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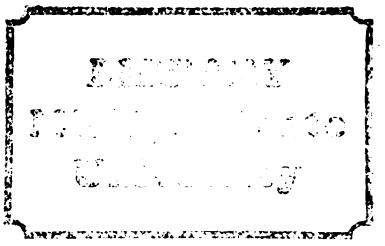

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LIFE STRESS AND DEPRESSION IN LOWER SOCIOECONOMIC BLACK FEMALES

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ANDERSON CLARKE FREEMAN

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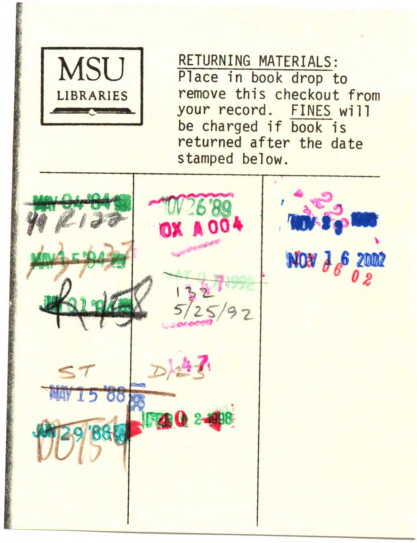

LIFE STRESS AND DEPRESSION IN LOWER SOCIOECONOMIC BLACK FEMALES

By

Anderson Clarke Freeman, M.A.

A DISSERTATION

Submitted to
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ABSTRACT

LIFE STRESS AND DEPRESSION IN LOWER
SOCIOECONOMIC BLACK FEMALES

BY

ANDERSON CLARKE FREEMAN, M.A.

The study examines the relationship between clinical depression and life stresses among black females from a low socioeconomic urban environment. The response of twenty clinically depressed black females to a stressful life event measure and a depression rating scale are examined and compared to those of a non-clinical group barring no history of psychiatric disturbance. Findings indicated there was no significant difference in the occurance of stressful life events, but there was a significant difference in the impact and reaction to stressful life events. More specifically, findings suggest the importance of the depressed individual's subjective experience of stressors, and also their ability to make adaptive responses. Implications for clinical treatment approaches are discussed.

ACKNOWLEDGEMENTS

The author wishes to express appreciation and sincere thanks to the members of his Dissertation Committee. To Dr. Bertram Karon, who served as chairman and more importantly was the guiding element that helped me persevere.

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In a field that is dominated by intrapsychic and endogenous explanations for mental illness, the importance of day to day life events is often of least concern to the clinical practitioner. The impact of both psychoanalysis and the medically oriented practice of psychiatry has made clinicians grossly aware of the psychic and biological inner processes of their clients, while less attention is paid to external life events and daily experiences. Without maligning the traditional understanding of mental disorder, this research attempted to clarify the relationship of life events and mental illness by focusing on a population of individuals whose lives are literally bombarded with events that range from mildly stressful to life threatening.

More specifically, this research focused on the effect of stressful life events on lower-socioeconomic Black females from an urban environment. The theoretical underpinnings of this study were based upon Selye (1956) and other stress theorists' notions of the influence of stressful life events on behavior, and upon cognitive theorists' (Beck, 1967; Stotland, 1969) view of the development of depressive symptoms.

The excerpts to follow testify to the impact of life stress on the Black female caught up in an impoverished, urban environment and its relation to depression.

> A middle-aged mother stays in bed most of the day. Nearby, blocked from view by a closed bedroom door, her troubled teenage children raise themselves in a chaotic and unstructured household.....

An adolescent mother on public aid, trapped by too many children still in diapers and the unyielding confinement of public housing, becomes agitated and tearful in the early morning hours and contemplates suicide....

Another woman, overweight and suffering from mysterious aches and pains, sits in the waiting area of a local clinic. She waits for pills and the brief attention of a young physician, before she listlessly trudges back to her dilapidated flat where an unresponsive mate and several relatives constantly remind her of her many inadequacies....

These excerpts, taken from real life, all illustrate the frustration, hopelessness, resignation, and despair inherent in ghetto life. Sociologically, they reflect the results of poverty, governmental indifference, and racism. Kenneth Clark, the author of Dark Ghetto (1965, p. 82), would state that the psychological malaise presented by these individuals is the "social consequences of racial prejudice."

From a clinician's point of view there are also present many of the signs and symptoms of clinical depression, agitation, withdrawal, somatic complaints, apathy, and self destruction are all apparent in these individuals' reactions to their living circumstances. Most evident in these circumstances are the intertwining of psychological distress and the environmental pathology of slum-ghetto life.

The backdrop of this scientific investigation is the author's experiences working with clients from a predominantly Black and poor, urban setting. Of note in his experience was the high frequency of Black females, usually public aid recipients, being treated for depression, and the more than obviously stressful living conditions evident in their surrounding environment. These observations, which were intensified by the intimacy of short and long term therapy contacts, led the author to question traditional endogenous and intrapsychic notions of the etiology of depression and re-focus on the role of life stress.

With the former experiences and observations in mind, along with some theoretical understanding of the relationship of stress and depression, it was not difficult to make the a priori assumption that depressive illness mainfested by individuals in this unique population is causally related to identifiable life events. Furthermore, this relationship should encompass both the onset of the illness and fluctuations in its symptoms.

Finally, the notion of relating life experiences to depression has already been emphasized by many theorists. In particular, actual, or symbolic life experiences of loss in the etiology of depression have been implicated by Freud 1950, Bibring, 1953, Stenback, 1965 and Lindemann, 1944. However, this research examines information such as the impact of life experiences other than losses on depression, with the hope of clarifying how individuals who become clinically depressed fail to cope with ghetto life. This study's underlying concern is with the cumulative effect of a broad range of events, and the role of social class in mediating these events (Dohrenwend and Dohrenwend, 1972).

Literature Review

Theoretical Considerations

Before relevant and recent research is cited this researcher would like to present some of the theoretical foundations underlying the important concepts of life stress and depression.

Life Stress

At the core of this investigation is the issue of life events and their role as stressors. Historically, the underpinning for systematic experimental research on life stress was initiated by Cannon (1929). Although he was chiefly concerned with physiological reactions to stress, his observations foreshadowed inquiry into the relationship of life stress and psychological states. In the following statements, which grew out of his laboratory preparations, Cannon links up physiology, psychological states, and external stress.

> "...The persistent derangement of bodily functions in strong emotional reactions can be interpreted as due to persistence of the stimuli which evoke the reactions. They may persist because not naturally eliminated by completion of the emotional impulse, or because completion of the impulse is made possible by circumstance" (1929, p. 261).

To illustrate his point and further clarify the relation between stressful stimuli, emotional reactivity, and disturbance in bodily function, Cannon cited the following examples from his clinical work.

> "... A case of persistent vomiting which started when an income tax collector threatened punishment if a discrepancy in the tax statement was not explained, and which ceased as soon as the clinician went to the collector, as a therapeutic measure, and straightened out the difficulty" (1929, pp. 253-254).

> "... A pathological thyroid condition was developed in a wife who saw her husband walking arm and arm with a strange woman and had a strong and persistent emotional reaction of jealousy and suspicion." (1929, p. 255).

After Cannon provided the necessary impetus for research on the harmful effects of stressful life events, other theorists concerned with reaction to stress begin to make contributions. Of note were the contributions of Adolf Meyer (1951), and Harold Wolff (1950).

Adolf Meyer advocated a life chart as an essential tool in medical and psychiatric diagnosis. He viewed changes of habitat, school entrance, graduation failures in schooling or work, births and deaths in the family as fundamentally important environmental incidents. Meyer theorized that life events may be an important part of the etiology of disorders, and need not be catastrophic to be pathogenic (1951, p. 53).

