Developmental psychopathology may be different from person to person. There are factors which are culturally determined and may influence development. These could be aspects of temperament, child-rearing practices, nature of development and other stressors which are culture specific as well as the symptoms which are considered pathological in a particular family, subculture or society as a whole.

In the Indian context, child rearing practices, family interactions, peer and school influences, nature of temperament, protective factors and social supports in the environment, social and cultural values, etc are important areas of study and research. The nature of cognitive, language, emotional, social, moral and sex-role development in some core groups such as those who are dependent or insecurely attached, those with attention deficit, those with internalising or externalising problems, and those who are mentally healthy or resilient need to be studied on a longitudinal basis. In a high risk population of children this would be of great value in term of planning of interventions (Kapur, 1995).

Depression during childhood or adolescence has a negative impact on social, academic and family functioning, as well as being associated with an increased risk for recurrence and impairment in social-emotional functioning that extends into adult life. It is not simply a disorder of mood regulation but
involves alterations in physiological and cognitive functioning. The study of depression requires careful attention to developmental issues especially the challenges of adolescence. Depression which first presents during the prepubertal depression is best explained by a model of interaction between genetic and environmental factors (Thapar and Mc Guffin, 1996). More importantly, prepubertal depression represents a strong, but non-specific risk for adult adjustment problems whereas adolescent depression is strongly linked to recurrent depressive episodes during adult life (Harrington et al., 1996). The striking age and gender patterns in depression rates indicate that a developmental theoretical framework is needed to understand factors that may increase vulnerability to depression, with close attention to risk factors for adolescent depression.

THE DEFINITION OF DEPRESSION

The nature and etiology of depression are subject to even more sharply divided opinion. Some authorities contend that depression is primarily a psychogenic disorder; others maintain just as firmly that it is caused by organic factors. A third group supports the concept of two different types of depression: a psychogenic type and an organic type (Butcher, 1992).

The modern text book descriptions of depression symptoms as: disturbed mood (sad, dismayed, futile); self-castigations (the accursed, hatred of the Gods); self-debasing behaviour (wrapped in sac-cloth or dirty rags, he
rolls himself, naked in the dirt); wish to die, physical and vegetative symptoms (agitation, loss of appetite and weight, sleeplessness); and delusions of having committed unpardonable sins.

Depression may be defined in terms of the following attributes.

1) A specific alteration in mood: sadness, loneliness, apathy.


3) Regressive and self-punitive wishes: desires to escape, hide or die.

4) Vegetative changes: anorexia, insomnia, loss of libido.

5) Change in activity level: retardation or agitation.

The term depression has been used to designate a discrete nosological entity. The term is generally qualified by some adjective to indicate a particular type of form, as for example: reactive depression, agitated depression or psychotic depressive reaction when conceptualised as a specific clinical entity, depression is assumed to have certain consistent attributes in addition to the characteristic signs and symptoms; these attributes include a specifiable type of onset, course, duration and outcome. There is a considerable body of evidence indicating that the clinical entity depression responds to certain drugs and/or Electro Convulsive Therapy (ECT), but there is no consensus as yet regarding its etiology.

**HISTORY OF DEPRESSION**

People have suffered from depression from the earliest recorded time.
Before the birth of Christ the Greek physician Hippocrates known as the father of medicine, attributed depression to an overabundance of “black bile” in the body. The Greeks called it “Melancholia or black bile” after one of the physiological “HUMORS” that they thought affected mood and controlled emotions. In 1904 Dr. Adolf Meyer an American Psychiatrist and Professor of Psychiatry at Cornell University and Johns Hopkins University concluded that the term “melancholy” gave a stamp of certainty to a vague condition in which there was no positive evidence of disease. He proposed using the term depression to differentiate between “melancholy” (or severe depression) and the more Universal down hearted periods that are part of the human experience. By the 1960s however some of the shortcomings of psychotherapy compared to the efficacy of the newly discovered antidepressants strengthened today’s neurochemical imbalances theory of depression (Horwath, 2004)

**MELANCHOLIA**

Melancholia is a mental condition characterized by an overriding inability to experience pleasure even in situations that are normally pleasurable. Melancholic individuals describe their depression (usually worse in the morning) as distinct from the sadness or grief they have felt before— even in connection with their depressed mood and loss of pleasure (Bellack and Hersen, 1993). Individuals with melancholia may also experience early awakening, loss of appetite and weight, in appropriate guilt feelings and
marked changes of life were suffering a special kind of depressive disorder referred to as involutional melancholia.

**ACUTE DEPRESSION**

Depression is referred to various terms and has several different subtypes that overlap and are not mutually exclusive. Consequently the term of reference used to refer to or describe a type or subtype can depend on whether a person is talking to a clinician, researcher or other mental health specialist. “Acute” depression is a term that overlaps with clinical, endogenous or Unipolar depression. Acute itself is a term used to describe a condition that quickly develop into a crisis. Thus acute depression seems to come about suddenly and rapidly as opposed to a depression that progress slowly and continues for a long time.

Although the symptoms for some clinical depression are long-lasting enough and sufficiently severe to require treatment, acute depression can be as brief as two weeks or last as long as a year or longer. When it is so short duration, it can clear up spontaneously without treatment. The symptoms develop over a period of four weeks or less. Generally they include such things as pessimism, loss of interest, loss of pleasure, helplessness, hopelessness, self-condemnation and tearfulness. The physical symptoms can include change in appetite, sleep disturbance, agitation, retardation of movement and bodily complaints (Horwath, 2004).
BIPOLAR AFFECTIVE DISORDER

In bipolar disorder also called Manic-Depressive disorder, a patient experiences mood swings of uncontrollable mania, alternating with episodes of severe depression. According to the American Psychiatric Association the disorder will affect nearly one in 100 people at some point in their lives.

