)	8)
	3)	6)	9)

나) 그러한 다른 사람들의 반응의 크기와 정도에 어느 만큼 만족하십니까?

6	5	4	3	2	1
대단히 만족	꽤 만족	약간 만족	약간 불만	꽤 불만	아주 불만

다) 그러한 다른 사람들의 반응의 내용과 질에 대해서는 얼마나 만족하십니까?

6	5	4	3	2	1
대단히 만족	꽤 만족	약간 만족	약간 불만	꽤 불만	아주 불만

(5) 가) 때로는 정서적인 도움(동정,이해,사랑,믿음···)을 받을수 있는데, 누구에게서 받습니까?

"아무도 없다"	1)	4)	7)
( )	2)	5)	8)
	3)	6)	9)

나) 이러한 정서적인 도움의 크기와 정도에 대해서 얼마나 만족하십니까?

6	5	4	3	2	1
대단히 만족	꽤 만족	약간 만족	약간 불만	꽤 불만	아주 불만

다) 이러한 정서적 도움의 내용과 질에는 얼마나 만족하십니까?

6	5	4	3	2	1
대단히 만족	꽤 만족	약간 만족	약간 불만	꽤 불만	아주 불만

(6) 가) 다른 사람의 보살핌에 싸여 안정과 위로를 받은 적이 있다면, 그들은 누구입니까?

"아무도 없다"	1)	4)	7)
( )	2)	5)	8)
	3)	6)	9)

나) 이렇게 받은 위안의 크기와 정도에 대해서 얼마나 만족하십니까?

6	5	4	3	2	1
대단히 만족	꽤 만족	약간 만족	약간 불만	꽤 불만	아주 불만

다) 이렇게 받은 위안의 내용과 질에 대해서는 얼마나 만족하십니까?

6	5	4	3	2	1
대단히 만족	꽤 만족	약간 만족	약간 불만	꽤 불만	아주 불만

(7) 가) 일상생활을 하는데 있어서 귀하가 돌보아야함, 귀하에게 의존하는 사람들이 있읍니까?

"아무도 없다"	1)	4)	7)
( )	2)	5)	8)
	3)	6)	9)

나) 귀하가 다른 사람을 돌보아야 하는 그 책임의 크기와 정도에 대해 얼마나 만족하십니까?

6	5	4	3	2	1
대단히 만족	꽤 만족	약간 만족	약간 불만	꽤 불만	아주 불만

다) 귀하는 지금까지 보다 더 많이 또는 더 적게 다른 사람을 돌보기를 원하십니까? (V 표 해주세요.)

_____더 많이 _____적당함 _____더 적게

(8) 가) 귀하의 지도와충고를 바라고 오는 사람이 있읍니까?

"아무도 없다"	1)	4)	7)
( )	2)	5)	8)
	3)	6)	9)

나) 이런 지도를 받으러 오는 사람들의 수에 만족하십니까?

6	5	4	3	2	1
대단히 만족	꽤 만족	약간 만족	약간 불만	꽤 불만	아주 불만

다) 더 많이 또는 더 적기를 바라십니까? (V 표 해주세요.)

_____더 많이 _____적당함 _____더 적게

(9) 가) 귀하가 해주는 일에 대해 참으로 고맙게 생각하는 사람이 있읍니까?

"아무도 없다"	1)	4)	7)
( )	2)	5)	8)
	3)	6)	9)

나) 고맙게 생각하는 표시를 받는 정도(양적인)에 얼마나 만족하십니까?

6	5	4	3	2	1
대단히 만족	꽤 만족	약간 만족	약간 불만	꽤 불만	아주 불만

다) 고맙게 생각하는 그 표시의 내용에 대해 얼마나 만족하십니까?

6	5	4	3	2	1
대단히 만족	꽤 만족	약간 만족	약간 불만	꽤 불만	아주 불만

(10) 가) 어떤 도움을 필요로 하는 처지에 놓였을때, 귀하의 가족들에게 도움을 청하기가 어렵습니까?

(한가지에만 v 표 하세요.)

1) 어떤 경우에도 어렵다.
2) 대부분의 경우에 어렵다.
3) 많은 경우에 어렵다.
4) 어떤 경우에는 어렵다.
5) 어떤 경우에도 어렵지 않다.

나) 도움이 필요할때 귀하의 친구들에게 도움을 청하기가 어렵습니까?

(한가지에만 v 표 하세요.)

1) 어떤 경우에도 어렵다.
2) 대부분의 경우에 어렵다.
3) 많은 경우에 어렵다.
4) 어떤 경우에는 어렵다.
5) 어떤 경우에도 어렵지 않다.

(11) 가) 도움이 필요할때, 도움을 주려는 가족의 도움을 받아들이기가 어렵습니까?

(한가지에만 V 표 하세요.)

1) 어떤 경우에도 어렵다.
2) 대부분의 경우에 어렵다.
3) 많은 경우에 어렵다.
4) 어떤 경우에는 어렵다.
5) 어떤 경우에도 어렵지 않다.

나) 도움이 필요할때, 도움을 주려는 친구의 도움을 받아들이기가 어렵습니까?

(한가지에만 V 표 하세요.)

1) 어떤 경우에도 어렵다.
2) 대부분의 경우에 어렵다.
3) 많은 경우에 어렵다.
4) 어떤 경우에는 어렵다.
5) 어떤 경우에도 어렵지 않다.

(12) 가) 전반적으로 지금 귀하가 받는 도움과 지원에 대해서 얼마나 만족하십니까?

