Interpersonal Expectations and Adjustment to Depression

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Abstract of the Dissertation

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Major depression places considerable burdens on patients and their interpersonal relations with friends and family members. This study explored patient perceptions of being unable to meet the expectations of significant others in several domains related to depression. It tested the hypothesis that perceived inability to meet expectations leads to poorer adjustment and examined whether perceived expectations are derived from unrealistic demands by others or from patient perfectionism. Forty-five clinically depressed patients were assessed prospectively for perceptions of family and friends expectations, socially prescribed perfectionism, depression, optimism, and quality of life. Significant others were asked about their expectations for patients. Patient neuroticism, perceived criticism, social support, and social desirability were also assessed as control variables. Results showed that perceived expectations reflected the actual expectations reported by family members and were a stronger and more consistent predictor of adjustment than social support, perceived criticism, or socially prescribed perfectionism.

Patients who viewed themselves as unable to meet the expectations of others were initially more depressed and less optimistic and reported a lower quality of life. These patients continued to be more severely depressed three months later. Additionally, changes in perceived expectations over time were associated with changes in depression, quality of life, and optimism. Mediational analyses indicated that neither family expectations nor perfectionism explained the relationship between perceived expectations and adjustment. The results of the study suggest that interpersonal perceptions are an important predictor of adjustment in depression. However, the source of these perceptions remains unclear and requires further study. Developing interventions to prevent or reduce miscommunication between patients and their family members may be effective in improving patient adjustment.

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Introduction

The study of interpersonal relationships has long been an important focus of research on the etiology and course of major depression. Over the last several decades, a substantial number of studies have demonstrated that depression leads to significant problems in social and family functioning. For example, Weissman and Paykel (1974) reported that depressed women experienced more friction and arguments with their husbands and children, had difficulty performing housework and other tasks, and showed decreased social activity and contact with friends when compared with nondepressed control women. More recent studies using varied patient populations and assessment procedures have continued to find that families of depressed patients experience significant difficulties during the acute phase of the illness. Moreover, these families continue to experience more problems than nonclinical families even after the diminution of depressive symptomatology (see review by Keitner, Miller, Epstein, & Bishop, 1990).

Problematic family relationships have themselves been shown to contribute to the onset of depression and to influence the course of depressive illness. Interpersonal stressors significantly increase the risk of developing clinical depression (Paykel et al., 1969) and studies of depressed women in discordant marriages have shown that marital discord tends to precede the development of depression rather than vice versa (Beach & Cassidy, 1991). Among depressed patients, conflict with friends and family members has a detrimental effect on the course of the illness (Finch & Zautra, 1992). Conversely, patients who report high levels of social support have less severe symptoms (Lara,

Leader, & Klein, 1997), are more likely to recover from a depressive episode (Goering, Lancee, & Freeman, 1992; Keitner et al., 1995; Keitner, Ryan, Miller, & Norman, 1992), and have a lower rate of relapse compared to those with few supportive relationships (Keitner & Miller, 1990).

The evidence for a reciprocal relationship between depressive symptoms and interpersonal relations may best be explained by an interactive, mutually reinforcing process. While the emergence of major depression is facilitated by disturbed marriages and family environments, depressive illness itself creates significant problems for those living with a depressed patient. If friends and family members do not have an effective way of dealing with the problems of depression, then the illness can be significantly prolonged and worsened (Keitner, Miller, Epstein, & Bishop, 1990). Family members may be particularly likely to aggravate the situation with unsuccessful attempts to influence the behavior and feelings of the patient. Although these attempts may be motivated by a sincere desire to alleviate the suffering of the patient, they are often carried out in ways that complicate and unwittingly worsen the depression (Coates & Wortman, 1988). At the same time, patients themselves may actively contribute to the escalation of interpersonal conflict and depressed mood by seeking support from their social environment with symptomatic behaviors that have the unintended effect of eliciting rejection from others and confirming negative beliefs about the self (Coyne, 1976).

An interactional view of depression maintenance is consistent with calls for a situational perspective that does not place blame on either patients or relatives, but

attempts to understand the problems that occur in the coordination of mutual needs and concerns among families with depressed patients (Coyne, Ellard, & Smith, 1990). From this perspective, it is particularly important to identify the nature of interpersonal conflicts that reduce support from significant others and contribute to the escalation of depressive symptoms. The present study focuses on the misunderstandings and misperceptions that may occur among patients and their families as the result of the depression itself. We hypothesize that adjustment to depression may be made more difficult when friends and family members fail to understand the magnitude of the illness and its effects. Family members who do not understand or lack information about the nature of depression are likely to develop expectations about the ability of patients to function and manage their illness that exceed the perceived capabilities of the patients themselves. As a result, patients may perceive that they are unable to meet the expectations of significant others in a number of important areas. This perception may lead patients to believe that their families and friends do not understand how seriously ill they are (Eitel, Hatchett, Friend, Griffin, & Wadhwa, 1995; Hatchett, Friend, Symister, & Wadhwa, 1997). Over time, perceived inability to meet expectations from significant others and the related feeling of being misunderstood may increase subjective distress and contribute to the maintenance of the depressive episode.

These hypotheses emerged from two recent studies that found a strong relationship between perceived expectations and adjustment in renal dialysis patients. Hatchett, Friend, Symister, and Wadhwa (1997) studied patient perceptions of family and medical staff expectations and found that perceived inability to meet the expectations of others

predicted changes in depression, optimism, illness intrusiveness, and quality of life over a three month period. Furthermore, perceived expectations were strongly correlated with patient reports of feeling misunderstood by family members. Although the study did not directly address the origin of the perceived inability to meet family expectations, two alternative explanations were proposed for these results. First, family members may lack knowledge about the nature and course of renal disease and its physical and psychological consequences, resulting in unrealistic and fluctuating expectations for the patient. Alternatively, patients may experience a loss of self-esteem due to their inability to function at a level they of expect of themselves. As they become frustrated at their own incapacity, they project this anger outward and come to believe that others also hold expectations that they cannot fulfill. These hypotheses were tested in a second study that measured patient self-esteem and also assessed family members regarding their expectations for the patient (Hatchett, 1997). Mediational analyses revealed that high levels of reported expectations on the part of family and friends led to patients perceiving that they were unable to meet these expectations, which in turn predicted patient adjustment. Self-esteem, on the other hand, did not explain the relationship between patient perceptions and adjustment. Thus, the author concluded that patient perceptions accurately reflected excessive expectations from family members and friends.

The theoretical perspective developed by Hatchett and colleagues (1997) and the present study is strongly influenced by the work of Solomon Asch, whose general theory of social psychology centered around the importance of shared psychosocial fields of perceptions, cognitions, and emotions (Friend, Rafferty, & Bramel, 1990). Asch

(1952/1987) argued that a consensus of shared perceptions and expectations forms the basis of social relations and plays a central role in making intelligible social action possible. In this context, Asch emphasized the fundamental importance of the object of judgment, arguing that perceptions and attitudes are determined primarily by the specific qualities or properties of the object as they are perceived by the individual. Shared understanding is the rule because common perceptual processes generally lead to similar perceptions among persons in a given situation. When individual perspectives differ or conclusions are based on inaccurate or incomplete data, however, lack of consensus in perceptions or expectations may result. Given the importance of shared cognitions in regulating social interaction, such disagreements may lead to frustration and the experience of substantial distress (Asch 1952/1987). The present study incorporates the Aschian framework by emphasizing the role of the object of judgment, in this case depression and its symptoms, in characterizing the relationship between patients and their family members and friends. We propose that interpersonal agreements and disagreements arise from the depression itself as understood or misunderstood by patients and their significant others. Thus, we examine several aspects of depression that may lead to conflicting interpersonal expectations among patients and their friends and family members.

Depression is characterized primarily by negative symptoms that are largely continuous with normative behavior and may not be recognized as signs of mental illness by others who lack information about the nature of the disorder (Beck, 1967). These symptoms represent a considerable burden for friends and family members of persons

with depression. Coyne et al. (1987), for example, found that family members of depressed patients were significantly more distressed than those living with recovered patients. Their increased distress was almost completely accounted for by difficulties related to negative symptoms such as fatigue, hopelessness, and lack of energy. Similarly, Fadden, Bebbington, and Kuipers (1987) found that spouses of depressed patients reported substantial problems due to negative symptoms including underactivity, dependence, self-neglect, and indecisiveness. Unlike positive symptoms such as hallucinations or delusions, negative symptoms were not attributed to the depression by spouses who generally reported that they were unaware of what behavior to expect from patients as a result of the illness.

The negative symptoms associated with depression may also make it difficult for patients to carry out the routine functions and activities of daily life. For example, Weissman and Paykel (1974) found that many depressed women in a community sample were unable to manage household or parenting tasks and severely decreased their involvement in social and leisure activities. They depended on their husbands to perform the majority of household chores and to assume responsibility for coordinating the social life of the family. Although the husbands generally tried to be helpful, most soon became resentful and demanded that their wives resume their normal activities. Consistent with these findings, the family members surveyed by Coyne et al. (1987) also reported significant difficulties related to patient lack of interest in social life and leisure activities. The results of these studies suggest that negative symptoms and the related impairment in role functioning are primary areas of conflict between patients and their families and

may be particularly likely to become the subject of perceived inability to meet the expectations of significant others. For example, family members who lack information about depression may expect patients to be more decisive and cheerful or to engage in more social and physical activities than the nature of the illness allows.

Friends and family members may also expect patients to cope more effectively with the depression than is realistically possible. Lazarus (1984) argues that although persons who are physically or mentally ill may be relieved from certain responsibilities in our society, they are nonetheless expected to adhere to cultural norms calling for independence and the expression of positive emotions. In particular, patients are expected to be optimistic about their recovery and to face adversity courageously. These expectations may be challenging for persons with any type of illness, but they are particularly difficult for depressed patients who are likely to suffer from significant dysphoria and hopelessness. Indeed, many symptoms of depression run directly counter to the behaviors considered desirable for sick persons in our society. Thus, cultural standards are likely to produce expectations for positive coping among family members that patients feel unable to meet by the very nature of their illness. This hypothesis is supported in part by the results of Hatchett and colleagues (1997), who found that renal dialysis patients (whose deficit symptoms overlap to some extent with those of depression) perceived themselves as unable to meet the expectations of their families in this domain.

Although research has yet to address the specific effect of perceived discrepancies in expectations for patient behavior and coping, previous findings indicate that

interpersonal disagreements more generally may contribute to depressive symptomatology. Semple (1992) found that disagreements involving family member attitudes were associated with increased depressive symptoms among caregivers of patients with Alzheimer's disease. Chapman, Hobfall, and Rittner (1997) studied patient and family estimations of stressful life events in a longitudinal study of pregnant inner-city women and found that women whose partners underestimated their stressful life experiences during the first trimester of pregnancy reported greater depressed mood three months later than those whose partners did not underestimate their stressful life experiences. The stress underestimation effect was not mediated by perceived partner support, indicating that discrepant perceptions about life stress do not necessarily affect relationship quality, but represent a significant stressor in their own right.