During the manic or high state people may feel well and strong, go without sleep for long periods and plunge into vast, often foolish, undertaking in their personal or business affairs. They have abundant energy and grandiose notions, feel agitated and excited, and believe they are capable of any undertaking (Horwath, 2004). Along with their constant talking, they exhibit an extremely elevated, ecstatic mood, inappropriate degrees of self-confidence, non-stop hyperactivity, increased sexual activity, a decreased need for sleep, heightened irritability and aggressiveness and self-destructive, impulsive behaviour, such as reckless spending.

When they are in a depressive phase they have bouts of inertia and may suffer from any of the symptoms associated with major depressive disorder, as they feel down, dispirited and sad.

UNIPOLAR DISORDER

A type of depression in which a person may be severely depressed and suffer from major depressive disorder but not from manic depressive disorder. It is defined as one depressive episode or a history only of depressive
episodes (as opposed to both manic and depressive episodes). A large percentage of people who experience a major depression have only one serious episode in their lifetimes. In other cases, the course of unipolar disorder may vary and episodes may be separated by long intervals, such as years or they may be closer together (Checkley, 1998). During a down episode victims are dispirited and listless and generally find it difficult to go about their work and other activities. Sometimes unipolar disorder merely drags a person into a state of the blues without interfering with work. It is a term that overlaps with clinical or endogenous depression.

FEATURES OF UNIPOLAR DEPRESSION

Age of Onset

Researchers have documented that the most typical age of onset of major depression in adolescence and young adulthood. (Burke, Riger & Rae, 1990). Young women in particular have enormous liability for depression onset between ages 15 and 19 or by age 25.

There are two important implications. One is that depression is especially likely to affect young people during critical periods of their development, including marriage, child bearing and establishment of careers. Impairment during these important functions might have persisting maladaptive consequences. A second implication is that relatively early onset of depression - or perhaps of any psychological disorder - may portend a
relatively worse course of illness, both because of developmental disruptions and because earlier onset may reflect a more severe form of the disorder.

**Episode Length**

Two trends are noteworthy concerning duration of major depressive episodes. One is that the majority of episodes appear to resolve within six months (including untreated depressions). The second trend however is that a substantial minority of depressions persist for long periods, and may even be chronic.

**IMPAIRMENT ASSOCIATED WITH DEPRESSIVE DISORDER**

It is hardly surprising that the low mood, loss of interest, decreased energy, sense of futility and low self-esteem associated with depressive disorders would result in dysfunction in important roles such as work, marital and parental adjustment. What is more surprising is the extent of debility, resulting as much or even more self-reported impairment than many serious medical disorders. In the language of illness burden to society due to economic and social disability as well as mortality, the WHO has termed disability in the world and the fourth course of disability in the world and the fourth greatest course of disease burden (expected to move to second most important by the year 2020) Murray and Lopez (1996).
Not surprisingly, studies of the consequences of depression in children and adolescents also indicate significant impairment of functioning. Those with depression show relative difficulties in school performance and conduct and problematic relationships with peers and family members.

**COURSE AND CONSEQUENCES OF UNIPOLAR DEPRESSION**

Much of what clinicians once believed about depression was that it occurs mostly in middle and older adulthood and rarely in youngsters and that it is commonly expressed as a single episode with full recovery has been found to be untrue.

**Who is Affected by Unipolar Depression**

Depressive disorders in young children are relatively rare, possibly affecting 2-3% of pre-adolescents and 1% of pre-schoolers. The epidemiological surveys of diagnosis among children have been much more limited in scope than those for adults. The rate of adolescent depression generally indicates much higher rates than in childhood. For instance, the Oregon Adolescent Depression study found that 3% met criteria for current major depression or dysthymia and a total of 20% had a lifetime diagnosis of depressive disorders.

**adolescent depression**

Today depressive illnesses appear to be occurring more commonly among adolescents. The National Institute of Mental Health (NIMH) report
that 8.3% of adolescent experiences depression. With the significant rise in
the rate of depression among adolescents had its start in the 1970’s when
psychiatric facilities reported that more patients were being diagnosed as
depressed and that they were younger than the standard textbook description
of depressed patients as middle aged. This trend very obviously contributes
to the dramatic increase in suicide attempts and in death by suicide among
adolescents and young adults (Bellack, 1993).

Depressed adolescents can experience feelings of emptiness, anxiety, loneliness, helplessness, guilt, loss of confidence and self-esteem and changes in sleeping and eating habits. In addition they often act out. That is, they try to cover their depression by acting angry, aggressive, running away or becoming delinquent (Verma and Saraswathi, 2002). Manic-depressive disorder in adolescents is often manifested by episodes of impulsivity, irritability and loss of control alternating with periods of withdrawal.

Depression in adolescents can and should be treated, but unfortunately this treatable disorder typically goes unrecognized when it is assumed that such storminess is natural to adolescence (Bellack, 1993). All too often the symptoms are simply chalked up to the normal adjustments of adolescence and as a result depressed young people do not get the help they need. Moreover adolescent people often don’t ask for or get the right help because they fail to recognize the symptoms of depression in themselves or in people they care about.
Introduction

Since adolescents are so noted for their quickly changing moods and behaviour, it may take careful watching to see differences between a depressive disorder and normal behaviour. The key to recognizing the depressive disorder is that the change in behaviour lasts for weeks or longer.

The people who are having the symptoms of depression for longer than a few weeks or who is doing poorly in school, seem socially withdrawn, uncaring, overly impulsive and no longer interested in activities once enjoyed, should be checked for a possible depressive illness (Verma and Saraswathy, 2002). A trained therapist or counsellor can help a depressed adolescent person learn more positive ways to think about himself or herself, change behaviour cope with problems.

CLINICAL DEPRESSION

The term clinical depression is a general term applied to a depression that lasts for more than a couple of weeks and with symptoms severe and lasting enough to require treatment. In addition to feeling, it can change behaviour, physical health and appearance, academic and job performance and the ability to handle everyday decisions and pressures. It is manifested by more dramatic behavioural changes than normal depression and it is a term that overlaps with major, unipolar or endogenous depression.

