

## Depression, Anxiety, and Attributional Style in a New Zealand Sample of Children

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Although maladaptive explanatory style correlates with depression, research has also linked maladaptive attributions with anxiety, suggesting that attributional style cognitions are not unique to depression. Minimal work has explored whether the pattern of relationships among attributional style, depression, and anxiety holds across cultures. Thus, the current study examined these relationships in a sample of New Zealand children and evaluated the specificity of maladaptive attributional cognitions to depression. Sixty-nine New Zealand school children ages 8 to 14 responded to three self-report measures: Children's Depression Inventory, Children's Manifest Anxiety Scale-Revised, Children's Attributional Style Questionnaire. Scores on the measures were comparable in some respects with those previously reported in the literature. Both depression and anxiety scores were significantly correlated with attributional style. However, multiple regression analysis revealed that depression but not anxiety significantly predicted overall attributional style. Thus, anxiety was no longer significantly correlated with maladaptive explanatory style upon controlling for depression. Given the high comorbidity of anxiety and depression, the present results have implications for prior research finding maladaptive attributions in other forms of psychopathology without controlling for depression.

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Nearly two decades ago, cognitive theorists proposed the attributional reformulation of the learned helplessness model of depression (Abramson, Seligman, & Teasdale, 1978; Abramson, Metalsky, & Alloy, 1989). Since then a substantial body of research has amassed supporting the theorized link between attributional style and depression. Attributional or explanatory style refers to how individuals account for positive and negative events. The internal-external dimension of attributional style refers to whether an individual attributes causes of events to themselves or to some outside force. The global-specific dimension involves whether the attributed cause of an event can occur across situations or only on specific occasions. Stability-instability refers to whether the cause is perceived by an individual as transient or permanent. The attributional theory of depression proposes that depressed individuals tend to attribute negative outcomes to internal, stable, global causes and positive events to external, unstable, specific causes (Abramson et al., 1978).

The presence of this maladaptive attributional style in individuals who display depressive symptomatology has been demonstrated in clinical and non-clinical samples for both adults (e.g., Sweeney, Anderson & Bailey, 1986) and children (e.g., Gladstone & Kaslow, 1995; Kaslow, Rehm & Siegel, 1984; Nolen-Hoeksema, Girgus, & Seligman, 1986). Gladstone and Kaslow's (1995) meta-analytic review of 28 studies on depression and attributional style in children and adolescents found depressive symptomatology was significantly associated with internal-stable-global attributions for negative outcomes and external-unstable-specific attributions for positive outcomes. Although such research efforts generally do not clarify the direction of causality, one

five-year longitudinal study of children found maladaptive explanatory style predicted the subsequent development of depressive symptomatology (Nolen-Hoeksema, Girgus, & Seligman, 1992), suggesting maladaptive attributional style precipitates depressive symptoms.

However, some researchers have suggested that maladaptive attributional style may characterize psychopathology in general rather than depression specifically (e.g., Benfield, Palmer, Pfefferbaum, & Stowe, 1988). Compared to depression, the study of anxiety as related to attributional style has been relatively neglected despite the high comorbidity of depression and anxiety. Supporting the need for research on anxiety, Houston (1995) found that attributional style was actually more predictive of anxiety than depression. One study found that depressed adolescents scoring highly on a measure of anxiety reported more maladaptive attributions than purely depressed adolescents (Curry & Craighead, 1990). Some have thus postulated that anxiety and depression, rather than representing distinct constructs, in fact form a general negative affectivity construct (Bell-Dolan & Wessler, 1994; Wolfe, Finch, Saylor, Blount, Pallmeyer, & Carek, 1987).

A maladaptive attributional style for positive, rather than for negative events, may be more specific to depression than for other forms of psychopathology (Benfield et al., 1988; Curry & Craighead, 1990). A recent study of the specificity of attributional style patterns found that maladaptive attributions for negative events were associated with both anxiety and depression, whereas maladaptive attributions for positive events were related to depression but not anxiety (Ahrens & Haaga, 1993). Such findings emphasize the ambiguity regarding the uniqueness of certain attributional patterns to depression. More research needs to include both anxiety and depression to further clarify distinctions in attributional style patterns.