Wolff's contribution grew out of his attempt to specify the effects of life stress. He developed the following three propositions.

> First, regardless of the apparent magnitude, the capacity of a given stress to evoke a protective reaction is a function of its significance to the implicated individual.
>
> Second, the significance of a given stress for the individual determines, according to his temperament and past experiences, the characteristic of the protective reactions.
>
> Finally, when an individual exhibiting a given protective reaction pattern with co-existing symptoms is confronted by a situation which, through its new and different meaning evokes correspondingly different protective reactions, the latter may so overshadow the former as to cause the symptoms to disappear temporarily (1950, p. 1079).

Although the former theorists made many contributions, the central figure in the study of life stress is Hans Selye. Selye devoted much of his life to "dissecting" stress. His major contributions were his definition of stress which he viewed as "The rate of all the wear and tear caused by life," and his description of the G.A.S. or General Adaptation Syndrome which he viewed as the basis of all bodily reactions to stressors. In his description of the G.A.S., Selye broke down stress reactions into three stages.

Initially, there is an alarm response which is a call to arms of all defensive forces in the organism. Next follows a stage of adaptation or resistance where the organism attempts to shift bodily functions to adapt to the stressor. And, finally, a stage of exhaustion is reached after prolonged exposure to stress and the organism's ability to adapt is overcome. At this point there is premature aging or permanent damage of the organism (Selye, 1956).

The relevance of Selye's formulations on life stress to the present study is based on two factors. First, Selye proposed that all life events are potentially stressful and contribute to wear and tear on an individual. An underlying premise of this study also follows this reasoning in terms of the adjustments that must be made to a broad range of concrete and identifiable life events and their implications for depressive illness. Second, Selye also formulated that mental as well as physical maladies can be attributable to life stress. He states that "In all people with a given hereditary structure it is often the stress of adjustments to life under difficult circumstances that causes a change from normal to queer, or from queer to frankly insane" (Selye, 1956, p. 171).

Two contemporary theorists in the area of life stress have developed models that delineate a number of factors that influence the impact of stressful events.

Rahe (1974), the dominant contemporary theorist in the area of stress, formulated a life stress-illness model that takes into consideration Selye's basic work in the area. Rahe proposed that stressors flowed along a particular pathway as they impacted on an individual. First, past experiences can determine or filter the way in which a subject perceives a stressful life event. Next, that perception is diffracted in part by the individual's psychological defenses. The remainder of the stressors leads to a psychophysiologic reaction; coping forces or compensatory measures may attenuate the responses, but in the absence or failure of such mechanisms illness behavior develops.

Kohn (1076) proposed a model of life stress based on his findings in studies of the etiology of schizophrenia. The essence of his formulations were that the conditions of life associated with lower class status, genetic processes, and stressful experiences interacted to produce a greater frequency of schizophrenia in lower socioeconomic groups. He added that in view of the increased amount of stressful events and circumstances encountered by lower socioeconomic status individuals, there are limitations in the external and internal resources that are available for coping, and such individuals are further disadvantaged by conceptions of reality derived from the continual experience of living in adversity and deprivation.

In summary it is evident that the key components in any conceptualization of life stress are the individual's perception of a specific event, that itself is mediated by past experiences, and the level of coping or adaptive response an individual is capable of summoning when faced with stress. Both these factors along with the nature of life events will

be given strong consideration in this study's analysis of the relationship between life stress and depression in a lower socioeconomic urban, ghetto population.

Depression and Life Stress

It is no accident of observation that this investigation links together stress, the symptoms of depression, and life in an impoverished, urban, ghetto. In many ways the development of symptoms of depression are over-determined for ghetto inhabitants. In particular, low self esteem related to lower class and minority status, political powerlessness, the presence of limited resources in their community and personal lives, and the constant impingement of stressful events all contribute to the manifestation of depression.

Theoretically, cognitive theories of depression offer a clear understanding of the development of depression, that also is relevant to the development of "despair" in the ghetto.

Beck (1967) felt depressive affect was triggered by events that evoke negative cognitions. Such events tend to have cue properties similar to those responsible for the initial acquisition of negative attitudes, and as a result precipitate depressive episodes. In simpler language, Beck felt depressives were predisposed to react to stressful situations with the symptomatology of depression by self-disparaging attitudes, indicative of low self worth, that have been internalized early in their life. The affective and physiological symptoms of depression are mainly evoked by a cognitive perception of low self worth that is facilitated by inadequate responses to life demands and stresses.

Stotland (1969, p. 34) argues that depression results when important goals are strongly devalued. He postulates that the greater the importance of a goal, and the lesser its probability of attainment, the higher the level of anxiety. Decreasing the importance of the goal alleviates anxiety. But since the motivation to act derives largely from the perceived probability of attaining important goals, diminishing the importance of goals lessens motivation. Thus, the reaction to lowered goals is depression, apathy, and withdrawal.

This formulation can be readily applied to the ghetto resident. For example, if one's central aim is "getting out of the ghetto," the continued frustration posed by poor upward mobility and limited access to vehicles for escape eventually result in initial frustration and anxiety, and eventual despair and depression when the goal is finally given up. At the same time the stress of ghetto life continually reinforces the depressive's belief in his own ineptness, and inability to change the conditions under which he or she lives.

Although most traditional psychoanalytic theorists have focused mainly on intrapsychic events and early childhood traumas in the development of depression, some psychoanalytic theorists concerned with self esteem in depression have some relevance to the present research.

Bibring (1953) proposed that the loss of self esteem is the central psychological problem in depression. He postulates that a predisposition to depression stems from early childhood traumatic experiences. However, he adds that self esteem may be decreased in later life, not only by frustration of needs for love and affection, but also frustration of other aspirations.

Jacobson (1954) concurs with Bibring's views of the importance of self esteem and states that "self esteem represents the degree of discrepancy or harmony between the self-representations and the wished-for concept of self." She regards all the determinants of self esteem as having relevance to depression.

The final theoretical view of relevance to this study, is behavioral. It corresponds well to cognitive theories, in that it also calls attention to the role of self concept in depression.

Using a model based on experimental studies with infrahumans, Seligman (1971) speculated that depression can be characterized as "learned helplessness." Basically the etiology of learned helplessness rests in the continual contact with unavoidable trauma which cannot be controlled by adaptive behavior. The organism (in this case experimental dogs subjected to inescapable electric shocks) begin to respond with passivity and withdrawal after he "learns" that he cannot escape or avoid punishments. Besides giving up, the response to these traumas is an inability to internalize or learn coping or adaptive behaviors

in later situations after the response of learned helplessness had been internalized. Even though Seligman does not consider the factor of one's predisposition in early life to handling stress, the significance of his formulations for the present study is obvious in terms of the continual life stress imposed on an individual living in the Ghetto, whose position is often powerless and untenable.

In summation, the theoretical views that have been presented shed some light on the role of life stress in depression. Also, most of them implicate the role of an individual's self perception, either as a result of inescapable stressful events (Seligman, 1971), or as a mediating factor in his ability to handle stressful events in later life (Beck, 1967; Stotland, 1969, Bibring, 1953, and Jacobson, 1954).

Relevant Research

The literature cited in the following section will be concerned with two areas relevant to this study. First, the epidemiology of mental illness and depression in relation to lower socioeconomic status, and race will be briefly examined. Secondly, some of the studies that have specifically tackled the research problem of relating life stress and depression will be presented. Hopefully, the review of both these areas will provide added insight into the issues and questions confronted by the present study.