EXPERIENCE OF DEPRESSION
Depression is a word in such common usage that it is often used interchangeably with upset, disappointed, or some similar term to refer to a negative emotion following a bad experience. Depression may be mood state, lasting only a few moments or hours – occasionally a few days – but in which other elements of the person’s functioning are unchanged. It is, in fact, normal to have mild and brief depressed mood following an important loss or disappointment. Depression as a psychological disorder is more than a temporary, mild mood state. It is a constellation of experiences of mood, physical functioning, quality of thinking and outlook, and behaviours (Horwath, 2004).

The depressed person may feel down or sad, but sadness may often be less apparent than a general lack of interest in activities that were once enjoyed. Changes in mood are accompanied by a gloomy outlook in which the future seems bleak and uninviting, and the person views himself or herself as flawed and inadequate, while circumstances may seem overwhelming, difficult or unrelenting in their deprivation and capacity for disappointment. Because of the negative outlook, the sufferer’s motivation and persistence may be impaired. A vicious cycle of negative thoughts and more depressed mood and behaviours may contribute to a prolonged period of depressive suffering.

Mood disorders are psychological disturbances defined by intense emotional experiences of depression or mania (or both). Mood disorders
encompass both common place and relatively rare disorders; their features may vary greatly from one individual to another. Some disorders of mood are apparently understandable reactions to life’s adversities, while others may seem baffling in their origin and accompanied by psychotic departure from reality. No segment of the population is immune; mood disorders afflict the young and the old; men and women, and people of any culture (Horwath, 2004). Depressive disorders are so frequent that they have been called the common cold of psychological disorders. Unlike the common cold, however, their consequences might be profoundly distressing and disruptive to the sufferer and his or her family. No matter how frequent and how impairing they may be, mood disorders are often misunderstood, both by society and by the sufferer and those in his or her life, and may be erroneously viewed by others as weaknesses of will or character and features of emotional self control.

**DIAGNOSIS OF DEPRESSION**

The current diagnostic and statistical manual of mental disorders—fourth edition (DSM IV, American Psychiatric Association (APA, 1994a) and International Classification of Diseases, 10\textsuperscript{th} Revision (ICD10, World Health Organization, 1992) have evolved from various efforts to provide systematic, reliable definitions. There are four key features of diagnosis of depressive disorders; presence of more than depressed or negative mood – requiring a variety of additional syndrome manifestations, duration over a
period of week or months to distinguish depression from temporary mood shifts and impairment, indicating that the depression interferes with normal functioning. The fourth feature is critical to distinguishing between unipolar and bipolar mood disorders. There must be information about prior symptomatology sufficient to determine whether the individual has ever experienced a mania or hypo manic episode. Only if there has never been such an experience could a person receive a diagnosis of unipolar depression. Those with histories of mania are diagnosed with bipolar disorder (Horwath, 2004).

**CLASSIFICATION OF CHILDHOOD DEPRESSION**

I. Associated with Organic Diseases

A. Part of primary organic disease

Example: Leukaemia

Degenerative diseases

Infectious diseases – juvenile paresis

Metabolic diseases – pituitary disease

Juvenile diabetes, thyroid disease etc.

B. Secondary (reactive) to a physical disease process
II. Deprivation syndrome – the reality based reaction to an impoverished or non-rewarding environment

A. Anaclitic depressions

B. Affectionless character types

III. Syndromes associated with difficulties in individuation

A. Problem of separation individualisation symbiotic psychotic reactions.

B. School phobias with depressive components.

C. Masochistic character structures.

IV. Mid Childhood types

A. Associated with object loss.

B. Failure to meet unattainable ideals.

C. Depressive equivalents (depression with depressive affect).
   1) Somatization.
   2) Hyperkinessis.
   3) Acting out syndromes.
   4) Delayed depressive reaction.
      a) Mourning at a distance
      b) Over idealisation process postponing reaction
      c) Denial patterns
   5) Eating disturbances (obesity syndromes)

D. Manic-depressive states
E. Affect less character types (generalised anhedonia)
F. Obsessional character (the compensated depressive)

V. Adolescent types

A. Mood liability as a developmental process.
B. Reactive to current loss.
C. Unresolved mourning from current losses.
D. Reaction to earlier losses (traumata).
E. Schizophrenias with prominent affective components.

(Flack and Denghi, 1975)

MAJOR DEPRESSIVE EPISODE AND DYSTHYMIC DISORDER

The two most common unipolar diagnosis are major depressive episode (MDE) and dysthymic disorder to meet diagnostic criteria for MDE, one must be depressed for at least two weeks, experience depressed mood nearly every day, all day or have a lose of interest or pleasure, and at least four of the remaining nine symptoms (covering a range of cognitive, physical and behavioural changes, such as diminished ability to think positively about self or future or to concentrate, thoughts of death, changes in speed and spontaneity of movement). Dysthymic disorders are milder chronic form of depression that includes depressive experiences, lasting for at least two years, accompanied by two or more of six milder depressive symptoms (Checkley, 1998). Both MDE and dysthymic disorder diagnosis required the presence of impaired functioning in the person’s important roles.
NATURE OF DEPRESSION IN CHILDREN AND ADOLESCENTS

Perhaps more than any other disorder in childhood and adolescence depression has presented challenges in conceptualisation and definition. These struggles have been the result of several factors. First, there was resistance to the idea that young people could experience serious depression because psychoanalytic theory held that depression could not occur in childhood or adolescence as a consequence of inadequate development of the super ego. Second, early conceptualisations of depression held that when this problem occurred it was masked by other symptoms or disorders, especially externalising disorders. Third, when the field finally comes to recognise that depression does occur in young people, the criteria that were applied were downward extension of adult criteria, with only minor exceptions, offering little or no acknowledgement of developmental differences. (Checkley, 1998)