The work of Laing, Phillipson, and Lee (1966) suggests that conflicting interpersonal expectations may also lead to feelings of being misunderstood. These authors explicitly related perceptions of agreement and disagreement to feelings of understanding and misunderstanding by arguing that the experience of being misunderstood arises from discordance between the perception of an event and the perception that another person perceives the event differently. Among depressed patients and their families, for example, patient perceptions of being unable to meet the expectations of family members may result in the belief that family members do not understand the nature of depression or the difficulties involved in living with the illness. This belief in turn may affect patient adjustment and worsen the course of the illness. Support for a causal relationship between misunderstanding and adjustment is provided

by Bromberger, Wisner, and Hanusa (1994), who studied postpartum women treated with antidepressants for major depressive disorder and found that feeling understood by their husbands was one of only three variables that reliably discriminated women who recovered from their depressive episode from those who did not. The amount of overt conflict within the marriage was not a significant predictor of patient recovery, indicating that feeling understood may be more important than general relationship quality in determining the course of depressive illness.

To clarify the links between interpersonal expectations, feelings of misunderstanding, and adjustment to depression, the present study explores patient perceptions of being unable to meet the expectations of others in several domains related to depression: coping with depression (patients perceive that their family and friends expect them to cope much better with the depression than they actually can), control over depressive symptoms (patients perceive that their family and friends expect them to have more control than they really do over symptoms such as hopelessness and worrying), and the ability to perform routine functions and social activities (patients perceive that their family and friends expect them to do much more than they are actually able to manage). It examines the relationship between perceived expectations and the feeling of misunderstanding resulting from the specific perception that significant others do not appreciate the severity of the illness or the difficulties experienced by the patient. Finally, it explores the effect of perceived expectations and feelings of being misunderstood on patient adjustment over time.

Comparison of Interpersonal Expectations with Other Perspectives

Perceived Criticism. Although most research on interpersonal process in depression has focused on objective measures of family functioning, it has become increasingly evident that the subjective perceptions of patients and family members may also play a significant role in interpersonal conflict and patient adjustment. Particularly important in this regard has been Hooley and Teasdale's (1989) recent work on perceived criticism. To test the hypothesis that objectively derived criticism ratings may not accurately reflect the amount of criticism actually experienced by patients, these authors developed an instrument to assess how critical patients believe their family members to be. In a sample of clinically depressed patients, they found that perceived criticism was only moderately correlated with the amount of criticism expressed by family members in structured interviews, yet represented a far better predictor of subsequent relapse. Although the only published attempt to replicate this study in clinically depressed patients (Okasha et al., 1994) failed to find a significant relationship between perceived criticism and relapse, it is likely that cultural differences in the Egyptian sample and the use of a modified criticism item were responsible for the discrepant findings.

The study of perceived criticism shares with our approach a focus on interpersonal perceptions in depressed patients and their families. However, Hooley and Teasdale (1989) consider these perceptions to reflect the personality attributes of family members or patients (i.e., highly critical relatives, patients who are especially sensitive to criticism, or both), while we focus on the manner in which specific aspects of the depression itself may contribute to interpersonal disagreements and misunderstandings. This situational focus makes it possible not only to specify the problem areas responsible for conflict

between patients and their significant others, but also to identify concrete misunderstandings that may respond to brief educational interventions. The global personality styles identified in the perceived criticism literature, on the other hand, may only be changed by more intensive behavioral or cognitive therapy (Hooley & Teasdale, 1989).

Despite the important differences between the two perspectives, it is possible that perceived criticism may overlap to some extent with the perceived inability to meet family and friends expectations. Patients who believe that they are unable to meet the expectations of their significant others may also be more likely to experience these individuals as critical and demanding. However, we believe that perceived expectations may also affect patient adjustment in the absence of perceived criticism. For example, family members may communicate their expectations in ways that are not viewed as critical or hostile, but nonetheless cause substantial distress for patients who are unable to meet these expectations.

Socially Prescribed Perfectionism. Socially prescribed perfectionism is a personality trait involving both the perceived need to meet the expectations of others and the belief that others have unrealistic standards for success and exert pressure to perform (Hewitt & Flett, 1991b). Depressed patients score higher than matched controls on measures of socially prescribed perfectionism (Hewitt & Flett, 1991a) and this trait is viewed as a significant risk factor for poor outcome in depressive illness. Specifically, patients high in socially prescribed perfectionism are considered to be particularly sensitive to criticism and likely to blame themselves for the failure to meet externally

imposed standards, which in turn may worsen the severity of the depression (Hewitt & Flett, 1993). Consistent with this hypothesis, socially prescribed perfectionism has been found to predict depression severity both cross-sectionally (Hewitt & Flett, 1993) and longitudinally (Hewitt, Flett, & Ediger, 1996) in clinical samples.

The concept of socially prescribed perfectionism is similar to our own approach in that it involves the perceived inability to meet the expectations of others. However, this view differs from ours in two important respects. First, our perspective focuses on the specific properties of the situation that structure or shape the interpersonal response. The perfectionism approach, on the other hand, focuses principally on stable personality differences regarding the belief in perfectionistic ideals. Second, our approach does not focus on standards of perfection, but on any expectations for patient behavior that are viewed as unattainable in the context of the depressive episode. Although some persons may indeed be especially sensitive to the standards of others, we believe that the nature of depression makes it almost inevitable that all patients will experience the feeling of being unable to meet the expectations of their families. Thus, high socially prescribed perfectionism scores among depressed patients may reflect the occurrence of very real disagreements with significant others rather than a characteristic cognitive bias. Consistent with this view, Flett, Hewitt, Garshowitz and Martin (1997) have recently acknowledged that socially prescribed perfectionism may at least in part represent a veridical report of actual social interactions. To date, however, no study has specifically examined whether actual life experiences or differences in perceptions are primarily responsible for the belief that others make excessive demands. Therefore, it remains

important to consider the possibility that even though many depressed patients may have a personality trait that predisposes them to overestimate the expectations of significant others, the nature of depression itself may lead others to develop expectations that patients feel they cannot meet.

The Present Study

The present study first determines whether interpersonal expectations predict psychological adjustment prospectively among patients with depression. We hypothesize that the perceived inability to meet family and friends expectations and the related feeling of being misunderstood are prospectively related to adjustment over a three month time period. Second, the study examines whether patient perceptions accurately reflect the expectations of significant others or are due to a tendency to view other people as critical and demanding. Family members or friends are asked about the expectations they have for the patient and patients are assessed on their level of socially prescribed perfectionism. Both factors are tested on their ability to predict perceived expectations and subsequent adjustment. This methodology provides the unique opportunity to clarify the origin of perceived expectations among depressed patients and to examine the prospective relationship between personality factors, interpersonal interactions, perceived expectations, and patient adjustment.

To reduce the likelihood of alternative explanations for any observed relationship between perceived family and friends expectations and adjustment, the study controls for perceived criticism, social support, neuroticism, and social desirability. Social support is an important predictor of depressive course and was correlated with perceived

expectations in the renal patients studied by Hatchett and colleagues (1997). Controlling for social support reduces the possibility that any effect of perceived expectations on patient adjustment is spuriously produced by the relationship of both factors to social support, and allows us to assess the independent effects of perceived expectations on patient adjustment over and above the more general quality of interpersonal relations. Neuroticism and social desirability may also be correlated with several of the measures used in the study. Individuals high in neuroticism tend to elicit negative social reactions and to report more psychological distress (Finch & Zautra, 1992). Thus, neuroticism may underlie both perceived expectations and adjustment. Similarly, social desirability has been found to correlate with depression severity (Eitel et al., 1995) and with interpersonal processes such as social support (Cutrona, 1986). Given the potential importance of these variables, the study explicitly controls for neuroticism and social desirability while exploring the association between expectations and adjustment.

Finally, the hypotheses are tested using several adjustment dimensions that reflect both symptom severity and psychological well-being. Although many studies use only a measure of depressive symptoms to characterize patient adjustment, some evidence suggests that negative and positive dimensions of mood or well-being are relatively independent (Watson, Clark, & Tellegen, 1988). Low depression scores, for example, do not necessarily imply high satisfaction with quality of life or optimism about the future. The present study incorporates three measures of adjustment relevant to patients with depression (depression, optimism, and quality of life), explores differences among them, and tests how each dimension is associated with interpersonal expectations.

Method

Participants

Data were collected from 86 persons with a current diagnosis of major depressive disorder. Forty-nine of these participants were patients of the Family Medicine Department at Stony Brook University Hospital, 32 were community residents who responded to advertisements in local newspapers, and five were Stony Brook University undergraduates enrolled in Introductory Psychology. Potential participants were excluded if they were illiterate, non-English speakers, or reported past or present dysthymia, bipolar disorder, substance abuse, or psychosis. Of the 86 individuals who were recruited to participate in the study, seven did not complete the Time 1 questionnaire and their data were dropped. A further 13 participants were excluded from the study because their scores on the Inventory to Diagnose Depression (IDD; Zimmerman, Coryell, Corenthal, & Wilson, 1986) indicated that they were not currently in a major depressive episode. Thus, 66 participants were included in the final sample. A total of 45 participants had completed data for each segment of the study (Time 1 questionnaire, Time 2 questionnaire, and family questionnaire), for a response rate of 68%. We compared the 45 participants who completed the second questionnaire with the 21 who did not and found no differences between groups in age, sex, ethnicity, education, marital status, treatment status, or the nine study variables.

Participants' mean age was 38.68 (SD = 12.81, range = 18-63) and their mean level of education was 13.84 years (SD = 2.91, range = 3-22). Sixty-seven percent were female and 86% were white. The non-white participants were African-American, Asian,

Hispanic, and Native American. Forty-one percent were never married, 35% married, 6% separated, 15% divorced, and 3% widowed. Eighty-five percent of participants were currently being treated for depression: 58% were being treated with medication and therapy, 23% with medication only, and 5% with therapy only. Fifteen percent of participants were receiving no current treatment for depression.

One family member or friend of each participant was solicited to complete the family expectations questionnaire. To identify this individual we asked patients to name the person with whom they engage most in the context of their illness and care. Six of these individuals refused to participate in the study or could not be reached by telephone. Thus, 60 significant others completed the family expectations questionnaire. Of these respondents, 27% were spouses, 25% parents, 13% friends, 12% siblings, 10% romantic partners, 8% adult children, and 2% other close confidants.

Procedure

Participants received an informed consent form, after which they were asked to complete a packet of questionnaires to assess perceived family and friends expectations, social support, socially prescribed perfectionism, perceived criticism, neuroticism, social desirability, depression, optimism, and quality of life (see Appendix A). Several days later, (M = 3.37 days, range = 0-33), the family member or confidant identified by each participant was contacted by telephone and asked to respond to questions about family and friends expectations (see Appendix B). Approximately three months later (M = 13.4 weeks, range = 9.3-29.4), participants were contacted again to complete a questionnaire assessing changes in family expectations, depression, optimism, and quality of life.