Socioeconomic Status, Race, and Depression

Generally, epidemiological studies of mental illness have linked lower socioeconomic status with a higher prevalence and incidence of serious disorders, while higher social class status is more related to milder (neurotic) disorders.

Two of the principal studies that have identified this pattern are the Midtown Manhattan Study (Srole et al., 1962) and Social Class and Mental Illness (Hollingshead and Redlich, 1958). Their specific analyses tended to characterize the lower class mentally ill as being more apathetic and socially detached with a high degree of schizophrenic disorders, aggressive and antisocial tendencies, and a high frequency of sociopathic disturbances. On the other hand, the middle and upper classes' mentally ill are characterized by feelings of interpersonal anxiety, inadequacy, and guilt with a high degree of neurotic and depressive disorders.

In regard to race, and particularly the high prevalence of severe pathology found in Black populations, Srole's findings indicated that when different racial groups are matched on socioeconomic variables, differences in pathology tend to disappear (Srole et al., 1962).

In viewing depression specifically, it has been traditionally asserted that depression is rarely found among Blacks (Bacock, 1895; Bevis, 1921; and Prange and Vitols, 1962). In early studies racial stereotypes apparently played a significant role in experimenters' findings and subsequent interpretations. For example, Bevis (1921) states "Most of the race, (referring

to Blacks), are carefree, live in the 'here and now' with a limited capacity to recall or profit by experiences of the past. Sadness and depression have little part in their psychological make-up."

In a later study, Prange and Vitol (1962) support these assertions, although in a much more sophisticated presentation. Couching their premises in psychoanalytic theory, they state "Since according to psychodynamic theory, depression is usually precipitated by the experience of a loss, and since the southern Negro has less to lose and is less apt to lose it, he is less vulnerable to depression. As defense against loss, he has attitudes of stoicism and subtle defiance, religiosity, and an extended family relationship; he can also "projectively" locate the source of misfortune outside himself, and thus, avoids using introjection which is the self blaming mechanism basic to depression. Prange and Vitol conclude that it is part of the white man's culture, and thus Negroes cannot be prone to depression."

For the most part these early studies have been refuted on methodological grounds, as well as the insensitivity and apparent racism that distorted findings. Most often sampling errors, failure to consider economic status, inabilities of interviewers to relate to Black patients, and a pervasive climate of bigotry and discrimination have invalidated early findings. More recently, studies have refuted these traditional notions through better research techniques and a more sensitive, in-depth look at individual Blacks.

Tonks, Paykel and Klerman (1970) used a large sample of psychiatric patients (875) from a variety of in and out patient settings to study the racial epidemiology of depression. Of the patients they screened thirty-two percent were diagnosed as depressed, and of these almost seventeen percent were Black. Since Blacks constituted only eleven percent of the Greater New Heaven area, where the study took place, they were somewhat overrepresented in the depressed group. Blacks and Caucasians did not differ in age, but there was a higher proportion of Black females (noteworthy for the present study) and Blacks were lower in socioeconomic class. The two groups differed in the incidence of ten depressive symptoms, but when incidence was adjusted for social class, differences were attenuated.

Using psychoanalytic interviewing techniques, Hendin (1969) studied the depression related phenomena of suicide in twenty-five Black patients. He not only sheds light on a previously ignored aspect of pathology in Blacks, but also related suicidal behavior to the general pressures, conflicts, and ultimate frustration of ghetto life.

Focusing in on the task at hand, specific experimental studies that have attempted to relate life stress and depression will be highlighted. Unfortunately, the issue of class status and race is not raised by these studies; however, they do represent a methodological foundation for the present researcher.

Forest, Fraser, and Priest (1965) investigated 158 depressed patients and 58 medically ill controls. In this investigation a schedule of more or less stressful life events prior to the depressive illness was arrived at for each

patient. Among the items listed were unemployment or loss of role in the household, marital discord, financial stress, medical operation, illnesses, loss by death or removal of a significant person, drug abuse, social isolation, and success reaction (i.e., promotion anxiety). The findings indicated that the depressed group differed significantly from controls on items of parental death prior to the age of fifteen, and unemployment or loss of role in the household. Although only two "items" were significant for the depressed patients, Forest et al felt the findings supported the suggestion made by Lewis (1934) that depressive illness has the effect of removing the individual temporarily from a noxious environment, thus allowing repair to the organism. Methodologically, Forest and his colleagues used inventories based on psychiatrist's perception to determine level of depression and differentiate endogenous vs. neutotic depression. Although this study was generally well controlled it lacked the "patient's view" of his own illness, and did not control for sex, race, and class variables. Also, experimental and control groups were not matched for any variable.

Hayes (1964) looked at clinical records and reported the modes of onset in 81 patients hospitalized for "psychotic depression." The criteria for psychotic depression was a fixed mood and biological concomitants of depression. Fourteen percent of his patients had illnesses with sudden onset and 86% had illnesses which either began gradually or presented a picture initially suggesting neurosis. The sudden onset group had a higher incidence of bereavement, childbirth, menopause, influenza-like illness, or rescipine treatment preceding their depression. Hayes' findings point to the difficulty in diagnosing psychotic vs. neurotic or reactive depression. He has looked solely at a population defined as psychotic depressives and identified a group of "reactive" psychotic depressives.

However, these findings suffer from a failure to specify the time interval between stress and onset of illness, and identify the incidence of stress for each group. Also, as in the case of Forest (1965) sex and social class were not considered.

Hudgens, Morrison, and Barchha (1964) compared forty psychiatric patients, thirty-four with depression and six with mania to a matched group of forty controls. Again the relationship between onset of affective disorder and precipitating events was examined. Hudgens found the only difference between the control and experimental group to be frequent changes of residence, and a higher incidence of interpersonal discord for the patients with affective disorders. Although Hudgens and his colleagues looked at a broad range of life events they failed to differentiate types of depression in their experimental group. This oversight possibly had a great effect on the findings.

A recent study by Beck and Worthen (1972) was addressed in part to the ways schizophrenics and depressives differed in their responses to precipitating stressors. The authors abstracted from case records the relevant data bearing on antecedent social events and life changes in depressives (neurotic depressives) and schizophrenics, and had persons in the waiting room of the hospital (of a social background similar to that of the patients) rate their data in terms of how upsetting it would be to them. The findings showed that there was a striking relation between clarity of precipitant and diagnosis with clear precipitants more often associated with depression. Second the mean hazard score (the upsettingness of the social circumstances of the patient) of depressives was significantly higher than schizophrenics. Schizophrenics'

life situations were seen as less hazardous than those of depressives. From this finding Beck and Worthen concluded that depressives fit a crisis model more appropriately. Although this study seemed to be somewhat loosely controlled (for example it is doubtful that appropriately matched controls could be obtained in such a cursory manner), it did have merit in its attempt to utilize the subjects' view of what they considered stressful events.

A focal problem in research on life stress, which was suggested by Meyer (1950, p. 1079) in his conceptualizations, was that the significance or stressfulness of a particular life event may be highly individualized. Many studies ignored or failed to control these individual variations despite the meanings they had both for findings and understanding the nature of stress. More recently, a small number of researchers have attempted to take individual differences in reaction to life events into consideration by employing newly developed instruments in their research. These instruments not only recorded the incidence and nature of life events during a given period, but also determined the significance of a particular event to an individual.