VARIETIES OF DEPRESSION ACCORDING TO DSM III – R

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Main Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organic mood disorder, depressed</td>
<td>The person has notably depressed mood, including symptoms associated with major</td>
</tr>
<tr>
<td>Primary degenerative dementia with depression</td>
<td>depression, whose primary cause is considered to be interference with normal</td>
</tr>
<tr>
<td>Multi-infarct dementia with depression</td>
<td>brain functioning by some organic process.</td>
</tr>
<tr>
<td>Hallucinogen mood disorder, depressed</td>
<td>Where the organic process is known (eg: multi-infarct dementia) it is specified in the diagnosis on Axis I or III</td>
</tr>
<tr>
<td>Disorder</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------------------</td>
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<tr>
<td>Major depression</td>
<td>The person has one or more major depressive episodes in the absence of any manic episode, symptoms include prominent and persistent depressed mood, accompanied by symptoms such as poor appetite, insomnia, psychomotor retardation, decreased sex drive, fatigue, feelings of worthlessness or guilt, inability to concentrate, and thoughts of death or suicide.</td>
</tr>
<tr>
<td>Bipolar disorder, depressed</td>
<td>The person experiences a major depressive episode (as in major depression) and has had one or more manic episodes.</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>For the past two years, the person has been bothered all or most of the time by a depressed mood, but not of sufficient severity to meet the criteria for major depression.</td>
</tr>
<tr>
<td>Cyclothymia, depressed</td>
<td>At present or during the past two years, the person has experienced episodes resembling dysthymia but also has had one or more periods of hypomania-characterised by elevated, expensive or irritable mood not of psychotic proportions.</td>
</tr>
</tbody>
</table>
| Adjustment disorder with                     | The person reacts with a maladaptive
**Introduction**

**CHARACTERISTICS OF DEPRESSED PERSON**

The depressive person is described by Franz Alexander and others as one who has exceptionally high standards and who cannot accept any compromises. He is ego centric and overacts to frustration and denial. His relationship to others is characterised as one of exploitative dependency, in which he control and manipulates others. He is serious, dedicated, and determined to achieve perfection in all things. He feels that he has failed to fulfil his own expectations as well as those of his parents. When he is forced by circumstances to acknowledge some deficiency or failure in his system of values, he feels humiliated by the notion that he has lost status and esteem in the eyes of others. This feeling is accompanied by feelings of hopelessness, despair and depression. It is inevitable that frequent depression will occur ranging from the mild to the several forms. Generally, it is a reaction to the loss or threatened loss of some value that leaves the person feeling powerless and hopeless.
The development of a depressive reaction is therefore potentially present in everyone and is not exclusively related to past experiences. It is intimately related to present hard steps and future expectations. It is accompanied by physiochemical changes in amino acids and Kelosteroids, and by other chemical changes that are reflected indefinable physiological and behavioural responses.

Dr. Metanic Kelien has published that the predisposition to depression is present in all individuals in the inevitable frustration of the infant in relation to mother. She suggests that the infant reacts with anger and feelings of helplessness and guilt. Until the infant is associated of mother’s love, these feelings may continue and be enhanced. This is called the depressive position, and in adult depression there is a regression to this period of infantile dependency.

In 1954 Mabel B. Cohen and others discovered that the depressive reaction occurs in response to the patient’s inability to live up to his parents and his own expectation of himself. His inability to deal with others as a whole, separate individual perpetuates his tendency to deal with others in extremes as good or bad, black and white and his response to frustration or loss is also in the extremes of depression or mania. They concluded that the depressed person does not suffer genuine feelings that express such feelings as an exploitative technique.
EFFECTS OF DEPRESSION ON OTHERS

A great deal of the social disability of depression is due to two particular aspects of impairment: maladaptive marital relationships and high risk for offspring of depressed parents to develop depression and other disorders. Marital dissatisfaction or divorce among depressed patients are more than among non depressed (Horwath, 2004). It appears that depressed persons themselves – as well as their sponsors – experience difficulties in the marital relationships.

SEX DIFFERENCES IN DEPRESSION

The gender difference has been noted, with many more women reporting or being treated for depressive disorders than men. The Cross National Collaborative Group found a gender difference in every culture studied and overall, the rate of approximately 2:1 is cited indicating women’s prevalence among those with unipolar depressive disorders. A variety of biological and psychological perspectives have been pursued with no final resolution, including hormonal effects and timing of puberty, differential exposure to stressors, gender differences in self esteem, cognition, and coping, societal expectations and access to achievement and many others (Verma and Saraswathy, 2002).

AGE TRENDS IN DEPRESSION

The model of understanding depression concerns evidence that young
people especially females experience an increasing rate of depression. It has been suggested that changing and increasing social mobility diminishing supportive resources plus increased stress in the form of heightened expectations and increased competition for careers may have contributed (Verma and Saraswathy, 2002).
THEORETICAL PERSPECTIVES ON DEPRESSION

Most researchers think that depression results from an interaction between a person’s biological and psychological vulnerabilities and the stressful events or difficult ongoing situations in his or her life (Akiskal, 1985).

Biological Perspective

Biological theories assume that the cause of depression lies either in the genes or in some physiological malfunction that may or may not have an inherited base.

Neurotransmitters

Depression is probably the result of a lack of certain chemical neurotransmitters at particular sites in the brain. Neurotransmitters systems, especially the monoamine neurotransmitters have been the most widely studied biological phenomena in depression. The most important monoamine is the catecholamine, neuropinephorine and dopamine and the indolomine serotonin. Other neurotransmitter that have been thought to play a role in depression include gamma – aminobutyric acid (GABA), which seems to inhibit neurotransmitter action and widely found in the central nervous system, and acetylcholine, which is found in both the central and the peripheral nervous system and can be either an inhibitor or a stimulator of transmission between neurons.
The billions of neurons in the brain interact with others by electrochemical means. When the neuron is stimulated, it releases neurotransmitters – chemical substances from vesicles, or storage areas, in the presynaptic neuron. Recent research on antidepressant drugs suggests that serotonin may play a central role in depression. The chemical name for serotonin is 5-hydroxytryptamine. The serotonin then moves into the synaptic cleft. Some of it find its way to specialized acceptors in the postsynaptic neuron. The post synaptic or receiving neuron then alters its electrical and chemical activity. However, serotonin can also be removed from the synapse ie. reuptake mechanisms in the presynaptic neuron take the serotonin back into the presynaptic neuron where it is reused or chemically returned into an earlier stage of the process by which it was synthesised in the neuron. Another way serotonin is deactivated in by the enzyme monoamine oxidase (MAO) that normally causes serotonin to change chemically. Both MAO and the reuptake mechanisms decrease the amount of serotonin available at the synapse.