Moreover, despite New Zealand clinicians' reliance on cognitive-behavioral principles, research has not established whether attributional patterns parallel overseas findings. Standard clinical practice in New Zealand also often involves the use of measures designed and standardized overseas, applied to New Zealanders based on the assumption that a shared language translates into shared psychological constructs. However, concerns about the direct utilization of psychological measures cross-culturally has been previously raised because New Zealand children may not approach and/or comprehend such measures exactly as their overseas counterparts (Tripp & Lodge, 1993).

No published studies have been conducted in New Zealand on the relationships among maladaptive attributional style, depression, and anxiety. A few studies are available pertaining to children's causal attributions on areas such as success or failure in educational contexts (Chapman & Lawes, 1984; Nicholls, 1978) and unemployment (Singer & Stacey, 1986), although these studies do not examine links to depression or anxiety. A psychometric evaluation of two anxiety questionnaires with school children led one group of researchers to recommend local normative data because of differences found between the New Zealand sample and comparison groups from Britain and Canada (Saklofske, McKerracher & Cameron, 1982). Consequently, such findings highlight the need for more stringent evaluation of measures that have been standardized in other countries, and research needs to confirm the comparability of psychological constructs, such as attributional patterns, cross-culturally.

The current study investigated whether New Zealand children demonstrate a maladaptive attributional style associated with depressive or anxious symptomatology. Multiple hierarchical regression analyses were performed to determine whether depression and anxiety contributed significant unique variance to attributional style in an attempt to explore the uniqueness of maladaptive attributional style to depression. The investigation also examined whether the pattern of maladaptive attributional style with depression and anxiety exists cross-culturally and whether the descriptive data for measures of depression, anxiety, and attributional style are comparable to overseas reports.

## Method

### Participants

Sixty-nine children (30 girls, 39 boys) ages 8 to 14 years ( $M = 11.1$ ,  $SD = 1.3$ ) were recruited from primary and intermediate schools in the Dunedin area. With regard to ethnic identification, the major group sampled was Pakeha/European New Zealander (85.5%), with 8.7% of Maori descent, and 5.8% 'Other' (including Pacific Islander, Asian, and unspecified). The majority of children sampled lived with both biological parents (59.4%), with the remaining subjects in either single-parent homes (18.8%), reconstituted families with step-parents (14.5%), or other custodial relatives (e.g., grandparent; 7.2%). Distribution of the sample based on annual family income was as follows: \$14,999 or less, 11.9%; \$15,000–29,999, 25.4%; \$30,000–44,999, 26.9%; \$45,000 or more, 35.8%.

## Measures

The *Children's Attributional Style Questionnaire* (CASQ; Kaslow, Tanenbaum & Seligman, 1978; Seligman, Peterson, Kaslow, Tanenbaum, Alloy & Abramson, 1984) is a 48-item forced-choice measure designed to assess attributional style in children ages 8 to 18 years. Children select one of two options that best explains why a hypothetical situation in each item would happen to them. The hypothetical situations vary along the three attributional dimensions of internality, stability, and globality, with half of the items involving negative outcomes and half positive outcomes. Thus, the CASQ yields dimensional scores (Internal Total, Stable Total, and Global Total) as well as a CASQ Total Composite score, calculated by subtracting the Negative Total score from the Positive Total score. Lower Total Composite and Positive Total scores and higher Negative Total scores correspond to more maladaptive attributional styles. To facilitate children's understanding, minor wording modifications were implemented for 10 items to reflect differences in New Zealand terminology (e.g., "mark" replaced "grade"; "lollies" for "candy").

With regard to psychometric characteristics, moderate coefficient alphas were reported for the CASQ Total Composite, Positive Total, and Negative Total scores (.73, .71, and .66 respectively; Seligman et al., 1984). A more recent study of a large sample of adolescents reported somewhat lower internal consistency for the Total Composite, Positive Total, and Negative Total scores (.56, .45, and .58 respectively; Gladstone, Kaslow, Seeley, & Lewinsohn, in press; Gotlib, Lewinsohn, Seeley, Rohde, & Redner, 1993). The temporal stability over six months was reported as .71 for Positive Total and .80 for Negative Total (Seligman et al., 1984), and for one year, .48 for Positive Total, .54 for Negative Total, and .56 for Total Composite (Gladstone et al., in press; Gotlib et al., 1993).