Paykel, Myers, Dienelt, Klerman, Lindenthal, and Pepper (1969) employed a modified version of Holmes and Rahe's (1967) Social Readjustment Rating Scale to study 185 depressed patients. They matched their depressed patients with an equal number of control subjects on socio-demographic variables. The frequency of occurrence of life events prior to the onset of depression was compared with a comparable six-month period in the control population. Findings indicated a general excess of life events prior to onset of depression. Analysis of different categories of events showed that events generally regarded as undesirable and those involving losses or exits from the social field were

particuarly relevant in that respect. Because of adequate controls, Paykel and his colleagues had strong findings supporting the importance of life stress in the etiology of depression. However, in modifying the use of the Social Readjustment Rating Scale they failed to take advantage of the instrument's ability to identify individual differences in response to live events. Also there was no attempt to differentiate depressive illness, with all types of depression being lumped together.

Markush and Favero (1971) did not study clinical types of depression, but did employ Holmes and Rahe's social readjustment rating scale to measure the relationship between depressed mood and life events in adults randomly selected from urban and rural communities. The respondents were asked to rate twenty life events according to the amount of readjustment necessary after the event occurred. This gave each subject a life change score (LCU) which identified life events which called for low adjustment, a medium amount of adjustment, and high adjustment. Among the many findings reported by the study was the relationship between LCU scores and measures of depressed mood. The strongest significant relationship found was in a lower socioeconomic urban Black population. This finding builds some expectations for the present research which is also focusing on this population.

Summary of Literature

The review of the literature has presented in brief other theorists' and researchers' notions on the relationship between life events and depression. It is undoubtedly apparent that there is a paucity of research which is both methodologically sound, tackles issues relevant to depression and stressful events, and focuses on urban ghetto life.

The present research deals with these methodological issues by employing a research design which will hopefully add more clarification to the role of stressful life events, depression, and urban ghetto living. Specifically, the approach used in this study will utilize patients' perceptions of their own illness under the scrutiny of strong experimental controls. These findings will then be related to the actual living circumstances of depressed individuals taking part in the study.

Statement of the Problem

Generally, the principal concern of this study is empirically demonstrating the relationship between stressful life events and the onset of depression in lower socioeconomic Black females. While remaining cognizant of the unique living circumstances of the population under study, this research was specifically designed to yield information that would: (a) scientifically demonstrate a positive relationship between stressful events and the onset of depression; (b) characterize the nature of stressors most relevant to clinical depression; (c) identify the subjective experience or impact of these stressors on depressed individuals, and (d) demonstrate cognitive and behavioral reaction to stressors that are components of the symptomatology of depression.

These questions were investigated through structured self-reports of clinically depressed individuals. Their responses were statistically compared to a group of non-depressed individuals residing in the same community.

To facilitate this investigation the following predictions were made of the expected differences between the groups of subjects diagnosed as clinically depressed (Group D) and a comparable sample of non-depressed subjects (Group ND) Thus, the hypotheses of this study were:

Hypothesis I. (Onset of Depression)

Group D will have a significantly greater incidence of stressful life events in the six months prior to intake than Group N-D.

Hypothesis II. (Type of Stressor)

Group D will have a significantly greater incidence of interpersonal stress than group N-D in the six months prior to intake.

Hypothesis III. (Impact of Stressors)

The subjective impact of stressors will be significantly greater for Group D than Group N-D.

Hypothesis IV. (Reaction to Stressors)

Group D will have a significantly less adaptive response to stressors than Group N-D.

Rationale for Hypotheses

The rationale for the above predictions are based upon several converging factors. In general, many of the hypotheses were generated on the basis of the author's clinical experiences, theoretical considerations, and the tentative results of a pilot study. Hypothesis I is based upon intake interviews with patients along with the theoretical consideration of the role of stressful events. Both sources of information suggest that clinically depressed persons experience more stressful life events than non-depressed individuals (Beck, 1967). Pilot data, however, did not differentiate the groups, mainly as a result of the limited amount of information obtained.

Hypothesis II was directly the result of tentative pilot data. Interpersonal discord was the predominant character of stressful events reported by the limited sample of depressed females, whereas, concerns related to finances were more apparent for the control group.

Hypotheses III and IV were based on tentative pilot information, clinical experiences, and the symptomatology of depression. Depressed individuals in the pilot sample seemed more "upset" by the events they reported, while their reactions suggested indecision, withdrawal, and psychomotor retardation more often than the nondepressed pilot subjects.

Methodology

Testing Site

The samples obtained for this study were gathered from the active case file of the Mental Health Department of Mile Square Health Center, Inc. Mile Square Health Center, Inc. is located in a highly urbanized near westside section of Chicago, Illinois. Mile Square's total registered * population of patients is approximately 31,000 persons, of which 98% are Black Americans. The patients come from the entire Metropolitan Chicago Area, but approximately 80% are residents of the Near Westside, a 3 square mile area of approximately 50,000 people bounded by Chicago Avenue, Roosevelt Road, the Chicago River, and California Avenue. It is an area of poverty in which more than 30% of the families have annual incomes of $15,000 and above.

Of the 31,000 registered patients that Mile Square serves, approximately 1,500 are registered in the Mental Health section of Mile Square. Of those registered in Mental Health approximately 150 patients received a primary diagnosis of depressive illness during intake. Diagnoses were arrived at through consensual agreement of psychiatrists using a standard psychiatric evaluation, an intake worker's judgment based on the presenting problems, and psychological testing in cases where differential diagnosis was unclear. Intake workers most often were master's level social workers, but also include Ph.D. psychologists and one bachelor's level mental health worker. Diagnoses met the guidelines of the DSM II manual for psychiatric diagnosis.

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*Patients using any of Mile Square's mental health or medical services are given a clinic number during their initial visits. This is the basic registration process which allows monitoring of subsequent visits by state and federal funding sources.

Subjects

Twenty subjects were assigned to the clinical group by employing the method explained in Step II of the following section on Procedure. Basic criteria for potential inclusion in the clinically depressed were:

1. An initial diagnosis of some category of depression according to DSM II guidelines.

2. Normal level of intelligence (all patients not diagnosed as retarded during intake).

3. No evidence of organic impairment or brain disorder (also decided during intake).

4. An annual income under $7,000.
5. Female.
6. Between 21 and 50 years of age.
7. Actively involved in treatment at a rate of at lease one contact per month.

Twenty-four subjects were assigned to the non-clinical group by selecting normals with no history of treatment for depression. These individuals were taken from groups of parents involved in community education programs sponsored by Mile Square's Consultation and Education program. Basic criteria for inclusion in the control gorup were:

1. No history of depressive illness.
2. Normal level of intelligence.
3. No evidence of organic impairment or brain disorder.
4. An annual income under $7,000
5. Female.
6. Between 21 and 50 years of age.
7. Not involved in treatment for any personal psychiatric illness.

Procedures

The following were employed to develop appropriate instrumentation for the study and collect the data necessary for hypothesis testing.

Step I of the procedure involved the development of a life stress instrument that was relevant to the community serviced by Mile Square Health Center, Inc. Professional staff members were consulted, and a list of stressful or upsetting events reported in therapy by patients was compiled. This list formed the basis for the environmental stress scale employed by the study.

Step II of the procedure involved a pilot study designed to test the face validity of the stress scale, further refine the stress scale, and the experimental procedure. The pilot study used three depressed and three non-depressed subjects. Subjects were chosen for the depression group according to the Diagnostic and Statistical Manual of Mental Disorders (DSM II). Working within the guidelines of DSM II, an intake worker, aided by a psychiatric evaluation, and psychological testing in many cases, established a working

diagnosis at intake. The non-depressed group was comprised of parents of children in the developmental disabilities program at Mile Square, with no history of psychiatric treatment themselves. The children of these parents had received diagnoses at intake of cerebral palsy, epilepsy, or retardation.