**Psychodynamic Perspective**

The psychological study of depression was begun by Sigmund Freud and to him depression is a complex reaction to loss. Depression, or melancholy, as Freud called it was grief gone haywire – excessive drawn out, often unrelated to the environment, and unjustified. Freud described both normal mourning and depression as response to the loss of some one or
something that was loved. He believed that a depressed person has a strong and punishing conscience or super ego. He thought that one reason the conscience becomes so strong is to control the anger and aggressive feelings that otherwise might come forth to hurt others.

Psychoanalytic theorists suggested that clinical episodes of depression happen because the events that set off the depression revive dimly conscious, threatening views of the self and others that are based on childhood experiences. These assumptions appear to be related to a childhood belief that one will never be loved by others, never become worthwhile, and will always lack the ability to control what happens. It may become the children’s inability to obtain a stable, secure relationship with others, which they feel repeatedly about how unlovable or incompetent they are. Some researchers suggest that a combination of traumatic childhood experience and acute external stressful events in adulthood is associated with a major depressive episode more than with other forms of depression or bipolar disorder.

A variation of psychodynamic therapy, interpersonal psychotherapy is often used with depressed clients. Therapists who use this approach believe that depression is best understood in an interpersonal context that emphasizes both peoples’ social effectiveness and the degree to which they experience social support. This therapeutic approach focuses on helping people learn to be more socially effective.
**Behavioural Perspective**

Behavioural theories proposed that depression is viewed as a function of inadequate or insufficient reinforcers (Lazarus, 1968) resulting in a weakened or impoverished behavioural repertoire. In other words, the depressed person’s behaviour is no longer positively reinforced because some important reinforcer has been withdrawn or lost.

A behavioural treatment plan for depression was first proposed by Lazarus in 1968. He outlined a variety of treatment approaches to be employed directly to combat the depressed person’s loss of reinforcement. He proposes a multimodal behavioural approach for use with severely and chronically depressed patients. The approach involves continuous monitoring and modification of seven behavioural modalities: overt behaviour, affective processes, sensory reactions, emotive imagery, cognitive components, interpersonal relationships and a medical modality. The therapist prescribes reinforcing responses in an effort to replace the lost reinforces that are at the root of depression. If the client remains unmotivated, it may be necessary for the therapist to make home visits and observations, which are described by Lewinsohn as a most powerful procedure.

Lazarus has also treated reactive (neurotic) depression with a combination of three other behavioural techniques. In Lazarus’s “time projection with positive reinforcement”, i.e., the patient is projected into a
future time and setting that is full of increased activity and enjoyment of old and new activities. He also prescribes “affective expression” – deliberate elicitation of anger, amusement, affection, sexual excitement and anxiety – in attempting to break the depressive cycle. Lazarus also recommends “behavioural deprivation and retaining”, procedure that involves enforcing a prolonged period of inactivity to the point of sensory deprivation. Following the stressful period, almost any stimulation is found positively reinforcing.

In contrast, numerous behaviour therapists have written about their use of more or less standard behaviour therapy methods to deal with mild to moderate depressions. The methods employed in this context include reinforcement, reinstatement, contingency management and task completion, interpersonal feedback, assertive training and self-reinforcement and desensitization etc.

**Cognitive Perspective**

The cognitive influential psychological theories of depression are derived from the cognitive perspective. The cognitive perspective on depression recognizes that not only cognition but also behaviour and biochemistry are important components of depressive disorders. According to this view depressed person consistently interpret events in distorted ways that result in negative views of themselves, their environment and what may happen in the future. One course of unjustified negative interpretations may
be the presence of schemes or ways of coding and interpreting behaviour. Cognitive therapy techniques are used to counter the effects of schemes and to help the client create new behavioural approaches and alter schemes to make them more adaptive.

**Cognitive Styles**

Particular cognitive styles are associated with and predict depression in both children and adults. According to Beck’s (1996) cognitive model of depression, the depressed individual has a negative view about the world, the self and the future as well as a negative organising self-schema. Abramson, et al., (1989) propose a model of depression which stresses the importance of attribution style. Depressed individuals are described as attributing the occurrence of negative events in their lives to stable, integral characteristics of themselves, while positive events are seen as chance occurrences outside the depressed person’s control. This pattern of thinking contributes to feelings of hopelessness and helplessness. A depressogenic cognitive style refers to the tendency to see the self and the environment in a negative light, as reflected in low self-esteem, hopelessness about the future and a negative attribution style or the tendency always to see the cup as half – empty rather than half-full. Cognitive distortions are not always a component of depression in adolescence but have been shown to differentiate depressed from non-depressed adolescents and to be more strongly associated with severe depression (Martin et al, 1997).
**Beck’s Cognitive – Distortion Model**

Aaron Beck’s cognitive distortion model of depression (Beck, 1996) has been the most influential of the cognitive approaches to depression. Beck believes that depression can best be described as a cognitive triad of negative thought about oneself, the situation and the future. A person who is depressed misinterprets facts in a negative way, focuses on the negative aspects of any situation and also has pessimistic and hopeless expectations about the future. The thoughts of depressed people either form on negative aspects of the past or reflect a negative outlook on what the future will bring. They think about how they have failed in the past, how terrible the future will be and how they will be unable to deal with it or improve it. They attribute or blame any misfortune on their personal defects. Any ambiguous situation is interpreted as evidence of the defect. These schemas affect all the elements of the cognitive triad in later life.