Undergraduate student participants received course credit for their participation, and community members were offered a free depression workshop in exchange for completing the study.

Measures

Perceived Expectations. Sixteen questions to assess perceptions of expectations from friends and family members were developed based on a review of the depression literature and interviews with depressed patients. Expectations pertain to four illness-related domains of daily life: (1) coping and adjusting to illness (e.g., „I sometimes feel that my family and friends expect me to cope much better with my depression than I actually can"), (2) lack of understanding of the illness (e.g., „I'm doing the best that I can but sometimes I think my family and friends don't understand what it is like to live with depression"), (3) depressive symptomatology (e.g., „At times I think that my family and friends expect me to feel more hopeful about the future than I can right now"), and (4) routine functions and activities (e.g., „At times I feel frustrated when my family and friends expect me to be more physically active than I'm capable of"). Each item describes the expectation or demand placed on the patient and assesses the degree to which the patient feels able to meet the expectation. Participants were instructed to respond to each item on a 5-point scale from 1 (strongly disagree) to 5 (strongly agree). Higher scores indicate larger perceived discrepancy in expectations. The measure of perceived expectations showed high internal consistency and reliability with a Cronbach alpha of .92 and a test-retest coefficient of .68. In order to correlate perceived expectations with understanding, the sum of items 2, 4, 6, and 7 was used to assess

understanding and the remaining items were summed to assess perceived expectations.

Family Expectations. To assess the accuracy of patient perceptions regarding expectations from significant others, a family and friends version of the questionnaire was developed. Each item was changed to reflect the actual expectations that others have for the patient. For example, the items listed above were rephrased as follows: „I sometimes feel she could cope much better with the depression than she actually does," „My knowledge and understanding of the symptoms of depression is limited," „At times I feel that she could be more hopeful about the future than she is right now," and „There are times when I expect her to be more physically active than she is now." The significant other identified by the patient was instructed to respond to each item on a 5-point scale from 1 (strongly disagree) to 5 (strongly agree). High scores indicate a higher level of expectations placed on the patient. The Cronbach alpha for this scale was .80, indicating adequate reliability. As with the perceived expectations scale, the sum of items 2, 4, 6, and 7 was used to assess understanding and the remaining items were summed to assess perceived expectations.

Perceived Criticism. Consistent with Hooley and Teasdale (1989), perceived criticism was assessed by asking „How critical of you do you feel your family and friends are?" Participants responded on a 10-point scale from 1 (not at all critical) to 10 (very critical indeed).

Perceived Social Support. Perceived social support was assessed by a modified version of the Perceived Social Support from Family scale (PSS-Fa; Procidano and Heller, 1983). The scale contains 20 items designed to assess the extent to which others

fulfill an individual's need for support, information, and feedback. Respondents answered „yes," „no," or „don't know" to a list of statements such as „My family/friends give me the moral support I need" and „My family/friends enjoy hearing what I think." PSS-Fa is highly correlated with other measures of perceived social support (Sarason, Shearin, Pierce, & Sarason, 1987) and has excellent test-retest reliability and internal consistency (Procidano & Heller, 1983).

Neuroticism. Neuroticism was assessed using the 12-item short form developed by Eysenck, Eysenck, and Barrett (1985) of the Neuroticism scale of the Eysenck Personality Questionnaire (Eysenck & Eysenck, 1975). Participants answered „yes" or „no" to questions such as „Do you ever feel just miserable for no reason?" and „Are you an irritable person?" High scores reflect the tendency to be nervous, moody, and easily upset. The short form is highly correlated with the full Neuroticism scale (Barrett & Eysenck, 1992) and has only slightly lower internal reliability (Eysenck, Eysenck, & Barrett, 1985).

Social Desirability. Reynolds' (1982) 13-item short form of the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960) was used to identify and control for the tendency of participants to endorse culturally appropriate behaviors. Respondents selected „true" or „false" to indicate their agreement with statements such as „I sometimes try to get even, rather than forgive and forget" and „I am always courteous, even to people who are disagreeable." Items are scored in the socially desirable direction, so that high scores indicate a high level of endorsement of socially desirable behaviors. The short form of the Marlowe-Crowne Social Desirability Scale is correlated

.93 with the full 33-item scale (Reynolds, 1982) and has excellent internal consistency and test-retest reliability (Zook & Sipps, 1985).

Perfectionism. The Socially Prescribed Perfectionism subscale of the Multidimensional Perfectionism Scale (Hewitt & Flett, 1991b) was used as a measure of perfectionism. This scale assesses the perceived need to attain standards and expectations prescribed by others. Respondents used a 7-point scale ranging from 1 (strongly disagree) to 7 (strongly agree) to rate their agreement with items such as „The people around me expect me to succeed at everything I do“ and „The better I do, the better I am expected to do.“ High scores imply the belief that significant others have unrealistic standards, evaluate one stringently, and exert pressure to be perfect. The Socially Prescribed Perfectionism scale has been found to be reliable and have excellent convergent and discriminant validity in both student and clinical samples (Hewitt & Flett, 1991b; Hewitt, Flett, Turnbull-Donovan, & Mikail, 1991).

Depression. The Inventory to Diagnose Depression (IDD; Zimmerman, Coryell, Corenthal, & Wilson, 1986) was used to confirm participant diagnoses of depression and to assess the severity of depressive symptoms. The IDD is a self-report inventory designed to diagnose major depression and to measure symptom severity. It contains 22 items, each of which assesses one depressive symptom using five statements arranged in order of severity. Respondents pick the statement in each group that describes the way they have been feeling for the past week and then indicate whether they have been feeling this way for more or less than two weeks. Answers can thus be summed for a total severity score or symptoms can be classified using Diagnostic and Statistical

Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994) criteria for major depression. The IDD has excellent test-retest reliability and internal consistency (Zimmerman & Coryell, 1987; Zimmerman et al., 1986). Scores on this scale are highly correlated with other self-report and interviewer rated depression scales and are sensitive to clinical change (Zimmerman et al., 1986). When used for diagnostic purposes, the IDD has high sensitivity (ability to correctly identify persons with major depression) and specificity (ability to correctly identify persons without major depression) in patients whose diagnosis is based on chart review or structured interviews (Zimmerman & Coryell, 1987; Zimmerman et al., 1986).

Optimism. Optimism was measured using the Life Orientation Test-Revised (LOT-R; Scheier, Carver, & Bridges, 1994). The LOT-R is a 6-item self-report measure (plus four filler items) assessing generalized expectancies for positive versus negative outcomes. Respondents were asked to indicate their degree of agreement with statements such as „In uncertain times, I usually expect the best“ and „I hardly ever expect things to go my way“ using a 5-point scale ranging from 0 (strongly disagree) to 4 (strongly agree). Of the six items, three are worded in a positive direction and three are worded in a negative direction. After reversing the scoring for the negatively worded items, item scores are summed to yield a total optimism score with high scores reflecting greater optimism. The LOT-R correlates .95 with the original Life Orientation Test (LOT; Scheier & Carver 1985) and has adequate psychometric characteristics (Scheier, Carver, & Bridges, 1994). Although scores on the LOT are moderately associated with depression as measured by the Beck Depression Inventory (BDI; Beck, Rush, Shaw, &

Emery, 1979), factor analyses conducted by Scheier and Carver (1985) suggest that depression and optimism represent conceptually distinct variables.

Quality of Life. Four items reviewed and suggested by Campbell, Converse, and Rodgers (1976) were chosen to measure global quality of life. Two items were selected from Bachman, Kahn, Davidson, and Johnston (1967) to assess satisfaction with life, „I generally feel in good spirits," and „I find a good deal of happiness in life." Respondents rated their agreement with these statements using a 5-point scale ranging from 1 (almost always true) to 5 (never true). Evaluation of life was assessed by two items from the Cantril Self-Anchoring Scale (1965), „Everything considered, how satisfied or dissatisfied would you say you are with your life these days?" with available responses ranging from 1 (very satisfied) to 7 (very dissatisfied), and „Everything considered, how would you rate your present life?" which ranges from 1 (not satisfactory) to 6 (very good), and is reverse scored. A previous study using these four items reported a Cronbach alpha of .74 and test-retest correlation of .76 (Hatchett et al., 1997).

Results

Overview

Four hypotheses regarding the relationship between perceived expectations and adjustment were tested. The first hypothesis predicted that perceived expectations are related to adjustment cross-sectionally, controlling for socially prescribed perfectionism, perceived criticism, social support, neuroticism, and social desirability. The second hypothesis predicted that perceived expectations are related to adjustment prospectively, again controlling for socially prescribed perfectionism, perceived criticism, social support, neuroticism, and social desirability. The third and fourth hypotheses involved two alternative models of the relationship between perceived expectations and adjustment. The family expectations model predicted that family expectations influence perceived expectations, which in turn influence adjustment. The perfectionism model predicted that socially prescribed perfectionism influences patient expectations, which in turn influences adjustment.

These tests are reported in the following manner: First, descriptions of the zero-order correlations between the study variables are presented, then the cross-sectional regressions assessing the relationship between perceived expectations and adjustment, followed by prospective regressions assessing the relationship between perceived expectations at Time 1 and adjustment at Time 2. Finally, the two models are tested by mediational analyses examining the relationship of family expectations with perceived expectations on adjustment and socially prescribed perfectionism with perceived expectations on adjustment.

Descriptive Analyses

Table 1 presents the Cronbach alphas, means, standard deviations, and ranges for all measures, as well as test-retest reliability for perceived expectations, perceived criticism, and the three adjustment measures. Participants reported significantly lower perceived expectations ($t(44) = 3.53$, $p < .01$) and depression ($t(44) = 2.78$, $p < .01$), as well as significantly higher quality of life ($t(44) = 3.41$, $p < .01$), from the Time 1 to the Time 2 assessment. However, no significant mean differences across time were found for optimism ($t(44) = 12.42$, ns) or perceived criticism ($t(44) = 2.17$, ns).

An important theoretical assumption underlying the development of the perceived expectations scale is that perceived agreement and disagreement in expectations is related to feelings of being understood and misunderstood. This assumption was tested by creating two subscale scores consisting of the items that measure perceived expectations and those that measure perceived understanding. Correlations between these subscale scores showed a relationship of $r = .79$ ($p < .01$) for perceived expectations and understanding. Thus, the conceptual link between perceived expectations and feeling understood predicted by the theories of Asch and Laing was confirmed. Similarly, the level of expectations reported by significant others was highly correlated with their knowledge and understanding of depression ($r = .61$, $p < .01$), supporting our hypothesis that the failure to understand depressive symptoms may play an important role in the development of discrepant standards for patient functioning among depressed patients and their friends and family members.