The *Children's Depression Inventory* (CDI; Kovacs, 1983, 1985) is a 27-item self-report measure of depressive symptoms suitable for children ages 8 to 17 years. Each item presents three statements representing graded levels of depressive severity, valued from 0 to 2. Higher total scores are indicative of more severe depressive symptomatology. Kazdin (1990) reports that the CDI has moderate test-retest stability, high internal consistency, and concurrent validity with other measures of depression. High internal consistency is reported for both children and adolescents, ranging from .83 to .94 (Saylor, Finch, Spirito, & Bennett, 1984; Smucker, Craighead, Craighead, & Green, 1986).

The *Children's Manifest Anxiety Scale—Revised* (CMAS-R; Reynolds & Richmond, 1978, 1985) is a 37-item self-report measure of anxiety symptoms for children ages 6 to 19 years. Each item is presented in a *Yes/No* format. The Total score indicative of overall anxiety level is converted to a standardized T-score which adjusts for age and gender differences. Nine items contribute to the Lie scale, designed to detect social desirability responding. The CMAS-R correlates more highly with internalizing than externalizing behaviours and the internal consistency of the Total score is reported at .82 (Reynolds, 1982; Reynolds & Richmond, 1985).

## Procedure

Interested caregivers returned contact information sheets sent home from the child's school. A convenient time for a session in the child's home was arranged by telephone. Upon arrival to the home, the caregiver reviewed the questionnaires prior to providing written informed consent. Children's written informed consent was also obtained following a study description that assured confidentiality unless their responses were clinically significant (which then required a follow-up phone consultation with the parent regarding the possibility of psychological referral). After consent was acquired, the child was taken to a quiet place in the home to complete the measures. The three questionnaires were administered to the sample of children in a counterbalanced order. Each item was read aloud to the child while they read along and wrote their answers privately on a separate form. After completing the three forms, the child was given either a \$2 video hire token or a \$2 video games voucher as a token of appreciation for their participation.

## Results

Means and standard deviations were calculated for the total scores of all three measures as well as the CASQ Positive, Negative, and dimensional scores (Internal, Stable, Global; see Table 1). Table 1 also displays the Pearson correlations for the three self-report measures. Initially, the pattern of associations between attributional style and depression and anxiety were evaluated. Multiple regression procedures were first employed to assess whether CASQ Positive and Negative Total scores predict CDI and CMAS-R Total scores. Both CASQ Positive and Negative Total scores contributed unique variance in predicting CDI scores,  $F(1, 66) = 9.99, p \leq .01$  and  $F(1, 66) = 9.44, p \leq .01$ , respectively. With both Positive and Negative scores in the equation,  $R^2 = .23$ ,  $F(2, 66) = 9.91, p \leq .001$ . In contrast, the CASQ Negative Total scores significantly predicted CMAS-

**Table 1:** Means, Standard Deviations, and Correlations for CDI, CMAS-R, and CASQ Scores

	Mean	(SD)	CDI ( <i>r</i> )	CMAS-R Total ( <i>r</i> )
<b>CDI Total</b>	8.45	(5.83)		
<b>CMAS-R Total</b>	48.84	(10.52)	.70**	
Lie Scale	8.83	(4.20)	-.22	-.31*
<b>CASQ Total Composite</b>	4.75	(4.19)	-.48**	-.34*
Positive Total	12.59	(3.25)	-.35*	-.18
Negative Total	7.84	(2.58)	.34*	.33*
Internal Total	7.78	(1.81)	-.14	-.04
Stable Total	6.06	(2.33)	-.05	.07
Global Total	6.59	(1.99)	.06	.10

\*  $p \leq .01$ \*\*  $p \leq .001$ 

R Total scores,  $F(1, 66) = 8.32, p \leq .01$ , but the CASQ Positive Total scores did not predict the CMAS-R Total scores,  $F(1, 66) = 2.30, p > .05$ .

To determine whether CDI and CMAS-R Total scores contribute significant unique variance to subjects' CASQ Total Composite scores, hierarchical regression techniques were conducted. A summary of these regression findings appear in Table 2. This table shows the unstandardized regression coefficients (*B*) and intercept, the standardized regression coefficients (Beta weights), the semipartial correlations ( $sr^2$ ), the multiple correlation coefficient (*R*), the squared multiple correlation coefficient ( $R^2$ ), and the adjusted squared multiple correlation (adjusted  $R^2$ ).