**The Humanistic – Existential Perspective**

The existential theorists focus on the loss of self-esteem. The theorists, such as Carl Rogers emphasize the difference between a person’s ideal self and his or her perceptions of the actual state of things as the source of depression and anxiety. To them depression is likely to result when the difference for the individual to tolerate. It depends on people’s high aspirations for achievement and is trying to fill several roles simultaneously.
Depression from a Vulnerability Resilience Perspective

In depression, heredity and other biological factors such as neurotransmitter activity, brain structure and metabolism may be but are not necessarily a result of genetic inheritance. Other personal factors that may play a role in depression include misattributions of the same events and the strength of the supportive relationship a person has. Both biological factors and these other personality related factors can contribute to vulnerability or resistance. Highly personally stressful events, especially those that occur in the context of chronic stress or ongoing difficulties and low levels of support are especially likely to result in depression. (Brown and Patten, 1991).

COMMON SIGNS AND SYMPTOMS

The severity of symptoms varies with individuals. The main signs and symptoms are feeling of apathy, indifference, anxiety, sadness, emptiness, hopelessness, hostility, helplessness, irritability, unworthiness, guilt, fatigue, restlessness, boredom, apprehension, pessimism, inadequacy, inertia, self-depreciation.

Other indications are constant negative thinking, downhearted periods that won’t go away, lack of interest in or pleasure from job, family life, hobbies or anything else, loss of self-esteem, sleep problems such as insomnia, a need to sleep too much, night sweats and waking up at early hours, headaches and unexplained physical pains that don’t respond to
treatment, constipation, decreased appetite and weight loss (or a compulsion to overeat and weight gain), drug or alcohol abuse, frequent or unexplainable crying spells , changes in sexual habits and behaviour, decreased powers of memory and concentration, inability to give or accept affection, thought of death or suicide (or suicide attempts).

People who are manic - depressive show such symptoms as inappropriate elation, grandiose notions, increased talking, moving and sexual activity, disconnected and racing thoughts, extreme energy, poor judgment and disturbed ability to make decisions, and unsuitable social behaviour.

**Symptoms of the Depressed/Anxious Syndrome based on Parent and Adolescent Reports**

<table>
<thead>
<tr>
<th>Parent Reports</th>
<th>Adolescent Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Complains of loneliness</td>
<td>I feel lonely</td>
</tr>
<tr>
<td>2. Cries a lot</td>
<td>I cry a lot</td>
</tr>
<tr>
<td>3. Fear he or she might do something bad</td>
<td>I am afraid, I might think or do something bad</td>
</tr>
<tr>
<td>4. Feels he or she has to be perfect</td>
<td>I feel that no one loves me</td>
</tr>
<tr>
<td>5. Feels or complains that no one loves him or her</td>
<td>I feel that others are out to get me</td>
</tr>
<tr>
<td>6. Feels others are out to get him or her</td>
<td>I feel worthless or inferior</td>
</tr>
<tr>
<td>7. Feels worthless or inferior</td>
<td>I am nervous and tense</td>
</tr>
</tbody>
</table>
8. Nervous, high-strung or tense I am too fearful or anxious
9. Too fearful or anxious I feel too guilty
10. Feels too guilty I am self conscious or easily embarrassed
11. Self-conscious or easily embarrassed I am suspicious
12. Suspicious I am unhappy, sad or depressed
13. Unhappy, sad or depressed I worry a lot
14. Worrying I worry a lot

<table>
<thead>
<tr>
<th>Causes of Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>In adults the broad causes of depression are many. According to Dr.Klerman the possibility of depression may be caused by biological factors, such as viral agent, or by some environmental substance or nutritional change should also be considered. He pointed out that the environmental risk factors could be biological including changes in nutrition, the possible role of viruses or the effect of an unknown depressogenic chemical agent in the water or air. Other environmental risk factors could be non biological.</td>
</tr>
<tr>
<td>As far as genetics is concerned research over the past decades strongly suggests a genetic link to depressive disorders and indicates that depression can run in families (Horwath, 2004). Bad life experiences(such as a serious</td>
</tr>
</tbody>
</table>
loss, chronic illness, difficult relationships, midlife crises, financial problems, career set backs, marital problems, frustrations, disappointment or any unwelcome change in life patterns) can also trigger a depressive episode.

People who have low self-esteem, who consistently view themselves and the world with pessimism and who are readily overwhelmed by stress are also prone to depression. Other personality traits that increase the chances of becoming depressed are overdependence, introversion, excessive need for approval, feeling of uselessness and the inability to live up to expectations (Horwath, 2004).

Partly because of experience with drugs that are effective against depression, it has become clear that severe depression can result from abnormalities in brain chemistry and a shortage of certain natural chemicals in parts of the brain.

**RISK FACTORS FOR DEPRESSION IN CHILDHOOD AND ADOLESCENCE**

Many social, psychological and biological factors have been examined as possible source of risk for depressive symptoms and disorder in children and youth. A wide range of theoretical perspectives including psychodynamic, behavioural, cognitive, interpersonal, family, biological and environmental models have been proposed that vary in their comprehensiveness and in their level of empirical support. Each model can
be used to identify factors that play an etiologic role in the development of depression and therefore may serve as target in preventive interventions for children and adolescents (Weissberg, et al., 1997).

Integration of these various perspectives has led to the developmental bio-psychosocial perspectives on depression during childhood and adolescence. Integrative models have important implications for the prevention of depression in young people. First, they emphasise that developmental processes and children’s developmental level must be taken into account in intervention process. Second, they highlight the need to consider a range of factors that may be associated with depression in children. To the extent that depression is a heterogeneous disorder, it is not surprising that there may be a wide range of risk factors and a variety of etiological paths. These include both internal characteristics of the children as well as features of the children’s social context. Third, integrative models recognise that the interplay among these factors and their salience may change with development.