A further assumption of this work is that the independent variable, perceived

expectations, is derived from the actual demands that family members place on patients. As shown in Table 2, perceived expectations were positively correlated with family expectations ($r = .35$, $p < .01$), confirming that patients who viewed themselves as unable to meet the expectations of significant others were in fact more likely to have family members or friends who expected them to do more. In addition, perceived expectations were positively associated with socially prescribed perfectionism ($r = .38$, $p < .01$), perceived criticism ($r = .32$, $p < .01$) and neuroticism ($r = .35$, $p < .01$), indicating that patients who perceived family members and friends as highly demanding were also likely to consider themselves unable to meet the expectations of significant others, to view others as highly critical, and to report higher levels of socially prescribed perfectionism and neuroticism. Perceived expectations were negatively correlated with perceived social support, ($r = -.26$, $p < .01$), indicating that patients who experienced more disagreements with family and friends also reported receiving less positive social support. These results suggest that the measure of perceived expectations has adequate discriminant validity, sharing some, but not all, of its variance with socially prescribed perfectionism, social support, neuroticism, and perceived criticism. Given the strength of the associations, however, socially prescribed perfectionism, social support, neuroticism, and perceived criticism were controlled for in the subsequent regression analyses. Social desirability was not related to perceived expectations ($r = .13$, ns) and was disregarded in subsequent analyses.

As hypothesized, perceived expectations were significantly associated with all three of the adjustment measures. At Time 1, perceived expectations were positively

correlated with depression ($r = .38$, $p < .01$) and quality of life ($r = .25$, $p < .05$), indicating that patients who perceived themselves as unable to meet the expectations of significant others were more severely depressed and experienced a lower quality of life. Time 1 perceived expectations were negatively correlated with optimism ($r = -.24$, $p < .05$) such that patients who viewed their families as demanding were less optimistic about the future. At Time 2, perceived expectations were similarly correlated with depression ($r = .56$, $p < .01$), quality of life ($r = .39$, $p < .01$), and optimism ($r = -.63$, $p < .01$).

Whereas perceived expectations were consistently related to the adjustment measures, the related constructs of socially prescribed perfectionism, social support, perceived criticism, and neuroticism were not. At Time 1, socially prescribed perfectionism was significantly correlated with optimism ($r = -.24$, $p < .05$) but not with depression or quality of life, while social support was correlated with quality of life ($r = -.28$, $p < .05$) but not with depression or optimism. Perceived criticism and neuroticism were not significantly associated with any of the adjustment measures at Time 1. The associations between the related constructs at Time 1 and adjustment at Time 2 were somewhat stronger. Socially prescribed perfectionism was significantly correlated with both Time 2 optimism ($r = -.54$, $p < .01$) and depression ($r = .30$, $p < .05$), but not with Time 2 quality of life. Social support was associated with Time 2 optimism ($r = .51$, $p < .01$), but not depression or quality of life. As at Time 1, perceived criticism and neuroticism were not significantly associated with any of the adjustment measures at Time 2.

Based on the results of previous research on socially prescribed perfectionism,

social support, perceived criticism and neuroticism, it was expected that these variables would be reliably associated with the adjustment measures. Thus, the lack of a consistent relationship observed in the data was puzzling. One possible explanation involves differences between the participants who completed the study and those who dropped out after Time 1. Because the correlations between the independent variables and the adjustment measures were stronger at Time 2 than at Time 1, we hypothesized that the data of participants who dropped out of the study may have reduced the magnitude of the Time 1 correlations. To test this possibility, we repeated the correlational analyses using only the data of the 45 participants who completed the study. As shown in Table 3, the correlations for these participants were virtually the same as those for the study sample as a whole (Table 2), indicating that differences between the Time 1 and Time 2 samples did not account for the observed pattern of correlations. Moreover, it is important to note that none of the other independent variables were related to all of the adjustment measures at either time point. Thus, the data suggest that perceived expectations are simply a stronger and more consistent predictor of adjustment than either socially prescribed perfectionism, social support, neuroticism, or perceived criticism.

The dependent variables were moderately intercorrelated at both time points in the study. At Time 1, quality of life was significantly correlated with depression ($r = .30$, $p < .05$) and optimism ($r = -.38$, $p < .01$), while there was no significant association between depression and optimism ($r = -.21$, ns). At Time 2, quality of life was again correlated with depression ($r = .39$, $p < .01$) and optimism ($r = -.67$, $p < .01$), and the association between depression and optimism was also significant ($r = -.69$, $p < .01$). Although the

correlations between the adjustment measures were relatively high, the results nonetheless appear consistent with previous work suggesting that specific dimensions of well-being are somewhat independent and should be assessed by a variety of measures (e.g., Watson, Clark, & Tellegen, 1988).

Cross-Sectional Relationship between Perceived Expectations and Adjustment

Preliminary analyses indicated that several demographic factors were significantly associated with the study variables. Specifically, age was positively correlated with family expectations ($r = .28$, $p < .05$), education was negatively correlated with neuroticism ($r = -.30$, $p < .05$), and sex was associated with quality of life such that women reported a higher quality of life than men ($t(1,64) = 3.13$, $p < .01$). Thus, these three demographic variables were controlled in subsequent regression analyses.

To test the hypothesis that perceived expectations predict adjustment cross-sectionally, a series of regression analyses was conducted in which adjustment was regressed on perceived expectations while controlling for age, education, sex, socially prescribed perfectionism, social support, neuroticism, and perceived criticism. A hierarchical regression analysis was conducted for each of the adjustment measures at Time 1. The covariates were entered in the first step and perceived expectations at Time 1 were entered in the second step to predict adjustment at Time 1. As shown in Table 4, perceived expectations significantly predicted two of the three adjustment measures, accounting for an additional 23% of the variance in depression ($R = .54$, F $(8,57) = 18.65$, $p < .01$) and 5% of the variance in quality of life ($R = .54$, F $(8,57) = 4.24$, $p < .01$) over and above that accounted for by socially prescribed perfectionism, social support,

neuroticism and perceived criticism. Perceived expectations also accounted for an additional 4% of the variance in optimism, which approached significance (R = .47, F (8,57) = 3.23, p = .08). Thus, the cross-sectional relationships between perceived expectations and adjustment indicate that patients who felt unable to meet family expectations were more depressed and pessimistic, as well as more likely to experience a lower quality of life, even when controlling for socially prescribed perfectionism, social support, and perceived criticism.

Prospective Relationship between Perceived Expectations and Adjustment

To test the hypothesis that perceived expectations predict adjustment prospectively, a series of regression analyses was conducted in which adjustment at Time 2 was regressed on perceived expectations at Time 1 while controlling for the same covariates as in the cross-sectional analyses. For each of the adjustment measures, the covariates at Time 1 were entered in the first step and perceived expectations at Time 1 were entered in the second step to predict adjustment at Time 2. Table 5 shows that perceived expectations predicted depression over time, accounting for an additional 12% of the variance in Time 2 depression (R = .54, F (9,35) = 7.51, $p < .01$) . Thus, patients who felt most unable to meet the expectations of family and friends at Time 1 were more likely to experience depressed mood at Time 2. This relationship was observed even when socially prescribed perfectionism, social support, neuroticism and perceived criticism were controlled for at Time 1. However, perceived expectations at Time 1 did not predict either quality of life or optimism at Time 2.

To determine whether the initial level of perceived expectations predicted changes

over time in each of the adjustment measures, residualized regression analyses were conducted for each of the adjustment measures at Time 2, controlling for age, education, sex, socially prescribed perfectionism, social support, neuroticism, and perceived criticism. The covariates and adjustment at Time 1 were entered in the first step and perceived expectations at Time 1 were entered in the second step to predict adjustment at Time 2. As shown in Table 6, perceived expectations did not predict changes in any of the three adjustment measures over time.

From a situational perspective, it is also useful to examine whether changes in interpersonal expectations are related to changes in adjustment over time. Thus, we calculated change scores for perceived expectations, depression, quality of life, and optimism, and then computed correlations between the change scores. Changes in perceived expectations were significantly correlated with changes in depression ($r = .41$, $p < .01$), quality of life ($r = .34$, $p < .05$), and optimism ($r = -.33$, $p < .05$). These correlations indicate that changes in perceived expectations were related to concurrent changes in adjustment. Patients who viewed themselves as becoming better able to meet the expectations of friends and family members over time also tended to improve on measures of depression and optimism and to report a higher quality of life.

To further examine the nature of the relationship between perceived expectations and the adjustment measures, we used Time 1 and Time 2 perceived expectations to calculate both average and difference scores for perceived expectations. These scores separate perceived expectations into trait and state components. Specifically, the average expectation scores reflect the variance due to individual differences, while the difference

scores reflect the variance due to changes in expectations over time. To examine the independent effect of each component of perceived expectations, residualized regression analyses were conducted for each of the adjustment measures at Time 2, controlling for age, education, sex, socially prescribed perfectionism, social support, neuroticism, and perceived criticism. The covariates and adjustment at Time 1 were entered in the first step, and average and difference scores for perceived expectations at Time 1 were entered in the second step to predict adjustment at Time 2. Expectations difference scores significantly predicted changes over time in quality of life ($\beta = .28$, $p < .05$) and optimism ($\beta = -.34$, $p < .05$), and there was a trend for expectations to predict changes in depression ($\beta = .25$, $p = .06$). Average expectations, on the other hand, did not predict changes in any of the adjustment measures. This analysis provides further evidence that stable individual differences in perceived expectations are not a significant predictor of changes in adjustment, while changes in expectations over time are strongly related to concurrent changes in the adjustment measures.

The analyses above were primarily designed to test the hypothesis that perceived expectations predict changes in patient adjustment over time. We also examined the alternative hypothesis that depressed or poorly adjusted patients may come to distort or misperceive the expectations of others. Three separate hierarchical regression equations were conducted using each adjustment measure by itself to predict Time 2 expectations controlling for Time 1 expectations and for age, education, sex, socially prescribed perfectionism, social support, neuroticism, and perceived criticism. In each regression, expectations at Time 1 and the covariates were entered in the first step and the

adjustment measure was entered in the second step. The results in Table 7 show that poorer adjustment did not lead to changes in perceived ability to meet family expectations in any of the three regression equations. Thus, these analyses did not support a causal direction leading from adjustment to expectations.

To examine whether changes in adjustment predicted changes in perceived expectations, we used scores on the Time 1 and Time 2 adjustment measures to calculate average and difference scores for depression, optimism, and quality of life. Separate residualized regression analyses were conducted using each of the adjustment measures to predict perceived expectations, controlling for age, education, sex, socially prescribed perfectionism, social support, neuroticism, and perceived criticism. In each analysis, the covariates and perceived expectations at Time 1 were entered in the first step, and average and difference scores for the adjustment measure at Time 1 were entered in the second step to predict perceived expectations at Time 2. In this analysis, optimism emerged as a significant predictor of changes in perceived expectations, with significant results for both average optimism ($\beta = -.28$, $p < .05$) and optimism difference scores ($\beta = -.25$, $p < .05$). Neither average nor difference scores calculated from the measures of depression (average $\beta = .21$, ns; difference $\beta = .18$, ns) and quality of life (average $\beta = .11$; ns, difference $\beta = .20$, ns) predicted changes in perceived expectations over time. Thus, optimism was the only adjustment measure to predict changes in interpersonal perceptions.