The CDI scores were entered first because, based on the research focus on the relationship between depression and attributional style, the CDI was theorized to be the more salient factor of interest. After the first step, with CDI Total scores added into the regression equation,  $R^2 = .23, F(1, 66) = 19.87, p \leq .001$ . At the second step, with CMAS-R Total scores added into the equation,  $R^2 = .23, F(1, 66) = .016, p > .05$ . With both CDI and CMAS-R Total scores entered into the equation, the multiple correlation coefficient was  $R = .48, F(2, 66) = 9.80, p \leq .001$ . Thus, the addition of the CMAS-R Total scores into the equation did not improve  $R^2$ . To test the theorized model further, a similar hierarchical regression analysis performed entering CMAS-R Total scores first into the equation confirmed that the CMAS-R adds no significant unique variance in CASQ Total Composite scores ( $p > .05$ ).

With regard to the cross-cultural utility of the measures, Table 1 indicates that the obtained mean score for the CDI is within the range reported in the overseas literature (8-10; Reynolds, 1994). In addition, the CMAS-R Total scores are standardized T-scores,

so the mean reported in Table 1 of 48.84 approximates the normative sample mean in the CMAS-R manual (Reynolds & Richmond, 1985). However, a substantial minority (38%) obtained elevated CMAS-R Lie scores (i.e., at or above the 92nd percentile), thus notably more frequent than the normative sample. The mean Total Composite CASQ score of 4.75 in the present study is significantly lower than the mean of 6.1 reported in the overseas literature (Seligman, et al., 1984), one sample  $t(68) = -2.67, p \leq .01$ . The mean obtained for CASQ Positive Total of 12.59 was similarly significantly lower than the mean of 13.81 previously reported (Nolen-Hoeksema et al., 1992), one sample  $t(68) = -3.11, p \leq .01$ . However, the mean of 7.84 CASQ Negative Total in the current study was comparable to that reported previously ( $M = 7.56$ ; Nolen-Hoeksema et al., 1992).

Next, the correlations between the outcome measures were compared to those previously reported in the literature in a further cross-cultural comparison. The CDI Total scores were significantly negatively correlated with the CASQ Total Composite and Positive Total scores and significantly positively correlated with the CASQ Negative Total scores. The correlations obtained are similar in magnitude to those reported previously in the literature (obtained CDI correlations with CASQ Total, Positive, and Negative of .48, .35, .34 compared with meta-analytic findings of .50, .36, .38, respectively; see Gladstone & Kaslow, 1995; Gladstone et al., in press). In addition, a strong positive correlation of .70 for the CDI Total scores with the CMAS-R Total scores is comparable to that obtained in an overseas study ( $r = .67$ ; Reynolds, Anderson, & Bartell, 1985). Also seen in Table 1, CMAS-R Total scores were significantly negatively correlated with the CASQ Total Composite scores and

positively correlated with the CASQ Negative Total scores. Although minimal research has correlated the CMAS-R Total with the CASQ Total Composite, one small overseas study reported a correlation comparable in magnitude to the  $r = -.34$  obtained in the present study ( $r = -.27$ ; Rodriguez & Routh, 1989).

## Discussion

The present study investigated the pattern of relationships among depression, anxiety, and attributional style in a non-clinical sample of New Zealand children. Research has yet to clarify whether maladaptive attributions are unique to depression or characteristic of affective psychopathology in general. In addition, to date, the research on associations among these three constructs has been conducted overseas. This reliance on overseas research rests on assumptions that the measures as well as the maladaptive attributional style associated with depression and anxiety are comparable cross-culturally.

Initial regression analyses indicated that, although maladaptive attributions for negative events was predictive of both depressive symptomatology and anxiety, attributions for positive events was predictive of only depression scores. Further hierarchical multiple regression analyses indicated that anxiety scores were *not* significantly associated with attributional style upon controlling for depression. In terms of cross-cultural utility of the measures, results of the current study supported the comparability of New Zealand children's performance on some aspects of the three self-report measures (Children's Depression Inventory, Children's Manifest Anxiety Scale-Revised, and Children's Attributional Style Questionnaire) with that of overseas children. In addition, maladaptive attributional style was correlated with depressive and anxious symptomatology similar to that found overseas

(cf. Gladstone & Kaslow, 1995; Rodriguez & Routh, 1989).

The regression analyses indicated that CASQ Negative Total and Positive Total scores were both predictive of CDI scores, but only CASQ Negative Total scores predicted CMAS-R Total scores. This result supports one study's finding that maladaptive attributions for negative events were associated with both anxiety and depression, whereas maladaptive attributions for positive events were related only to depression (Ahrens & Haaga, 1993). Furthermore, these findings support the suggestion that a maladaptive attributional style for positive, rather than for negative events, is more specific to depression than for anxiety (Benfield et al., 1988; Curry & Craighead, 1990).