**Social Problem Solving and Coping Skills**

Deficiencies in coping skills and social problem-solving strategies have also been examined as an individual source of vulnerability to depression. Various studies have indicated that depressed children are relatively impaired in various areas of social functioning. A few longitudinal
Introduction

studies suggest that social deficiencies such as poorer quality of friendships and lower social competence increase the risk for future depression.

Developmental factors: Family, Individual and Environment might contribute to or constitute a predisposition to onset of depression during adolescence.

Children of parents with affective disorders are at risk for a host of behavioural and emotional problems. Childhood depression seems to be specifically associated with parental depression. The interaction of genetic and environmental factors are also critical in the development of more severe forms of depression (Rende, et al., 1993). For example, depressed parent’s styles of interacting with their children may increase their child’s vulnerability to developing depression. Depressed mothers are more likely to use withdrawal, conflict, avoidance or over-controlling strategies rather than negotiation to cope with child non-compliance compared to nondepressed mothers (Cumming and Davies, 1994). Depressed mothers also tend to be more hostile and irritable compared to controls. (Beardstee and Wheelock, 1994). Thus, a depressed parent may serve as a model for depressive thinking and coping or may contribute to an overall home environment which increases risk for depression. Increased risk of insecure attachment and disruptions in emotional regulation has also been associated with maternal depression which in turn leads to depression in their children.
Parental Rejection, Hostility and Family Conflict

Depressive symptoms in youths have also been associated with parental rejection (Whitbeeck et al., 1992). More extreme forms of negative parent behaviour, such as severe punishment and maltreatment, have also been associated with childhood depression (Downey and Walker, 1992). Although family conflict may be predictive of depressive symptoms both currently and prospectively, family conflict and hostility appear to be characteristics of families of adolescents with a variety of emotional and behavioural problems. The observational studies indicate that depressed youths may not express overtly negative affect (especially anger) and may, in fact, show higher levels of positive affect relative to controls (Sanders et al., 1992).

A few studies have investigated parental over control and over protection as it relates specifically to depression in adolescent. Burt et al., (1992) found an association between adolescent perceptions of more parent control and depressive symptoms and Stark et al., (1990) found that a less democratic parenting style and an enmeshed family environment were associated with depression. Adolescent depressive symptoms are also found associated with family interaction characterised by high levels of maternal dominance and low levels of adolescent communicative assertiveness (Kobak and Ferenz-Gillies, 1995).
Adolescent Challenges

Adolescents are faced with significant changes in every aspect of their lives; pubertal development, cognitive maturation, school transition and increased performance pressures in all arenas-academic, sports, social and family. Some have hypothesised that the increase in depression during the adolescent period, which is particularly noteworthy in girls, is secondary to the hormonal changes and brain maturation which accompany pubertal development (Angold and Rutter, 1992). For boys pubertal development, as marked by transition to Tanner stage III or higher, has at least a short-term effect of reducing prevalence of depression. In girls, however, mid-puberty marks an emergence of increased risk for depression (Angold et al., 1998). It was initially unclear whether this increased risk for girls is related to the direct influence of the changing neuro-endocrine environment or whether it is an indirect effect of the social and emotional implications of the girls change in physical presentation.

Angold and Colleagues (1999) explored this further by investigating the risk of physical development as reflected in Tanner stage and changes in hormone levels. These analyses indicated that hormone levels – specifically increasing levels of oestrogen and testosterone levels above the 60th percentile were significantly associated with depression. The researchers conclude that while hormonal changes are not sufficient to cause depression, they do place developing girls into a hormonal risk pool more similar to that
of adult women. Hormonal changes, while related to change in mood, may not be as important in explaining depressed mood as other environmental stressors – (Brooks-Gunn and Warren, 1989). However, the physical, environmental and developmental changes and the stressors associated with these changes appear to play an important role in the onset of depression in adolescence.

**Biological Factors**

Biological factors including genetics, neurotransmitter process, brain structure and functioning and neuroendocrine processes play a central role in most current models of depression. Research on biological process in child and adolescent depression reflect biological dysregulation of multiple systems including the endocrine system, neurotransmitter functions, and basic body rhythms including sleep cycles.

**Physiological Markers**

The concept of physiological markers is a useful way to think about physiological influences upon psychopathology in general and depression in particular. The physiological bases of depression focus on the limbic system, specifically the hypothalamus-pituitary axes. Those involving the adrenal (HPD), the thyroid (HPT), the gonadal (HPG) and the somatotropic (HPS) axes have been studied, with all systems exhibiting varying degrees of dysregulation is associated with depression. Additionally, sleep architecture
changes and melatonin secretion has been the subject of study, with alterations occurring in many depressed individuals.

Several endocrine systems are involved in depression – In all cases, a releasing hormone in the hypothalamus moves to the pituitary gland and influence the release there of a stimulating hormone. This hormone then stimulates the release of a hormone by the particular gland in question (thyroid, adrenal, gonad). This hormone is secreted with circulation, where it acts to inhibit the production of the releasing and stimulating hormone at the hypothalamic and pituitary levels (Sheldon et al., 1991).

**Neurological Impact**

A depressed mood as a reaction of neurological disability in common place and can be different to distinguish from persistent depression, which may be more intimately related to the neurological disturbance itself. Diseases of the basal ganglia and of connections to the frontal lobe are particularly liable to course depressive illness. Depression is a common accompaniment of Parkinson’s disease, and is not achieved by improvement in motor function following drug treatment; this may indicate an overlap in the underlying biochemical disturbance of monoamine system. Cerebrovascular disease in a frequent cause of mood change, with up to a third of patients developing depression of the stroke and appropriate follow up is essential. Hypomania and euphoria are much less common but can
occur with cerebral infarcts and with Huntington’s disease. It is often stated that patients with multiple sclerosis develop euphoria and, although this may occur, it is infrequent, depressive illness still being the major mood change (Watson, 1993).