Step III involved the actual administration of instruments in the final study. A $4.00 incentive was promised and paid to all subjects who completed the study. Testers were taken from the psychiatric social work and occupational therapy staff of the mental health section of the Mile Square Health Center, and each tester was assigned four subjects, two from each group. All testers were Black females, possessing either a master's degree in social work, or in two cases, a bachelors degree in occupational therapy.

All members of the clinical group (Group D) were administered the Personal Data Sheet, Depression Scale (SDS), and Environmental Stress Scale (ESS) in individual sessions over a two-week period. After administration of the Personal Data Sheet and Depression Scale, subjects were asked to retrospectively identify life events occurring over a six-month period prior to intake into mental health. The ESS was employed for this purpose, and was also used to gather individual data on the impact of, and reaction of designated events (see section on instruments).

Data from the non-depressed group was gathered from parents involved in consultation and education programs in the surrounding community. Interviewing teams administered the research instruments using the same procedure followed for the clinical group. The fundamental difference in administration between the groups was the retrospective responses for the ESS were reported for the

six month period prior to the date of the interview for the non-clinical group, and for the six month period prior to intake for the clinical group.

Hypothesis testing in relation to the procedure involved (a) group comparisons of retrospective data on stressful events from the ESS. (Hypothesis I); and (b) group comparisons of total reported events, impact of reported events, impact of reported events, and reactions to reported events. (Hypotheses II, III, IV).

Instruments

Self Rating Depression Scale (SDS). The instrument employed to measure depression levels and make group comparisons in Step III of this study was the Self Rating Depression Scale (Zung, 1965). It is a pioneering scale in the study of depression, and it has been used in innumerable studies to assess the severity of depression. The scale consists of twenty items covering affective, physiological, and psychological concomitants of depression. Items are rationally derived and expressed in verbatim patient language. The SDS correlates.70 with the MMPI Depression Scale and differentiates depression from other diagnostic categories at statistically significant levels. Its status as a measure of severity of depression is supported by higher initial score for depressive in-patients, and by the decreased scores of in-patients upon discharge (Zung, 1965; Zung, Richards, and Short, 1965).

The rationale for employing this measure over more recently developed depression scales is its simplicity. The items are readily understandable, even for individuals with limited education, while at the same time the items

coincided well with specific depressive symptoms. Also a self report was chosen over therapist ratings because of this study's inherent goal to understand the depressed patient in terms of his own phenomenology. Adjective check lists were also deemed inappropriate for the population under study, due to the difficulties they present in understanding long lists of "middle class oriented" adjectives.

The final consideration was the ease of administration and scoring. In using the SDS the patient is asked to rate each of the twenty items in terms of how it applies to her during a specific time period. The forced choice quantitative rating a patient applies to herself may have a numerical value of one to four for each of the twenty symptoms rated. An index for the SDS is devised by dividing the sum of the raw score values obtained from the twenty items by the maximum possible score of eighty coverted to a decimal and multiplied by 100. (The actual form of the SDS as it was used this study is illustrated in Appendix A.)

The Environmental Stress Scale (Ess). The Environmental Stress Scale was developed specifically for this research as a means of systematically compiling data on the occurrence of stressful life events. The items were derived rationally from the author's experiential knowledge of the life events most apt to affect the patients living in the community served by Mile Square Health Center. Besides the author's own personal experiences in growing up in a similar environment, a heavy reliance was placed on discussions with patients, patients' relatives, and co-workers in compiling the items on this scale. Information was gathered from the above individuals over a two-year period of intense clinical work in the "Mile Square Community."

The author designed the scale to assess the incidence, nature, and impact of life events encountered in the lives of the sample subjects that could be used to meaningfully compare the depressed and control groups.

The scale itself was structured according to six classes of events that are relevant to the population being studied. The classes themselves are (a) financial discord; (b) interpersonal conflict; (c) losses and separations; (d) physical problems; (e) environmental dangers, and (f) daily concerns. Each class is made up of fourteen related events. Twelve are specified and two are left blank to allow subjects to identify stressors that have either been overlooked in the initial development of the scale, or are "idiosyncratic" to the lives of individual subjects.

Along with a specific list of events for each class there is a simple forced-choice self report device for measuring both the impact of the event and the subject's immediate cognitive and behavioral reaction to each designated event.

Instructions for completing the scale are simple; essentially the subject's task is to:

1. Identify the event that has occurred in her life for each class of events, during a given time period.

2. Self-assess the impact or stressfulness of each event that is designated by using a forced-choice rating system where three increasing levels of stressfulness are presented.

3. Self-assess her individual reaction to each event designated by using a forced-choice rating system where three basic types of cognitive and behavioral reactions are presented.

The scoring of the data gathered by the scale involved compiling or summing the raw score for all events reported, establishing an individual index for the impact of reported events, and the reaction to these events. Finer analysis involved comparing these scores for the different classes of events. (The actual form of the ESS, as it was used in this study, is illustrated in Appendix B.)

The Personal Data Sheet. A personal data sheet was constructed for the purposes of this study to ascertain descriptive and demographic information on each subject involved in the study. (The actual from of the personal data sheet is illustrated in Appendix C.)

RESULTS

The analysis of the data was performed in three parts. In the first part group D and group ND were compared in terms of both the overall number of stressful life events endorsed, and the total number endorsed in each of the six categories. An analysis of variance was performed to test the significance of difference between the two groups on these measures and test hypotheses I and II (Tables 4 and 5).

In the second part, the subjective experience or impact of stressful life events, and subjects' reactions to the stressors were examined. An analysis of variance was again used to test for significant differences between the two groups on their impact and reaction scores (Tables 6 and 7.)

Finally, to assure that the groups were properly differentiated in terms of depression, an analysis of variance was performed to determine whether there was a significant difference in level of depression in each group.

Actual presentation of the results will be in terms of each hypothesis and the comparison relevant to testing them.

Hypothesis I: The first hypothesis states:

Group D will have a significant greater incidence of stressful life events within the six months prior to the interview than Group ND.

TABLE I

Analysis of Variance of the Total Number of Stress Occurrences Between the Clinical and Non-Clinical Group

Source of Variation	df	SS	MS	F
Between Group	1	151.37	151.37	F = .788
Within Group	42	8,061.42	191.94	(ns)
Total	43	8,212.79		

As can be seen in Table I, no significant difference was found between the two groups on the total number of stressful events endorsed. The actual incidence of life events, without consideration of their nature, impact, or the type of reaction they foster, appears the same for depressed and non-depressed subjects. The F value of .788 shows no significance, although there was a slight numerical superiority for stressful events in the depressed group.

Hypothesis II: The second hypothesis states:

Group D will endorse a significantly greater incidence of interpersonal stress events than group N-D.

Table 2

Mean Scale Scores for the Clinical and Non-Clinical Group on the Six Categories of the Environmental Stress Scale

	Clinical (20)		Non-Clinical (24)		
Scales	X	SD	X	SD	Significance Level*
Financial Discord	3.65	2.79	3.04	2.80	ns.
Interpersonal Conflict	4.40	2.54	3.41	2.70	ns.
Loses and Separations	2.70	2.51	2.70	2.40	ns.
Physical Problems	4.35	2.58	2.87	2.87	ns.
Environmental Dangers	3.65	2.71	2.91	2.87	ns.
Daily Concerns	5.75	2.71	4.95	3.12	ns.

* Based on the t-test of difference between means.

Table 2 indicates that there were no significant differences on the six categories of events between group D and group ND. Although there were definite, higher levels (means) of events for the four categories of financial discord, physical problems, environmental danagers and daily concerns in Group D, none of these differences reached significance. More importantly, expectations that group D would have more interpersonal stress events are completely eclipsed by the data.