Mediational analyses

Two alternative models were developed to describe the relationship between

perceived expectations and adjustment. The family expectations model hypothesized that family expectations influence perceived expectations, which in turn influence adjustment. The perfectionism model hypothesized that socially prescribed perfectionism influences patient expectations, which in turn influences adjustment. A multiple regression approach to testing mediated effects (Baron & Kenney, 1986; Holmbeck, 1997) was used to test each model individually. In this approach, a variable is considered a mediator if the following four conditions are met: (1) the predictor is significantly associated with the hypothesized mediator; (2) the predictor is significantly associated with the dependent measure; (3) the mediator is significantly associated with the dependent measure; and (4) the impact of the predictor on the dependent measure is reduced after controlling for the mediator.

Regression analyses to test the family expectations model showed that only the first condition required by Baron and Kenney (1986) was satisfied by the data. Family expectations significantly predicted perceived expectations cross-sectionally, accounting for an additional 6% ($R = .60$, $F\,(8,51) = 5.26$, $p < .05$) of the variance in perceived expectations over and above that accounted for by socially prescribed perfectionism, social support, neuroticism and perceived criticism. This finding suggests that perceived inability to perform is, in fact, related to the actual demands that family members and friends place on patients. However, family expectations did not predict Time 2 depression ($ß = .03$, ns), optimism ($ß = -.11$, ns), or quality of life ($ß = -.11$, ns). Thus, the mediational model could not be further tested and the hypothesis that family expectations operate through perceived expectations to affect adjustment in depression

was not supported.

Regression analyses to test the perfectionism model showed that neither of the first two conditions required by Baron and Kenney (1986) was satisfied. Although there was a significant correlation between socially prescribed perfectionism and perceived expectations at Time 1 ($r = .38$, $p < .01$), socially prescribed perfectionism did not predict expectations after controlling for age, sex, education, social support, neuroticism, and perceived criticism ($ß = .20$, ns). Moreover, Time 1 perfectionism was inconsistently associated with the adjustment measures, showing significant or near significant correlations with depression ($r = .30$, $p < .05$), optimism ($r = .53$, $p < .01$), and quality of life ($r = .27$, $p = .07$) at Time 2 but only with optimism ($r = -.24$, $p < .05$) at Time 1. Thus, the perfectionism mediational model could not be further tested and the hypothesis that socially prescribed perfectionism operates through perceived expectations to affect adjustment was also not supported by the data.

Discussion

The present study was conducted to examine the effect of perceived expectations on adjustment in persons with major depression. As in previous research with renal dialysis patients, perceived expectations were related to adjustment both cross-sectionally and prospectively over a three month time period. Moreover, these relationships remained significant even when controlling for socially prescribed perfectionism, perceived criticism, social support, and neuroticism. Although initial levels of perceived expectations did not predict changes in adjustment over time, a significant relationship was found between changes in perceived expectations and changes in the adjustment measures. Analyses testing the reverse causation hypothesis that initial adjustment predicts changes in perceived expectations over time were not significant. Two alternative models were tested to determine whether family expectations or socially prescribed perfectionism were responsible for the relationship between perceived expectations and adjustment. Neither model was supported by the data.

The construct of perceived expectations was derived from the social psychological theories of Asch and Laing. Hatchett and colleagues (1997) further developed this construct and applied it to chronic medical illness. The measure of perceived expectations developed for the present study was based on the family expectations scale used by Hatchett and colleagues (1997) to assess perceptions of disagreement between dialysis patients and their families and medical staff. When adapting the scale to reflect the experiences of depressed patients, we focused specifically on areas of concern in this population, including depressive symptomatology, coping with the illness, and the ability

to perform routine functions and activities.

A major purpose of the study was to assess the psychometric properties of the perceived expectations and family expectations scales in a sample of clinically depressed patients. We found that perceived expectations were relatively stable over a three month time period and that both scales had high internal consistency. Moreover, participants and their significant others strongly endorsed the items on both scales, suggesting that these instruments accurately capture the interpersonal disagreements that occur in families coping with major depression. During the interviews with depressed patients, it was clear that many participants could identify with the items on the perceived expectations scale. For example, one patient reported that she was often unable to get out of bed in the morning due to the lack of energy and motivation she experienced during a depressive episode. She complained that her husband usually responded by accusing her of being lazy and urging her to „just snap out of it.“ Conversely, many family members in the study spontaneously expressed the opinion that patients could be more active or even overcome their depression completely if they simply tried hard enough. Thus, the scales appear to be an accurate reflection of very real discrepancies in the beliefs and expectations of patients and their significant others regarding patient abilities and behavior.

Although we modified the perceived expectations scale and used different measures of optimism and depression than Hatchett and colleagues (1997), we found a similar relationship between perceived expectations and various indicators of patient adjustment. These results suggest that the construct of perceived expectations can usefully be

generalized to explain interpersonal conflicts in coping with a variety of illnesses. Consistent with this view, Leake (1999) recently found that discrepant interpersonal expectations predicted adjustment in patients with coronary heart disease. Her study also expanded the definition of perceived expectations to include the perception that families may be simultaneously overprotective (expecting patients to do less than they are capable of) and demanding (expecting patients to do more than they are capable of). Thus, the research suggests that the construct of perceived expectations has the flexibility to capture the different interpersonal issues involved in a large variety of physical and mental disorders.

As predicted by the theories of Laing, Phillipson, and Lee (1966), we found that the perception that significant others have excessive expectations was substantially correlated with feelings of being misunderstood. In the context of depression, friends and family members have specific expectations about how patients should manage and cope with their illness. By the very nature of their illness, persons with depression are not able to consistently meet many of these expectations. We found that this discrepancy was a substantial source of distress in its own right. Patients reported feeling angry and upset when they were unable to meet the perceived expectations of others, even though they viewed these expectations as unreasonable or excessive.

There was strong evidence that the perceptions of the patients accurately reflected the expectations of their friends and family members. Patients who reported that they felt unable to meet the expectations of significant others tended to have family members who believed that patients should cope better with their illness and engage in more activities.

Thus, both patients and family members reported significant difficulties around the issue of discrepant expectations for patient behavior and functioning. Underlying this discrepancy may be insufficient knowledge about the effects of the illness on the part of friends and family members. We found a substantial correlation between the level of expectations reported by significant others and their reported knowledge about depression, suggesting that a general lack of information about depression and mental illness may be a major reason for the development of discrepant expectations among depressed patients and their friends and family members.

Consistent with our predictions, perceived expectations predicted adjustment cross-sectionally. Patient perceptions of being unable to meet family expectations were associated with greater depression, less optimism, and lower quality of life, suggesting that perceived expectations are strongly related to concurrent psychological distress and well-being. Perceived expectations also predicted more severe depression prospectively, but did not predict optimism or quality of life over the three month time period of the study. This finding implies that symptom severity and psychological adjustment may have different determinants over time. The perceived expectations scale was developed specifically to take account of depressive symptoms and emerged as an accurate predictor of symptom severity in this study. The outcomes assessed by measures of optimism and quality of life, on the other hand, may be more closely related to other elements of patient or family functioning. Thus, future research should continue to incorporate separate measures for the negative and positive dimensions of mood or well-being.

The relationship between perceived expectations and adjustment was apparent

while controlling for a large number of potential confounding variables. The study controlled for social support, socially prescribed perfectionism, neuroticism, and perceived criticism. These variables were moderately correlated with perceived expectations such that patients who reported being unable to meet the expectations of significant others also reported more neurotic mood, higher levels of socially prescribed perfectionism, more critical relatives, and fewer social supports. With one exception, however, the control variables did not account for the relationship between perceived expectations and adjustment, which remained significant even when controlling for possible confounds. The single exception was the prospective relationship between perceived expectations and optimism, which was reduced to insignificance when covariates were entered into the equation.

Interestingly, none of the other predictors assessed in the study was as reliably associated with adjustment as perceived expectations. Perceived criticism, neuroticism, and social desirability were not associated with any of the adjustment measures at either time point measured in the study. Social support and socially prescribed perfectionism, on the other hand, were moderately associated with adjustment but showed inconsistent patterns of correlation with the outcome measures at the two time points. These results suggest that perceived criticism, neuroticism, social support, and socially prescribed perfectionism were not important correlates of adjustment in this sample, nor did they account for the relationship between perceived expectations and the adjustment measures. These findings run counter to the results of prior studies, which have reported a significant association between depression severity and perceived criticism (Hooley &

Teasdale, 1989), neuroticism (Finch & Zautra, 1992), social support (Goering, Lancee, & Freeman, 1992), socially prescribed perfectionism (Hewitt, Flett, & Ediger, 1996), and social desirability (Eitel et al., 1995). Our failure to find a significant relationship between these predictors and patient adjustment may be due in part to the small sample size of the study and the resulting lack of statistical power. Nevertheless, the fact that perceived expectations was significantly associated with adjustment indicates that lack of power can not completely explain our results. Thus, perceived expectations may be a more potent predictor of adjustment in depressed patients. Unlike other constructs that focus on general aspects of personality or relationships, the perceived expectations scale measures specific interpersonal disagreements about coping with depression and related functional impairment. To the extent that such disagreements are an extremely salient aspect of the illness experience for many patients, a measure that captures the nature of these interactions may be more closely related to patient mood and well-being than broader measures of personality or social support.

Contrary to predictions, perceived expectations did not predict changes in adjustment prospectively. It is possible that perceived expectations were unable to predict these changes because patient adjustment did not vary sufficiently during the three month time period assessed in the study. However, the fact that significant differences across time were found in two of the adjustment variables contradicts this reasoning. It is more likely that initial levels of perceived expectations were simply not a strong predictor of changes in adjustment over time. Thus, we failed to support our hypothesis that patients who perceive significant others as excessively demanding tend to

become more depressed and less well adjusted over time.

An alternative hypothesis suggests that the causal direction between perceived expectations and psychological adjustment is such that poorly adjusted patients come to distort or misperceive the expectations of others. That is, more severely depressed patients perceive significant others as expecting more of them than do less depressed patients. While such an interpretation is consistent with cognitive theories suggesting that depressive episodes may be accompanied by distorted thoughts and beliefs (e.g., Beck, 1967), the present study does not provide support for this direction of causality. We found that neither initial levels of depression nor changes in depression over time were a significant predictor of changes in perceived expectations.

Although individual differences in perceived expectations were not associated with changes in depression and vice versa, we did find a relationship between changes in perceived expectations and changes in depression. Moreover, this relationship was found at all levels of perceived expectations and was replicated with all of the adjustment measures. Patients who came to view themselves as better able to meet the expectations of friends and family members over the course of the study also became less depressed, more optimistic, and experienced a higher quality of life. These findings are directly relevant for intervention because they suggest that changing expectations should result in corresponding changes in adjustment among depressed patients.