6	5	4	3	2	1
대단히 만족	꽤 만족	약간 만족	약간 불만	꽤 불만	아주 불만

나) 지금 귀하가 외롭이이고 외롭다는 느낌을 얼마나 자주 갖게 되십니까?

5	4	3	2	1
전혀 없음	드물게 있음	가끔 있음	자주 있음	언제나

집안에서 받는 도움

다음의 문항들에 대해서 답해주시면 감사하겠읍니다.

낳은 아이: 딸( )
아들( )

(1) 갓난아이를 돌보는데 도와주는 사람이 있읍니까? (본인과의 관계로 적어주십시오. 보기: 시누이, 친정 어머니, 올케, 파출부···)

"아무도 없음"	1)	4)	7)
( )	2)	5)	8)
	3)	6)	9)

(2) 다음은 각 기간별로 도와주셨던 분들 모두를 도와주신 시간의 양에 맞추어 아래의 빈 칸에 적어 넣는 것입니다.

	산후 첫주간	산후 3주간	그 이후
같이 살며 도와줌			
매일 7시간 이상			
매일 3-4시간			
매일 그보다 짧게			
매주 2-3일(7시간 이상)			
매주 2-3일(3-4시간)			
매주 2-3일(그보다 짧게)			
매주 하루(7시간 이상)			
매주 하루(3-4시간)			
매주 하루(그보다 짧게)			
필요한 때는 언제나			

(3) 도움 받은 시간의 양에 대해서 얼마나 만족하셨읍니까?

6	5	4	3	2	1
대단히 만족	꽤 만족	약간 만족	약간 불만	꽤 불만	아주 불만

(4) 원하시는 종류의 도움을 받으셨읍니까?

6	5	4	3	2	1
대단히 만족	꽤 만족	약간 만족	약간 불만	꽤 불만	아주 불만

(5) 도와주신 사람과 편안한 관계입니까?

6	5	4	3	2	1
대단히 편안함	꽤 편안함	약간 편안함	약간 불편함	꽤 불편함	아주 불편함

어떻게 어려움을 극복하십니까?

살아가면서 겪는 문제들을 어떻게 극복하셨는지를 알아보려 합니다. 우선 지난 두달 동안 일어난 어려운 일들이나 혹은 그전에 있었던 일이지만 아직도 어려움이 남아 있는 것들을 구체적으로 적어 주십시오. 다음 항목들을 보시고 지난 두달동안 개인적으로 부닥친 문제들의 항목에 (V)표를 해 주십시오.

(1) 인간관계 문제 ..... ( )

(보기: 남편/남자친구,부모,형제,자매 사이의 문제,또는 가정문제나 싸움에 휘말려든 경우, 앞으로도 관계를 끊을수 없는 중요한 사람과의 나빠진 인간관계)

(2) 죽음 ..... ( )

(보기: 귀하와 가까운 이의 죽음, 특히 어머니,아버지,형제,자매,자녀,절친한 친구의 죽음이나 또는 귀하가 죽은 사람을 보았거나, 장례식에 갔거나, 슬픔당한 사람을 위로한 경우)

(3) 원하는 목표를 이루지 못한 경우 ..... ( )

(보기: 중요한 시험, 원하던 진로, 그밖에도 귀하에게 중요한 일을 성취하지 못하고 실패한 경우)

(4) 위기나 사고 ..... ( )

(보기: 죽음 이외의 사고, 곧 귀하 자신이나 귀하에게 가까운 이가 홍수, 화재, 사고, 부상을 당했거나 기대치 않게 직업을 잃었거나, 예상하지도 않았던 문제를 당한 경우)

(5) 자신이 범죄사건의 피해자가 된 경우 ..... ( )

(보기: 도난 사건, 신체적 피해, 그밖에 여러가지 범죄행위의 피해자가 된 경우)

(6) 개인적인 건강 문제 ..... ( )

(보기: 전신마취가 필요한 수술, 생명에 위태로운 병, 불구나 불능을 가져올수 있는 병, 또는 한달 이상 집에서의 요양이 필요한 경우)

(7) 어머니의 역할 ..... ( )

(보기: 최근에 아기를 낳았거나 자녀가 중요한 시험을 치를 준비중에 있는 경우)

(8) 돌보는 책임 ..... ( )

(보기: 노인이나 친척을 장기적으로 돌보는 일이나, 거동이 불편한 이를 위해 오랫동안 잔일을 가외로 해야하는 경우)

(9) 그밖의 일들 ..... ( )

(위의 항목들에 해당되지 않더라도 당신에게 어려움을 안겨 주었거나 마음에 부담을 주었던 괴로운 일을 경험했던 경우)

이제는 앞에서 표시한 항목들에 대해 구체적인 내용을 간단히 적어 주십시오. 그리고 표시하지 않은 항목은 비워 두십시오. 사건이 어머가지일지라도 그것들 모두를 적어 주시면 감사하겠읍니다

(1) 인간관계 문제

구체적으로 언제쯤 일어난 일인지요

(2) 죽음

구체적으로 언제쯤 일어난 일인지요

(3) 원하는 목표를 이루지 못한 경우

구체적으로 언제쯤 일어난 일인지요

(4) 위기나 사고

구체적으로 언제쯤 일어난 일인지요

(5) 자신이 범죄사건의 피해자가 된 경우

구체적으로 언제쯤 일어난 일인지요

(6) 개인적인 건강문제

구체적으로 언제쯤 일어난 일인지요

(7) 어머니의 역할

구체적으로 언제쯤 일어난 일인지요

(8) 돌보는 책임

구체적으로 언제쯤 일어난 일인지요

(9) 그밖의 일들

구체적으로 언제쯤 일어난 일인지요