Hypothesis III: The third hypothesis states:

The subjective impact of stressors will be significantly greater for Group D than Group N-D.

Table 3

Mean Percentage of the Impact Responses Based on the Total Number of Stress Occurrances

	Clinical		Non-Clinical		
	X	SD	X	SD	Significance Level*
Impact (1)					
Bothered me a little	.368	.136	.531	.261	.01
Impact (2)					
Very upsetting	.353	.153	.336	.195	ns.
Impact (3)					
Upsetting, I can't get it off my mind	.283	.175	.094	.161	.001

* Based on the t-test of difference between means.

Table 3 indicates that there is a significant difference in the impact scores between Group D and Group N-D. Thus, the hypothesis was supported.

More specifically, Impact (1), the least amount of impact, was more often endorsed by the non-clinical subjects in Group N-D. This comparison by itself showed strong significance in the expected direction ($p. < .01$).

In addition, Impact (3) which revealed that Group D more often endorsed the extreme impact statement gave added directional support to the fact that the impact of stressors was greater for Group D, and, in fact, reached significance at the .001 level.

Hypothesis IV: The fourth hypothesis states:

Group D will have a significantly less adaptive response to stressors than Group N-D.

Table 4

Mean Percentage of the Reaction Responses Based on the Total Number of Stress Occurrences

	Clinical		Non-Clinical		
	X	SD	X	SD	Significant Level*
Reaction (1) Immediately tried to do something about situation	.512	.149	.697	.215	.01
Reaction (2) Thought about it but didn't do anything about it	.285	.124	.170	.131	.01
Reaction (3) Didn't think about it, just ignored the situation	.204	.154	.094	.118	.01

* Based on the t-test of difference between means.

Table 4 indicates a significant difference between the compared group on Reaction (1). Based on this finding, the hypothesis is supported. According to expectation Reaction (1), the most adaptive response, was more often endorsed by the non-clinical group than the clinical group and show strong significance in the expected direction ($p. < .01$). Reactions (2) and (3), both less adaptive responses, were more often endorsed by the clinical group. In both cases, significance was reached at the .01 level in the expected direction. This additional finding added support to the findings in regard to Reaction (1).

Table 5

Analysis of Variance of the Measure of Depression
Between the Clinical and Non-Clinical Group

Source of Variation	df	SS	MS	F
Between Group	1	.5340	.5340	$F = 52.81$
Within Group	42	.4246	.1011	$P < .001$
Total	43	.9586		

Table 5 reflects a higher degree of depression in the clinical group. The F value indicates significance between the groups at the .001 level.

This finding suggests several possibilities. First, one is again confronted with the possibility that the stressor itself is less important than the reaction of the individual to it, and its idiosyncratic meaning. Selye (1976), who views all aspects of life as inherently stressful, would concur with this supposition. The adjustments made by individuals to life changes seem far more relevant than the life changes or stressors themselves. Even such grossly different stressors as losses of significant relatives and the failure of an elevator to perform when needed may have similar or very different impacts depending upon the stressed individual's reaction and his view of the situation.

In relation to the population studied, the survival oriented lifestyle of many ghetto residents exaggerates even the "smallest" stressors. For example, an inoperative elevator may be devastating when one is faced with carrying groceries up several flights in a poorly lighted housing project. The individual who constantly has to deal with such situations cannot afford the luxury of viewing this as a minor stress. Because of its close tie with the basic day to day problems of providing for a family, it may take on just as much importance as the lost of a loved one. This explanation clearly considers the factor of what stressors may mean to a given set of individuals.

The failure to identify any differences between a sample of clinically depressed patients and a group of "normals" across a wide spectrum of different types of stressors also challenges some basic traditional notions regarding the etiology of depression. Foremost, orthodox psychoanalytic notions of the role of losses of significant others, (Freud, 1930) were not supported by the data.

Discussion of Results

The Experimental Hypotheses

Hypothesis I dealt with the comparative incidence of stressful life events during the six months prior to participation in the study for both groups. The expectation was that a higher incidence of stressful events would be endorsed by the clinically depressed subjects. As stated in the results section, no significance was found in the incidence score between the groups.

If one can clearly rule out such methodological factors as subject's failure to remember stressful events over a six-month period, and/or their reluctance to reveal events that may have been embarrassing or guilt-laden, this finding has importance for understanding the role of stressors in depressive illnesses. Basically, a lack of difference in the frequency of stressors suggests that variables other than mere incidence are important in the etiology of depression. Since according to these findings stressful living experiences alone are not sufficient explanatory factors, one must consider more carefully the nature of the stressor, the subjective experience of the stressed individual, and untested issues, such as the meaning of the event to the stressed individual.

In relation to incidence one aspect of the stressors which was not deeply considered by this research was the relationship of stressful events occuring earlier in life to the individual's current reaction patterns (i.e., depression). Perhaps stressors occurring at more vulnerable and earlier periods in the lives

of depressed patients are more significant in laying the foundation for serious depressive reactions later in life. Such predispositions may have been more powerful in differentiating the sample groups in terms of frequency. In relation to the experience of lower socioeconomic Black females in a urban ghetto, the historical destruction of the Black family structure during formative years and the resulting loss of a proper buffer and support against stresses is of monumental importance. Thus, regardless of frequency, stressors impacting on an individual who is already at a "developmental" disadvantage may take their toll "latently" and set the stage for depressive illness in adulthood.

The only concrete data collected in regard to the question of what point in the life cycle are stressors more significant is demographic in nature, and informs us only of the incidence of parental deaths (Table 8). Unfortunately, it is inconclusive as a result of both groups having a similar frequency of parental losses on inspection. Also there is no way of determining how immediate the loss was since there were no data collected that would identify when parents of subjects died.

Hypothesis II focused on testing the relationship between the specific nature or characteristic of stressors, and depression. Whereas, in Hypothesis I the concern was with the frequency of stressors, this hypothesis was concerned with what form the stressors actually take. The expectation based on pilot data and clinical information was that interpersonal stressors (arguments, fights, etc.) would play a significant role in depression. The actual findings, of course, did not support prior expectations. In fact, no particular types of stressors were peculiar to either group.

Perhaps, the loss of prestige or self esteem as a result of inability to cope with stressors of any sort is a more telling factor than the form that the stressor takes. This view is more in keeping with the alternate psychoanalytic views of Bibring (1953) and speaks more to the nature of the meaning of the stressor. Also this view is concordant with Beck's (1967) belief that negative cognitions provoked by life events are central to depressive reactions.

Hypothesis III deal with the subjective impact of stressful events. Specifically, it was expected that the depressed group would have significantly greater impact score than the non-depressed subjects. In contrast with the prior hypothesis, this expectation is supported by the results. This finding suggests that the subjective experience of stressful events is a critical component in the depressed Black female's reaction to stress. Clinically, this finding singles out the loss of emotional control, and more in-depth analysis of this state of "upsetness" may have revealed actual feelings of worry, fear and anxiety. At any rate, it has at least been demonstrated that the clinical group becomes more emotionally insecure when faced with stressful events.

Furthermore, the implications of this finding suggest difference in coping style between the groups. The emotional reactivity of the depressed group would cloud their perceptual processes and increase the perceived threat of the stressor to their personal security. This factor would also undermine the depressed individual's use of more rationale problem solving components of her intellect.

This findings also reinforces the importance of the meaning of the stressor which is a central component of the emotional reactivity of coping style of the depressed individual. Inspite of this studies concern with events in the current life experience of individuals, the issue of differing reactivity between the groups singles out the importance of early life experiences in forging the characteristic coping style of depressed individuals.