We tested two alternative models of the relationship between perceived expectations and adjustment to determine the source of the perceived discrepancy in expectations. The family expectations model was derived from the idea that family

members make demands on patients that they are unable to meet. The perception of being unable to meet the expectations of significant others in turn influences patient adjustment. Although we found that the expectations reported by family members were associated with the perceived expectations reported by patients, family expectations did not predict patient adjustment either cross-sectionally or prospectively. Thus, the data did not support the hypothesis that family expectations operate through perceived expectations to affect adjustment.

A second model proposed that socially prescribed perfectionism may be the source of the reported discrepancy in expectations. We hypothesized that patients may endorse the items on the perceived expectations scale because they have a general tendency to believe that others have unrealistic standards for success and exert pressure to perform. This personality trait may then be responsible for the relationship between expectations and adjustment. Findings from the present study indicate that socially prescribed perfectionism was correlated with perceived expectations, but was not a significant predictor of expectations when other variables were controlled. Moreover, socially prescribed perfectionism was consistently related to only one of the adjustment measures, optimism. It is possible that beliefs about the future are related to general personality style and that individuals who view other people in general as excessively demanding and impossible to please also tend to be less optimistic about the possibility of change. Socially prescribed perfectionism was not related to depression severity or quality of life, however, and it failed to explain the relationship between expectations and adjustment.

The lack of support for both models tested in the study suggests that a third variable

may be responsible for the relationship between patient expectations and adjustment. We controlled for many potential confounding variables believed to be associated with patient expectations and adjustment, including social support, neuroticism, perceived criticism, and social desirability. However, other potential determinants of perceived expectations are possible. For example, Hatchett (1997) suggested that patients may experience a loss of self-esteem from feelings of inadequacy brought about by their actual or perceived inability to function at a level they expect of themselves. Patients who perceive themselves as weak or inactive may then justify their inactivity by suggesting that others expect too much. These patients may experience poor adjustment over time when family members make high demands on them. Future research should examine low self-esteem as well as other potential third variables as possible sources of discrepant expectations between depressed persons and their friends and family members.

Although we successfully predicted adjustment among depressed patients using a measure of perceived expectations, the study was limited by several design and statistical issues. First, all of the participants were depressed before the study began so that we could not fully assess the effects of the depression itself. Ideally, we would study a large population of participants and assess them before and after the onset of a depressive episode to determine more conclusively whether interpersonal conflicts are due to the characteristics of the depression or to stable personality factors such as perfectionism or neuroticism. Second, the exclusive use of questionnaire measures as indicators of observable behavior makes it impossible to be sure that patient and family reports accurately reflected their interpersonal expectations and behavior. Research on the

related construct of perceived criticism has found that patient ratings correspond poorly with the amount of criticism actually expressed by family members (Hooley & Teasdale, 1989), suggesting that important differences may also exist between perceived expectations and the actual expectations for patient behavior and functioning that are communicated to the patient by significant others. Although our primary interest is in patient perceptions, it would be useful to compare self-reported data to direct observation of patient interactions with friends and family members. Finally, the relatively high dropout rate among participants reduced the statistical power of our analyses and may have limited our ability to detect important relationships between interpersonal expectations, personality factors, and measures of adjustment. In particular, lack of power may have contributed to our inability to support either of the mediational models we proposed.

While this study has a number of limitations, it also has several major strengths. First, all of the participants in the study met diagnostic criteria for major depression. Many prior studies have used analog samples selected for high levels of dysphoric mood or self-reported distress rather than diagnosable depression, severely limiting the applicability of the research findings to clinical populations (Coyne, 1994). Second, we assessed a range of social and personality variables in order to understand the relationship between these variables and adjustment and to test the predictive power of perceived expectations over and above the effect of similar constructs. Finally, we used a prospective design in which participants were followed for a three month period, allowing us to test hypotheses about the temporal relationships between interpersonal

expectations and adjustment.

An important contribution of this study was the development of reliable and internally consistent measures to assess perceived expectations and family demands among persons with major depression. The success of the perceived expectations scale in predicting adjustment in this population suggests that a theoretical model of discrepant interpersonal expectations (Hatchett et al., 1997) can be used to predict outcome across a variety of disorders. Unlike other correlates of adjustment in depression such as social support and perceived criticism, moreover, the construct of perceived expectations focuses on the specific properties of the situation that structure or shape the interpersonal response. Because it identifies the concrete misunderstandings that families and patients are likely to experience in the course of a depressive episode, future treatment programs derived from the perceived expectations approach will be able to address these problem areas with specific interventions. Thus, our findings add to the literature on interpersonal treatments for depression (e.g., Klerman, Weissman, Rounsaville, & Chevron, 1984) by characterizing important areas of disagreement between patients and significant others. Furthermore, the results of the study are consistent with recent suggestions for cognitive therapy by researchers who argue that effective treatments should include family members and address the specific conflicts that may result from divergent expectations for patient behavior (Alford & Beck, 1997).

In summary, the results of the present study suggest that perceived expectations are an important predictor of adjustment in depression. However, the source of these expectations remains unclear. It is important to examine a variety of possible causal

factors, including self-esteem, in order to fully understand the nature of perceived expectations. Additionally, future studies should examine the effectiveness of treatment programs that educate patients and significant others about the nature of depression and the symptoms and functional impairment that may be associated with the illness. By helping to prevent or reduce miscommunication between patients and their family members, such interventions may be an effective way to improve the interpersonal relationships and adjustment of persons with major depression.

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Table 1

<u>Reliability, Means, SDs, and Ranges of Measures</u>

Measure	Cronbach Alpha	Test-Retest Reliability	Time 1				Time 2	
			Mean (# of Items)	SD	Possible Range	Actual Range	Mean	SD
Perceived Expectations	.92	.68	61.11 (16)	12.05	16-80	31-80	56.64	13.12
Family Expectations	.80		44.53 (16)	10.11	16-80	24-69		
Social Support	.89		10.59 (20)	5.56	0-20	0-20		
Neuroticism	.64		9.47 (12)	2.11	0-12	3-12		
Social Desirability	.72		6.05 (13)	2.90	0-13	0-12		
Perfectionism	.84		60.35 (15)	16.40	15-105	21-99		
Perceived Criticism		.67	5.86 (1)	2.88	1-10	1-10	5.87	2.35
Depression	.79	.55	39.55 (22)	11.87	0-88	14-62	33.07	14.67
Optimism	.58	.59	8.48 (6)	3.91	0-24	0-16	9.13	4.83
Quality of Life[a]	.77	.59	16.58 (4)	3.23	4-23	10-23	15.42	4.16

<u>Note</u>. <u>N</u> = 66 for Time 1 variables; <u>N</u> = 60 for Family Expectations; <u>N</u> = 45 for Time 2 variables.
[a]Higher scores indicate lower quality of life.

Table 2

Correlations of Study Variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. T1 Perceived Expectations														
2. T2 Perceived Expectations	.68**													
3. Family Expectations	.35**	.41**												
4. Social Support	-.26*	-.40**	-.06											
5. Neuroticism	.35**	.06	.00	.11										
6. Social Desirability	.13	.14	.03	-.03	-.30*									
7. Perfectionism	.38**	.53**	.07	-.29*	.22	.02								
8. T1 Perceived Criticism	.32**	.49**	.14	-.32**	.26*	.03	.52**							
9. T2 Perceived Criticism	.33*	.68**	.34*	-.54**	.05	.09	.48**	.67**						
10. T1 Depression	.38**	.36*	.23	.09	.04	.13	.08	.03	.16					
11. T2 Depression	.41**	.56**	.15	-.26	-.03	.22	.30*	.03	.36*	.55**				
12. T1 Optimism	-.24*	-.28	.01	.23	-.06	.14	-.24*	-.20	-.23	-.21	-.39**			
13. T2 Optimism	-.32*	-.63**	-.14	.51**	-.07	-.10	-.54**	-.31*	-.55**	-.28	-.69**	.59**		
14. T1 Quality of Life	.25*	.17	.09	-.28*	-.04	-.09	.04	.20	.26	.30*	.40**	-.38**	-.38**	
15. T2 Quality of Life	.15	.39**	.07	-.25	.09	.08	.27	.07	.38**	.21	.73**	-.35*	-.67**	.59**

Note. N = 66 for Time 1 variables; N = 60 for Family Expectations; N = 45 for Time 2 variables. T1 = Time 1; T2 = Time 2.
*p<.05, **p<.01 (two tailed)

Table 3

Correlations of Study Variables for Participants who Completed the Study

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. T1 Perceived Expectations														
2. T2 Perceived Expectations	.68**													
3. Family Expectations	.30*	.41**												
4. Social Support	-.23	-.40**	-.10											
5. Neuroticism	.34*	.06	-.07	.16										
6. Social Desirability	.23	.14	.04	-.23	-.23									
7. Perfectionism	.55**	.53**	.08	-.41**	.27	-.01								
8. T1 Perceived Criticism	.38*	.49**	.20	-.33*	.29	.14	.43**							
9. T2 Perceived Criticism	.33*	.68**	.34*	-.54**	.05	.09	.48**	.67**						
10. T1 Depression	.51**	.36*	.13	-.05	.07	.21	.05	.01	.16					
11. T2 Depression	.41**	.56**	.15	-.26	-.03	.22	.30*	.03	.36*	.55**				
12. T1 Optimism	-.20	-.28	.04	.26	-.16	.29	-.24	-.12	-.23	-.27	-.39**			
13. T2 Optimism	-.32*	-.63**	-.14	.51**	-.07	-.10	-.54**	-.31*	-.55**	-.28	-.69**	.59**		
14. T1 Quality of Life	.13	.17	.14	-.20	-.00	-.03	.03	.12	.26	.48**	.40**	-.42**	-.38**	
15. T2 Quality of Life	.15	.39**	.07	-.25	.09	.08	.27	.07	.38**	.21	.73**	-.35*	-.67**	.59**

Note. N = 45. T1 = Time 1; T2 = Time 2.
*p<.05, **p<.01 (two tailed)

Table 4

Cross-Sectional Regression Analyses Predicting Adjustment from Perceived Expectations at Time 1

Predictors	Depression ß	Depression R^2 change	Depression F	Quality of Life ß	Quality of Life R^2 change	Quality of Life F	Optimism ß	Optimism R^2 change	Optimism F
Step 1									
Age	-.11			-.05			.28*		
Education	.06			.14			-.06		
Sex	.14			.36**			-.15		
Perfectionism	.14			-.06			-.20		
Social Support	.15			-.19			.16		
Neuroticism	.01			.03			-.01		
Perceived Criticism	.02			.18			-.07		
Step 2									
Perceived Expectations	.59	.23	18.65**	.28	.05	4.24*	-.26	.04	3.23

Note. N = 66, df = (8,57)
*p<.05, **p<.01

Table 5

Prospective Regression Analyses Predicting Time 2 Adjustment from Perceived Expectations