However, multiple regression analyses indicated that CMAS-R anxiety scores did not account for significant unique variance in CASQ Total Composite scores beyond that variance already accounted for by the CDI. Thus, anxiety was no longer correlated with maladaptive attributional style when controlling for depressive symptomatology. This finding suggests that overall maladaptive attributional style is indeed more specific to depression. Perhaps prior links between anxiety and attributional style did not adequately address issues of comorbidity or statistical control of the effects of depression.

With regard to the cross-cultural comparison of constructs, mean total scores for both the CDI and CMAS-R were comparable to that previously reported in the literature (cf. Reynolds & Johnston, 1994 and Reynolds & Richmond, 1985, respectively). These results appear to support the utility of these measures in the assessment and diagnosis of depression and anxiety in New Zealand children. However, a significant percentage of the present sample obtained

**Table 2:** Hierarchical Multiple Regression of CDI and CMAS-R Total Scores on CASQ Total Composite Scores

	CASQ Total	CDI Total	B	Beta	$sr^2$ <sup>a</sup>
CDI Total	-.48**		-.334	-.465	.23**
CMAS-R Total	-.34*	.70**	-.008	-.020	.00
Intercept = -7.95					
$R^2 = .23$					
Adjusted $R^2 = .21$					
$R = .48**$					

\*  $p \leq .01$

\*\*  $p \leq .001$

<sup>a</sup> Incremental change in  $R^2$

elevated Lie scores on the CMAS-R (at or above the 92nd percentile), which is more frequent than for the overseas normative sample. The Lie scale is designed to detect social desirability of responding, which would suggest that the children in the current study were attempting for some reason to present themselves in a more positive manner. The implication remains that in clinical contexts, the CMAS-R Lie scale may be of questionable utility with New Zealand children.

Investigation of the descriptive data obtained for the CASQ found only the Negative Total score comparable to previous reports in the literature (cf. Nolen-Hoeksema et al., 1992). Both the CASQ Total Composite and Positive Total mean scores found in the present study were significantly lower than that reported in the overseas literature, which suggests the current sample exhibited more maladaptive attributional styles. Given the nature of the CASQ, specified scores are not considered clinically significant but simply informative. Thus, further research needs to establish whether New Zealand children are more susceptible to manifesting maladaptive attributional styles.

The correlations among the CDI, CMAS-R, and the CASQ obtained for the present study were comparable to intercorrelations reported in previous literature, supporting that the pattern of relationships found overseas occurs cross-culturally. In support of the vast amount of research on the strong comorbidity of anxiety and depression (e.g., Norvell et al., 1985), the CDI and CMAS-R Total scores were significantly correlated, which would suggest a strong relationship between symptoms of anxiety and depression for New Zealand children. However, concerns have been raised regarding overlap in item content between the measures, which would contribute to the strong correlations (Bell-Dolan & Wessler, 1994).

The present study involved a small sample of children from Dunedin, which may not represent New Zealand children in general. Comparison of the current sample characteristics with the 1991 New Zealand Census (Department of Statistics, 1992) indicates that although family composition and annual family income approximate Census distributions for Dunedin and New Zealand overall, ethnic grouping in the current sample is underrepresented by those of Maori descent. Ultimately, a larger sample of children from various regions in New Zealand would be needed to replicate the findings for cross-cultural comparability. Furthermore, the results reported here involve a non-clinical sample, so future research should involve clinical samples of New Zealand children.

An additional direction for future research would

involve the use of different measures of the three constructs investigated because of the present study's reliance on self-report measures (i.e., the conclusions may have been enhanced by shared method variance). Moreover, a comprehensive multitrait-multimethod study involving depression and anxiety may clarify whether the prior association between anxiety and attributional style is actually because of comorbid depressive symptomatology. For example, a study could examine attributional style in a group of children with comorbid anxiety and depression compared to a group of children presenting with anxiety alone. Such a research design could clarify whether cognitive behavioral techniques such as attributional retraining would benefit children presenting with anxiety problems in the absence of depressive symptoms. Given the high comorbidity of anxiety and depression, the present results have implications for prior research finding maladaptive attributions in other forms of psychopathology without controlling for depression.

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