Hypothesis IV is also supported by the results. It is basically concerned with demonstrating the failure of depressed individuals to take action when faced with a stressor. Obviously, this hypothesis is concerned with comparing basic coping skills which are implicit in the alternatives presented by the stress scale devised for this study. Clinically, the failure to take action or make an attempt to deal with stressors may be an artifact of the depression itself (i.e., psychomotor retardation) and only be diagnostic of an illness that is already present. However, since the patients in this study reported the stressors immediatly before their depressions, this reachers feels that this findings points to a basic feeling of ineffectiveness and lack of motivation that may predispose certain individuals to cope poorly with stressful events. Depression is correlate of this failure to cope when one perceives her failure in the face of adverse life events.

The immobilization suggested by the previous statements in relation to data on hypothesis IV can be accounted for or explained by a number of theoretical positions. Unfortunatly the data did not uncover anything definitive in relation to these theories. However, it is worthwhile to entertain a deeper understanding of the depressed subjects inability to take action.

Additional Findings

In the following tables descriptive data are presented for both the depressed group (Group D) and non-depressed group (Group ND). These data were collected from individual survey responses to the Personal Data Sheet (See Appendix C). Comparisons were made on variables thought likely to be important in (a) contributing to stressful living circumstances (i.e., marital status, crowding, number of dependents, residence), (b) affecting ability to cope with stress (i.e., education, age), and (c) playing role in theoretical notions of the development of depression (i.e., parental losses).

Table 6

Comparison of Group D and Group ND on $\bar{X}$ Age and Educational Background

		Level of Education		
	$\bar{X}$ Age	GS	HS	Some College
Group D	35.4	60%	20%	20%
Group ND	34.0	24%	38%	42%

Table 6 indicates the mean age of both groups, as well as comparisons of the educational makeup of each group in terms of percentages. Both groups are comparable in relation to age, with the non-depressed group being slightly younger. Comparison of educational background between groups reveals more dramatic differences. In particular, the depressed group has a much lower overall level of education as compared to the non-depressed subjects. This factor is evidently the result of the use of parents involved in educational

programs in their children's schools. Such individuals would probably show a greater interest in the educational process of their dependents because of their own academic successes. Clinically, this factor would tend to spotlight, at least in terms of intellectual problem solving, a potentially higher ability of the non-clinical subjects to cope with stressful events.

Table 7

Comparison of Group D and Group ND on Demographic Factors of Marital Status, Crowding, and Number of dependents, and Type of Residence

	% Marr.	"Crowded" households	Dependents X	Proj.	Apt.	Hou.
Group D	40%	20%	3.51	25%	31%	44%
Group ND	58%	50%	4.7	50%	11%	39%

Table 7 highlights a number of differences in the demographic make-up of the groups. Generally, it appears that the clinical group is living under less "potentially stressful circumstances" if one considers a lower percentage of crowded households, fewer dependents per subject and fewer individuals residing in public housing (projects). However, these factors were somewhat offset by a higher number of individuals who were married in the non-clinical group. This would tend to indicate individuals in Group ND may have spouses available for support and aid in coping with factors such as dependents. Also crowded households may be positive indicators of the presence of other "support" individuals (i.e., grandparents, in-laws, etc.).

Table 8

Group Comparisons of Parental Losses

	% Loss 1 Parent	% Loss 2 Parent
Group D	25%	25%
Group ND	29%	29%

Table 8 identifies percentages of significant losses or deaths of parental figures for each group. Differences between groups do not appear to be an outstanding factor that might make either group more prone than the other to depression. Also of concern in this comparison were the early losses and their implication for "anaclitic types of depression." However, the percentage from each group of parental losses in childhood, much less early childhood, were too small to be considered "analyzable."

Clinically the depressed patients did seem somewhat different. It was more difficult for interviewers to terminate interviews during data collections. In many cases the depressed subjects were verbally preoccupied with their life problems and seemed very self centered. This suggests a coping style described by Bonime who reports that neurotic depressives use their helplessness and distress as a way of reaching out and/or manipulating others to help them (Bonime, 1962). In relation to the current research this suggests a failure of the depressive to take effective action himself in dealing with stress.

Summary

This study was derived from the clinical experiences of the researcher while working in a high stress, impoverished urban environment. Contacts with numerous cases of depression in black females living in these circumstances suggests a link between their emotional difficulties and the setting in which they resided. Of particular concern was the quanitative and qualitative impact of stressful events on these individuals with specific interest in the frequency, impact, and reaction to stressors.

Along with standardized, established scales for the measurement of depressive symptomatology, a special life stress instrument was constructed for the particular population under study and comparisons were made between similar groups of Black females. One of these groups was composed of individuals in treatment for depression, while the other group consisted of individuals from similar living circumstances with no prior history of treatment for depression.

Statistical comparisons using analysis of variance and *t*-tests between means tended to implicate individual's ability to cope with stress as more relevant to the etiology of depression than merely the frequency or type of stressful event that a subject encounters. Specifically, depressed subjects are more likely to "over-react" to stressful events emotionally, and more often have inadequate coping responses with stressful events impinging on them. Other important factors in helping to cope with stressors revealed by a post hoc inspection of demographic data were level of education, family make-up in terms of the presence of a spouse, and the number of individuals living in the stressed individual's household. Thus,

academic achievement, the availability of support from a mate or spouse, and uncrowded living circumstances appear to help decrease the negative impact of stressors.

Finally, future clinical implications for this study point to the importance of treatment modalities which improve ego functioning in coping with stressors. Also, future investigation should take into consideration the effect of stressors on individuals living under other environmental circumstances. Of particular concern in studying other social and economic groups should be a comparative analysis of how emotional disorders are affected by the stressors they encounter.

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APPENDICES

APPENDIX A

	Little of the time	Some of the time	Good part of time	Most of the time
1. I feel down-hearted and blue.				
2. Morning is when I feel the best.				
3. I have crying spells or feel like it.				
4. I have trouble sleeping at night.				
5. I eat as much as I used to.				
6. I still enjoy sex.				
7. I notice that I am losing weight.				
8. I have trouble with constipation.				
9. My heart beats faster than usual.				
10. I get tired for no reason.				
11. My mind is as clear as it used to be.				
12. I find it easy to do the things I used to.				
13. I am restless and can't keep still.				
14. I feel hopeful about the future.				
15. I am more irritable than usual.				
16. I find it easy to make decisions.				
17. I feel that I am useful and needed.				
18. My life is pretty full.				
19. I feel that others would be better off if I were dead.				
20. I still enjoy the things I used to do.				