	Time 2								
	Depression			Quality of Life			Optimism		
Predictors Time 1	ß	R^2 change	F	ß	R^2 change	F	ß	R^2 change	F
Step 1									
Age	.07			.07			.07		
Education	-.23			-.05			-.03		
Sex	.31			.44*			-.17		
Perfectionism	.36*			.36*			-.44*		
Social Support	-.17			-.12			.34*		
Neuroticism	-.01			-.06			-.02		
Perceived Criticism	-.14			-.06			-.03		
Step 2									
Perceived Expectations	.43	.12	7.51**	.08	.00	.20	-.11	.01	.52

Note. N = 45, df = (9,35)
*p<.05, **p<.01

Table 6

Prospective Regression Analyses Predicting Changes in Adjustment from Perceived Expectations

	Time 2								
	Depression			Quality of Life			Optimism		
Predictors Time 1	ß	R^2 change	F	ß	R^2 change	F	ß	R^2 change	F
Step 1									
Age	.10			.15			-.09		
Education	-.24*			-.19			-.04		
Sex	.23			.19			-.04		
Perfectionism	.36*			.33*			-.30*		
Social Support	-.13			-.03			.25		
Neuroticism	-.07			-.10			.01		
Perceived Criticism	-.11			-.12			.00		
Adjustment	.52**			.57**			.47**		
Step 2									
Perceived Expectations	.04	.00	.04	-.05	.00	.12	-.06	.00	.17

Note. N = 45, df = (9,35)
*p<.05, **p<.01

Table 7

Prospective Regression Analyses Predicting Changes in Perceived Expectations from Adjustment

Time 2 Perceived Expectations

Predictors Time 1	ß	R^2 change	F
Step 1			
Age	-.05		
Education	-.13		
Sex	.07		
Perfectionism	.18		
Social Support	-.08		
Neuroticism	-.27*		
Perceived Criticism	.29*		
Perceived Expectations	.60**		
Step 2: Depression	.11	.01	.65
Step 2: Quality of Life	.05	.00	.16
Step 2: Optimism	-.11	.01	.83

Note. N = 45, df = (9,35)
*p<.05, **p<.001

Appendix A

Patient Questionnaire

A. Perceived Expectations Scale

B. Socially Prescribed Perfectionism Scale

C. Eysenck Personality Questionnaire--Revised Neuroticism Scale

D. Marlowe-Crowne Social Desirability Scale

E. Quality of Life

F. Inventory to Diagnose Depression

G. Life Orientation Test

H. Perceived Social Support

A. PERCEIVED EXPECTATIONS SCALE

These items ask about your experiences with your family and friends. Please circle the number that corresponds to how you feel using this scale:

1	2	3	4	5
strongly disagree	disagree	somewhat agree	agree	strongly agree

1. I sometimes think that my family and friends expect me to take more responsibility for my depression than I can manage.

   1 2 3 4 5

2. I sometimes feel frustrated when my family and friends do not understand how difficult it is for me to deal with my depression.

   1 2 3 4 5

3. I sometimes feel that my family and friends expect me to cope much better with my depression than I actually can.

   1 2 3 4 5

4. I'm doing the best that I can but sometimes I think my family and friends don't understand what it is like to live with depression.

   1 2 3 4 5

5. Sometimes I think my family and friends assume that I can adjust to changes in my relations with them much more easily than I actually can.

   1 2 3 4 5

6. I feel upset at times when my family and friends don't recognize how ill I really am.

   1 2 3 4 5

7. My family and friends have difficulty tolerating my depression.

   1 2 3 4 5

8. I sometimes get frustrated when my family and friends assume that I should be

able to easily carry out everyday activities which I have difficulty with (work, travel, shopping).

1 2 3 4 5

9. Sometimes I feel that my family and friends expect that I can do much more around the house than I really can (housework, yard work, errands).

1 2 3 4 5

10. At times I think that my family and friends expect me to feel more hopeful about the future than I can right now.

1 2 3 4 5

11. I feel angry at times when my family and friends assume that I could get over my depression if only I really wanted to.

1 2 3 4 5

12. Sometimes I think my family and friends expect me to be more cheerful and positive than I can manage.

1 2 3 4 5

13. I sometimes feel that my family and friends expect me to take more responsibility for making decisions than I'm capable of.

1 2 3 4 5

14. At times I feel frustrated when my family and friends expect me to be more physically active than I'm capable of.

1 2 3 4 5

15. I sometimes feel that my family and friends expect me to cope with many more social activities than I actually can (recreation, travel, shared activities).

1 2 3 4 5

16. Sometimes I think my family and friends assume that I can stop worrying and thinking about my problems much more easily than I actually can.

1 2 3 4 5

B. SOCIALLY PRESCRIBED PERFECTIONISM SCALE

Listed below are a number of statements concerning personal characteristics and traits. Read each item and decide whether you agree or disagree and to what extent. If you strongly agree, circle 7; if you strongly disagree, circle 1; if you feel somewhere in between, circle any one of the numbers between 1 and 7. If you feel neutral or undecided the midpoint is 4.

1.	I find it difficult to meet others' expectations of me.	1 2 3 4 5 6 7
2.	Those around me readily accept that I can make mistakes too.	1 2 3 4 5 6 7
3.	The better I do, the better I am expected to do.	1 2 3 4 5 6 7
4.	Anything that I do that is less than excellent will be seen as poor work by those around me.	1 2 3 4 5 6 7
5.	The people around me expect me to succeed at everything I do.	1 2 3 4 5 6 7
6.	Others will like me even if I don't excel at everything.	1 2 3 4 5 6 7
7.	Success means that I must work even harder to please others.	1 2 3 4 5 6 7
8.	Others think I am okay, even when I do not succeed.	1 2 3 4 5 6 7
9.	I feel that people are too demanding of me.	1 2 3 4 5 6 7
10.	Although they may not show it, other people get very upset with me when I slip up.	1 2 3 4 5 6 7
11.	My family expects me to be perfect.	1 2 3 4 5 6 7
12.	My parents rarely expected me to excel in all aspects of my life.	1 2 3 4 5 6 7
13.	People expect nothing less than perfection of me.	1 2 3 4 5 6 7
14.	People expect more from me than I am capable of giving.	1 2 3 4 5 6 7
15.	People around me think I am still competent even if I make a mistake.	1 2 3 4 5 6 7

C. EYSENCK PERSONALITY QUESTIONNAIRE--REVISED
NEUROTICISM SCALE

Please answer each question by putting a circle around the YES or NO following the question. There are no right or wrong answers, and no trick questions. Work quickly and do not think too long about the exact meaning of the questions.

1.	Does your mood often go up and down?	YES	NO
2.	Do you ever feel „just miserable“ for no reason?	YES	NO
3.	Are you an irritable person?	YES	NO
4.	Are your feelings easily hurt?	YES	NO
5.	Do you often feel „fed up“?	YES	NO
6.	Would you call yourself a nervous person?	YES	NO
7.	Are you a worrier?	YES	NO
8.	Would you call yourself tense or „highly strung“?	YES	NO
9.	Do you worry too long after an embarrassing experience?	YES	NO
10.	Do you suffer from „nerves“?	YES	NO
11.	Do you often feel lonely?	YES	NO
12.	Are you often troubled by feelings of guilt?	YES	NO

D. MARLOWE-CROWNE SOCIAL DESIRABILITY SCALE

Read each statement carefully, then circle **T (TRUE) or F (FALSE)** for each item.

1.	It is sometimes hard for me to go on with my work if I am not encouraged.	T	F
2.	I sometimes feel resentful when I don't get my way.	T	F
3.	On a few occasions, I have given up doing something because I thought too little of my ability.	T	F
4.	There have been times when I felt like rebelling against people in authority even though I knew they were right.	T	F
5.	No matter who I'm talking to, I'm always a good listener.	T	F
6.	There have been occasions when I took advantage of someone.	T	F
7.	I'm always willing to admit it when I make a mistake.	T	F
8.	I sometimes try to get even, rather than forgive and forget.	T	F
9.	I am always courteous, even to people who are disagreeable.	T	F
10.	I have never been irked when people expressed ideas very different from my own.	T	F
11.	There have been times when I was quite jealous of the good fortune of others.	T	F
12.	I sometimes get irritated by people who ask favors of me.	T	F
13.	I have never deliberately said something that hurt someone's feelings.	T	F

E. QUALITY OF LIFE

Circle the **NUMBER** that corresponds to how you feel:

1. I generally feel in good spirits.

1	2	3	4	5
always true	often true	sometimes true	seldom true	never true

2. I find a good deal of happiness in life.

1	2	3	4	5
always true	often true	sometimes true	seldom true	never true

3. Everything considered, how satisfied or dissatisfied would you say you are with your life these days?

1	2	3	4	5	6	7
very satisfied	somewhat satisfied	satisfied	neutral	dissatisfied	somewhat dissatisfied	very dissatisfied

4. Everything considered, how would you rate your present life?

1	2	3	4	5	6
not satisfactory	clearly below average	a little below average	a little above average	clearly above average	very good

F. INVENTORY TO DIAGNOSE DEPRESSION

On this questionnaire are groups of 5 statements. Read each group of statements carefully. Then pick out the one statement in each group that best describes the way you have been feeling the **PAST WEEK**. Circle the number next to the statement you picked.

For every group in which you circled 1, 2, 3, or 4 answer the follow-up question as to whether you have been feeling that way for more or less than 2 weeks.

1.
   - 0 I do not feel sad or depressed.
   - 1 I occasionally feel sad or down.
   - 2 I feel sad most of the time, but I can snap out of it.
   - 3 I feel sad all the time, and I can't snap out of it.
   - 4 I am so sad or unhappy that I can't stand it.

   *** If you circled 1, 2, 3, or 4: Have you been feeling sad or down for more or less than 2 weeks? more less

2.
   - 0 My energy level is normal.
   - 1 My energy level is occasionally a little lower than normal.
   - 2 I get tired more easily or have less energy than usual.
   - 3 I get tired from doing almost anything.
   - 4 I feel tired or exhausted almost all of the time.

   *** If you circled 1, 2, 3, or 4: Has your energy level been lower than usual for more or less than 2 weeks? more less

3.
   - 0 I have not been feeling more restless and fidgety than usual.
   - 1 I feel a little more restless or fidgety than usual.
   - 2 I have been very fidgety, and I have some difficulty sitting still in a chair.
   - 3 I have been extremely fidgety, and I have been pacing a little bit almost every day.
   - 4 I have been pacing more than an hour per day, and I can't sit still.

   *** If you circled 1, 2, 3, or 4: Have you felt restless and fidgety for more or less than 2 weeks? more less

4. 0 I have not been talking or moving more slowly than usual.
   1 I am talking a little slower than usual.
   2 I am speaking slower than usual, and it takes me longer to respond to questions, but I can still carry on a normal conversation.
   3 Normal conversations are difficult because it is hard to start talking
   4 I feel extremely slowed down physically, like I am stuck in mud.

*** If you circled 1, 2, 3, or 4: Have you felt slowed down for more or less than 2 weeks? more less

5. 0 I have not lost interest in my usual activities.
   1 I am a little less interested in 1 or 2 of my usual activities.
   2 I am less interested in several of my usual activities.
   3 I have lost most of my interest in almost all of my usual activities.
   4 I have lost all interest in all of my usual activities.

*** If you circled 1, 2, 3, or 4: Has your interest in your usual activities been low for more or less than 2 weeks? more less

6. 0 I get as much pleasure as usual out of my usual activities.
   1 I get a little less pleasure from 1 or 2 of my usual activities.
   2 I get less pleasure from several of my usual activities.
   3 I get almost no pleasure from most of the activities which I usually enjoy.
   4 I get no pleasure from any of the activities which I usually enjoy.

*** If you circled 1, 2, 3, or 4: Has your enjoyment in your usual activities been low for more or less than 2 weeks? more less

7. 0 I have not noticed any recent change in my interest in sex.
   1 I am only slightly less interested in sex than usual.
   2 There is a noticeable decrease in my interest in sex.
   3 I am much less interested in sex.
   4 I have lost all interest in sex.

*** If you circled 1, 2, 3, or 4: Has your interest in sex been low for more or less than 2 weeks? more less

8 0 I have not been feeling guilty.
1 I occasionally feel a little guilty.
2 I often feel guilty.
3 I feel quite guilty most of the time.
4 I feel extremely guilty most of the time.

*** If you circled 1, 2, 3, or 4: Have you had guilt feelings for more or less than 2 weeks? more less

9 0 I do not feel like a failure.
1 My opinion of myself is occasionally a little low.
2 I feel I am inferior to most people.
3 I feel like a failure.
4 I feel I am a totally worthless person.

*** If you circled 1, 2, 3, or 4: Have you been down on yourself for more or less than 2 weeks? more less

10. 0 I haven't had any thoughts of death or suicide.
1 I occasionally think life is not worth living.
2 I frequently think of dying in passive ways (such as going to sleep and not waking up), or that I'd be better off dead.
3 I have frequent thoughts of killing myself, but I would not carry them out.
4 I would kill myself if I had the chance.

*** If you circled 1, 2, 3, or 4: Have you been thinking about dying or killing yourself for more or less than 2 weeks? more less

11. 0 I can concentrate as well as usual.
1 My ability to concentrate is slightly less than usual.
2 My attention span is not as good as usual and I am having difficulty collecting my thoughts, but this hasn't caused any problems.
3 My ability to read or hold a conversation is not as good as it usually is.
4 I cannot read, watch TV, or have a conversation without great difficulty.

*** If you circled 1, 2, 3, or 4: Have you had problems concentrating for more or less than 2 weeks? more less

12. 0 I make decisions as well as I usually do.
1 Decision making is slightly more difficult than usual.
2 It is harder and takes longer to make decisions, but I do make them.
3 I am unable to make some decisions.
4 I can't make any decisions at all.

*** If you circled 1, 2, 3, or 4: Have you had problems making decisions for more or less than 2 weeks? more less

13. 0 My appetite is not less than normal.
1 My appetite is slightly worse than usual.
2 My appetite is clearly not as good as usual, but I still eat.
3 My appetite is much worse now.
4 I have no appetite at all, and I have to force myself to eat even a little.

*** If you circled 1, 2, 3, or 4: Has your appetite been decreased for more or less than 2 weeks? more less

14. 0 I haven't lost any weight.
1 I've lost less than 5 pounds.
2 I've lost between 5-10 pounds.
3 I've lost between 11-25 pounds.
4 I've lost more than 25 pounds.

*** If you circled 1, 2, 3, or 4: Have you been dieting and deliberately trying to lose weight? Y N

Have you been losing weight for more or less than 2 weeks? more less

15. 0 My appetite is not greater than normal.
1 My appetite is slightly greater than normal.
2 My appetite is clearly greater than usual.
3 My appetite is much greater than usual.
4 I feel hungry all the time.

*** If you circled 1, 2, 3, or 4: Has your appetite been increased for more or less than 2 weeks? more less

16. 0 I haven't gained any weight.
1 I've gained less than 5 pounds.
2 I've gained between 5-10 pounds.
3 I've gained between 11-25 pounds.
4 I've lost gained than 25 pounds.

*** If you circled 1, 2, 3, or 4: Have you been gaining weight for more or less than 2 weeks? more less

17. 0 I am not sleeping less than normal.
1 I occasionally have slight difficulty sleeping.
2 I clearly don't sleep as well as usual.
3 I sleep about half my normal amount of time.
4 I sleep less than 2 hours per night.

*** If you circled 1, 2, 3, or 4: Have you been having sleep problems for more or less than 2 weeks? more less

18. 0 I am not sleeping more than normal.
1 I occasionally sleep more than usual.
2 I frequently sleep at least 1 hour more than usual.
3 I frequently sleep at least 2 hours more than usual.
4 I frequently sleep at least 3 hours more than usual.

*** If you circled 1, 2, 3, or 4: Have you been sleeping extra for more or less than 2 weeks? more less

19. 0 I do not feel anxious, nervous, or tense.
1 I occasionally feel a little anxious.
2 I often feel very anxious.
3 I feel very anxious most of the time.
4 I feel terrified and near panic.

*** If you circled 1, 2, 3, or 4: Have you been feeling anxious, nervous or tense for more or less than 2 weeks? more less

20. 0 I do not feel discouraged about the future.
1 I occasionally feel a little discouraged about the future.
2 I often feel very discouraged about the future.
3 I feel very discouraged about the future most of the time.
4 I feel that the future is hopeless and that things will never improve.

*** If you circled 1, 2, 3, or 4: Have you been feeling discouraged for more or less than 2 weeks? more less

21. 0 I do not feel irritated or annoyed.
1 I occasionally get a little more irritated than usual.
2 I get irritated or annoyed by things that usually don't bother me.
3 I feel irritated or annoyed almost all the time.
4 I feel so depressed that I don't get irritated at all by things that used to bother me.

*** If you circled 1, 2, 3, or 4: Have you been feeling more irritable than usual for more or less than 2 weeks? more less

22. 0 I am not worried about my physical health.
1 I am occasionally concerned about bodily aches and pains.
2 I am worried about my physical health.
3 I am very worried about my physical health.
4 I am so worried about my physical health that I cannot think about anything else.

*** If you circled 1, 2, 3, or 4: Have you been worried about your physical health for more or less than 2 weeks? more less

G. LIFE ORIENTATION TEST

Please indicate the extent to which you agree with each of the following statements.

0	1	2	3	4
strongly disagree	disagree	somewhat agree	agree	strongly agree

1. In uncertain times, I usually expect the best. 0 1 2 3 4
2. It’s easy for me to relax. 0 1 2 3 4
3. If something can go wrong for me, it will. 0 1 2 3 4
4. I’m always optimistic about the future. 0 1 2 3 4
5. I enjoy friends a lot. 0 1 2 3 4
6. It’s important for me to keep busy. 0 1 2 3 4
7. I hardly ever expect things to go my way. 0 1 2 3 4
8. I don’t get upset too easily. 0 1 2 3 4
9. Overall, I expect more good things to happen to me than bad. 0 1 2 3 4
10. I rarely count on good things happening to me. 0 1 2 3 4

H. PERCEIVED SOCIAL SUPPORT

The statements which follow refer to feelings and experiences which occur to most people at one time or another in their relationships with their families and friends. For each statement there are three possible answers: Yes, No, Don't know. Please circle the answer you choose for each item.

Yes No Don't Know 1. My family/friends give me the moral support I need.

Yes No Don't Know 2. I get good ideas about how to do things or make things from my family/friends.

Yes No Don't Know 3. Most other people are closer to their family/friends than I am.

Yes No Don't Know 4. When I confide in the members of my family/friends who are closest to me, I get the idea that it makes them uncomfortable.

Yes No Don't Know 5. My family/friends enjoy hearing about what I think.

Yes No Don't Know 6. My family/friends share many of my interests.

Yes No Don't Know 7. My family members/friends come to me when they have problems or need advice.

Yes No Don't Know 8. I rely on my family/friends for emotional support.

Yes No Don't Know 9. There is a family member/friend I could go to if I were just feeling down, without feeling funny about it later.

Yes No Don't Know 10. My family/friends and I are very open about what we think about things.

Yes No Don't Know 11. My family/friends are sensitive to my personal needs.

Yes No Don't Know 12. My family/friends come to me for emotional support.

Yes No Don't Know 13. My family/friends are good at helping me solve problems.

Yes No Don't Know 14. I have a deep sharing relationship with a number of family members/friends.

Yes No Don't Know 15. My family/friends get good ideas about how to do things or make things from me.

Yes No Don't Know 16. When I confide in my family/friends it makes me uncomfortable.

Yes No Don't Know 17. My family/friends seek me out for companionship.

Yes No Don't Know 18. I think that my family/friends feel that I'm good at helping them solve problems.

Yes No Don't Know 19. I don't have a relationship with a family member/friend that is as close as other people's relationships with family members/friends.

Yes No Don't Know 20. I wish my family/friends were much different.

Appendix B

Family Member Questionnaire

A. FAMILY AND FRIENDS EXPECTATIONS SCALE

These items refer to (patient name) and how s/he copes with depression. Please choose the number that corresponds to how you feel using this scale:

1	2	3	4	5
strongly disagree	disagree	somewhat agree	agree	strongly agree

1. I sometimes think that s/he could take more responsibility for her/his depression than s/he actually does.

   1 2 3 4 5

2. My knowledge and understanding of mental illness is somewhat limited.

   1 2 3 4 5

3. I sometimes feel s/he could cope much better with the depression than s/he actually does.

   1 2 3 4 5

4. My knowledge and understanding of the symptoms of depression is limited.

   1 2 3 4 5

5. At times I think that s/he could do a lot more even though s/he is depressed.

   1 2 3 4 5

6. I sometimes feel that s/he is not as sick as s/he makes out to be.

   1 2 3 4 5

7. There are times when I have difficulty tolerating her/his depression.

   1 2 3 4 5

8. I sometimes think that s/he could carry out more everyday activities (work, travel, shopping) than s/he does now.

1 2 3 4 5

9. Sometimes I feel that s/he could do much more around the house than s/he actually does (housework, yard work, errands).

1 2 3 4 5

10. At times I feel that s/he could be more hopeful about the future than s/he is right now.

1 2 3 4 5

11. I sometimes think that s/he could get over her/his depression if only s/he really wanted to.

1 2 3 4 5

12. Sometimes I feel s/he could be more cheerful and positive than s/he actually is.

1 2 3 4 5

13. I sometimes feel that s/he should take more responsibility for making decisions than s/he does now.

1 2 3 4 5

14. There are times when I expect her/him to be more physically active than s/he is now.

1 2 3 4 5

15. I sometimes feel that s/he could carry out many more social activities than s/he actually does (recreation, travel, shared activities).

1 2 3 4 5

16. Sometimes I think s/he should stop worrying and thinking about her/his problems.

1 2 3 4 5

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