THE ENVIRONMENTAL STRESS SCALE

Part I. Financial Discord

ITEMS	IMPACT			REACTION		
	Brother me a little	Very upsetting	So upsetting, I can't get it off my mind	Immediately to do something about situation	Though about it but didn't try to do anything about situation	Didn't think about it, just ignored the situation
1. You lost a job.						
2. Your boyfriend or husband lost a job.						
3. Your aid check was stolen.						
4. You lost your aid check						
5. No money for a special occasion (i.e., birthday, holiday, graduation)						
6. Unexpected bill came.						
7. Cash money stolen from your house .						
8. Your aid check is late.						
9. No money for rent						
10. No money in house for food.						
11. You lost money gambling or betting.						
12. No money to spend on yourself.						
13.						
14.						
TOTALS						

Part II. Interpersonal Conflict

ITEMS	IMPACT			REACTION		
	Borthered me a little	Very upsetting	So upsetting, I can't get if off my mind	Immediately to do something about situation	Thought about it but didn't try to do anything about situation	Didn't think about it, just ignored the situation
1. Argued with husband or boyfriend.						
2. Physical fight with husband or boyfriend.						
3. Argued with relatives (i.e., Mother, in-law, cousin, uncle)						
4. Physical fight with relative.						
*5. Argued with neighbor.						
*6. Physical fight with neighbor.						
7. Children's behavior upsets you.						
8. Argued with teacher or other offical at your child's school.						
9. Argued with social worker, public aid worker, or housing manager.						
10. Argued with a stranger.						
11. argued with a bill collector.						
12. Someone said something or acted a certain way to upset you.						
13.						
14.						
TOTALS						

Part III. Losses and Separations

ITEMS	IMPACT			REACTION		
	Bothered Me a little	Very upsetting	So upsetting, I can't get it off my mind	Immediately tried to do something about situation	Throught about it but didn't try to do anything about sit-situation	Didn't think about it, just ignored the situation
1. Distant relative died.						
2. Close relative passed away						
3. Boyfriend or husband died.						
4. Neighbor or close friend moved away.						
5. Broke up with boyfriend.						
6. Separated or divorced from legal o common-law husband.						
7. One of your children left home to live elsewhere.						
8. Person other than your child, husband, or boyfriend leaves your household.						
9. Cherished possession is lost or broken (i.e., picture, piece of furniture).						
10. Moved to new home or apartment.						
11. Relative put in institution.						
12. Lost use of part of body.						
13.						
14.						
TOTALS						

Part IV. Physical Problems

ITEMS	A IMPACT: Borthered me a little	Very upsetting	So upsetting, I can't get get it off my mind	REACTION: Immediately tried to do something about situation	Throught about about it but didn't do anything about situation	Didn't think about it, just ignored the situation
1. Had minor illness (cold, mild flu, etc.)						
2. Had major illness (in bed at home for one day, but not hospitalized)						
3. Had serious illness (hospitalized at least overnight, or required minor or major surgery).						
4. Close adult relative put in hospital for physical problem.						
5. Close friend put in hospital for physical problem.						
6. Sustained minor injury in car or home accident.						
7. Sustained major injury requiring outpatient care or hospitalization.						
8. Child too sick to go to school.						
9. Child sick enough to see doctor.						
10. Child hospitalized for physical problem.						
11. Helped friend, relative, or neighbor with their sick or injured child.						
12. Had to see dentist.						
13.						
TOTALS.						

Part V. Environmental Dangers

IMPACT

REACTION

Part V. Enironmental Dangers

ITEMS	IMPACT			REACTION		
	Bothered me a little	Very upsetting	So upsetting I can't get it off my mind	Immediately tried to do to do something about situation	Though about it but didn't try to do anything about situation	Didn't think about it, just ignored the situation
1. Close relative put in jail or arrested.						
2. You found out a close relative is using drugs (street drugs or alcohol to excess).						
3. You were robbed.						
4. Your home was broken into.						
*5. You are stopped by police						
6. You had to walk home in dark, ride dark elevator, or walk down dark hallway.						
7. You were threatened by a gang of teenagers or adults loitering on street.						
8. Witnessed adults fighting on street.						
9. Witness someone committing crim (i.e., robbery, burglary).						
10. Your property is vandalized or destroyed.						
11. Police came to neighbor's house.						
12. Almost hit by car.						
13.						
14.						
Totals						

Part VI. Daily Concerns

	ITEMS	IMPACT			REACTION		
		Bothered me a little	Very upsetting	So upsetting, I can't get if off my mind	Immediately tried to do something about situation	Thought about it but didn't try to do anything about situation	Didn't think about it, just ignored the situation
1.	Elevator in building wasn't working.						
2.	There was no heat in building.						
3.	Problem with plumbing (i.e., no hot water, stopped drain, leaks.)						
4.	Car wouldn't start or broke down.						
5.	Garbage was not picked up.						
6.	Had to visit school because of academic or behavior problem with child						
7.	Your children got in a fight with other children in neighborhood.						
8.	Dinner burned or not ready on time.						
9.	Bothered by noise made by neighbors or people outside.						
10.	Had to wait on bus a long time.						
11.	Missed an important appointment.						
12.	Snow not removed on sidewalk.						
13.							
14.							
	Totals						

APPENDIX C

PERSONAL DATA SHEET

1. Subject No._____

2. Residence
( ) Projects_____
( ) Two-Flat_____
( ) Single family dwelling_____
( ) Apt. Bldg., 3 fls. or more_____
( ) Transient-Hotel or Motel_____
( ) Other Specify:_____

3. Age_____ 4. Religion: ( ) Protestant ( ) Catholic
( ) Other Specify:_____

5. Marital Status: ( ) Single, Never married ( ) Divorced
( ) Married ( ) Separated ( ) Widowed

6. Number of times married: ( ) 0 ( ) 1 ( ) 2 ( ) 3
( ) 4 or more

7. If divorced, how long: ( ) Less than one month ( ) 1-6 months
( ) 6-12 months ( ) more than one year

8. If widowed, how long: ( ) Less than one month ( ) 1-6 months
( ) 6-12 months ( ) more than one year
( ) over 5 years

9. Number of children: ( ) 0 ( ) 1 ( ) 2 ( ) 3
( ) 4 ( ) 5 or more

10. Number of children ages between 12-18: ( ) 0 ( ) 1 ( ) 2
( ) 3 ( ) 4 ( ) 5

11. Number of children ages between 0-11: ( ) 0 ( ) 1 ( ) 2
( ) 3 ( ) 4 ( ) 5 or more

12. Time at present address: ( ) Less than 12 weeks ( ) 12 weeks - 1 year
( ) 1-2 years ( ) more than 2 years

13. Birth Place: ( ) Chicago ( ) North ( ) South ( ) West ( ) East

14. How long lived in Chicago? ( ) Less than a year ( ) 1-2 years
( ) 3-5 years ( ) 5-10 years ( ) 10 years of more

15. Mother's place of birth: _____
(Country, or City) State

16. Mother's education (check highest level)

( ) attended grade school ( ) Graduated grade school
( ) Attended high school ( ) Graduated high school
( ) Attended colleg ( ) Graduated college

17. Mother's occupation:

( ) Unskilled ( ) Semi-skilled ( ) Skilled ( ) Professional
( ) Other Specify:_____

18. Is Mother ( ) Alive ( ) Deceased

19. If deceased, her age at death _____ Your age at time_____

20. Father's Place of birth:_____
(Country, or City) State

21. Father's education (check highest level)

( ) Attended grade school ( ) Graduated grade school
( ) Attended high school ( ) Graduated high school
( ) Attended college ( ) Graduated college

22. Father's occupation:

( ) Unskilled ( ) Semi-skilled ( ) Skilled ( ) Professional
( ) Other Specify:_____

23. Is Father ( ) Alive ( ) Deceased

24. If deceased, his age at death_____Your age at time_____

25. Number of people presently living with you? Include everybody except yourself:
( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) 6
( ) 7 or more

26. Number of rooms in your place of residence? ( ) 2 ( ) 3
( ) 4 ( ) 5 ( ) 6 ( ) 7 or more.

27. Your own education (circle highest grade completed)

Grade School: 1 2 3 4 5 6 7 8 Graduated: Yes_____ No_____

High school: 1 2 3 4 Graduated; Yes_____ No____

College: 1 2 3 4 Graduated: Yes_____ No_____

28. Are you presently employed Yes_____ No._____

29. If yes, what is your occupation:_____

30. If no, what is your major source of income:

( ) Public Aid ( ) Social Security ( ) Husband's Income

( ) Other Sepcify:_____