**Psycho-neuroendocrinology**

Brain functioning and neuroendocrine processes may provide possible mechanisms. Dysregulation of the human stress response of the Hypothalamus-Pituitary Adrenal (HPA) axis in depressive disorders. The subset of depressed people with abnormal HPA functioning may have a worse type of depression or at least a form that perhaps stems from an underlying disorder of the stress response system. Stress-related neuroendocrine processes may also affect brain development, predisposing to depression (Watson, 1993). Early stress experiencing may sensitize specific neural circuits, resulting in depressive reactions in later life in response to stressful life events.

**Cognitive Factors**

On the basis of cognitive models of depression in children, it has been established that depressed and non-depressed children differ in most major cognitive processes associated with depression. For example, depressed children have low self-esteem, they often feel hopeless about their future, a risk factor for suicidal behaviour and they also report more negatively
distorted cognitions. Depression particularly is associated with negative cognitions regarding loss and self-concept and the maladaptive attribution styles may also be seen as risk factors for depression.

**Stress**

Many people use the word stress but fail to define precisely what they mean by stress, how they visualize stress, and how they consider that the mechanism of stress operates. But in psychology stress means a bodily or mental tension resulting from factors that tend to alter an existent equilibrium. Cooperand Marshall notes that stress is often used to denote pressure on the individual, or the effects of this pressure, or an individuals’ reactions (Kahn and Cooper, 1993).

Two terms associated with stress are stressor and strain. ‘Stressor’ refers to those things in the environment (i.e., outside the individual), which might result in the triggering of ‘stress’. Strain refers to the way in which the individual responds to ‘stress’ whether that reaction is physical, psychological, or related to an individual’s behaviour. These responses indicate the ill-health or well-being of an individual (Lovallo, 1997).

A sense of reduced control in the face of perceived threat occurs commonly in daily life. Work by Weiss shows that uncontrollable shock leads to behavioural changes corresponding to human depression, namely poor appetite and weight loss, poor performance in tasks requiring
Introduction

psychomotor performance, loss of energy and apparent fatigue, loss of interest in usual activities (Weiss, 1991). The study of Weiss, Serison, Ambrose, Webster and Hoffman (1985) report the development of depression due to central nervous system alterations associated with uncontrollable stress. Psychological stressors perhaps affect health both physical and mental, because of their meaning to a person and the impact of their meaning for the persons daily life with some awareness of immediate or long term consequences. It is reported that psychological stress responses are internally generated and affect the body in a top-down fashion. Such responses after associated with negative emotions may occur frequently in social settings without being acted out behaviourally. These repeated responses may have negative health consequences (Lovallo, 2005). The threat value depends largely on individual’s interpretation of the events and its meaning for their own lives. Perceptions and evaluations of ongoing events may alter the life of the individuals with consequences for how stress reactions are produced and in relation to which circumstances.

Coping Styles

According to Lazarus, coping is the cognitive and behavioural efforts to manage specific external or internal demands (and conflicts between them) that are appraised as taxing or exceeding the resources of a person. There are three aspects of this definition.
Introduction

First: Coping is a response to specific demand which is context bound.

Second: Coping strategies are defined by effort, which accounts for just about anything an individual does in his or her transaction with the environment, that is purposeful. Therefore coping need not be a successfully completed act but an attempt to deal with the problem. The attempt may consist of behavioural acts or cognitions.

Third: Coping is seen as a process that changes overtime during a particular encounter (Frydenberg, 1999).

Coping strategies vary in their adaptive value. Coping process range from the helpful to the counter productive. We will distinguish between coping patterns that tend to be helpful and those that tend to be maladaptive. No coping strategy can guarantee a successful outcome. Furthermore the adaptive value of a coping technique depends on the exact nature of the situation (McDougall and William, 1999).

Events that are potential or known threat require some adaptive behavioural intervention to ensure that harm is avoided or its negative effects are limited. Problem focused strategies are found to increase the persons awareness, level of knowledge and range of behavioural and cognitive coping options.

Frustration Tolerance

Frustration occurs when one’s stressing are threatened, either by obstacles that block progress toward a desired goal or by absence of an
appropriate goal. The frustrations we face depend heavily on such factors as age and the personal characteristics, our specific life situations and the society in which we live (Rosenzweig, 2002). The choice of one alternative leads to frustration with regard to the other. Frustration arises when we must choose one alternative and give up the other. So, the necessity of making a choice commonly involves cognitive strain and often difficult to make up one’s mind when each alternative offers values that the other does not the choice is an important one (Coleman, 1988).

**Personal Belief and Self Esteem**

Personal belief/self-esteem, the evaluative dimension of the self-concept is to do with how worthwhile or confident the persons feel about themselves (Haysen, 1994).

Self-esteem is the complex cognitive affective response, which accompanies behaviour in accordance with conscience. The cognitive aspects include the verbal judgement of the following sort, I am good and worthwhile person. I respect myself as a person because of the way that I act. The affective aspects of the self-esteem is something analogues to the feeling which accompany the expectation of pleasant thing. When a person has high self-esteem he probably anticipates affection praise or admiration from others (Burns, 1982).

The concept of personal belief assumes that the individual has a need to enhance his self-evaluation and to increase, maintain or confirm his
feelings of personal satisfaction, worth and effectiveness. The self-esteem varies with individuals. It is assumed that this variation is reflected in attitudinal measures of self-esteem and that persons with high self-esteem are relatively more satisfied with respect to this need than persons low self-esteem. Self-esteem need is responsive to evaluative information the individual gains from his own behaviour and comparative or reflected appraisal from other people (Burns, 1982). Self-esteem is defined in terms of self-attitudes, which have an emotional and behavioural component. Individual with high self-esteem consider themselves as worth and as equal with others. They can recognize limitation and they expect to grow and improve.

People with low self-esteem who expects to do poorly in a test will likely experience high anxiety and therefore will not work as hard. As a result they actually fail which in between confirms their negative view of themselves (Baron and Byron, 1995). People with high self-esteem tend to be less lonely than those who’s self-esteem is low, suggesting that a positive self-evaluation is associated with good social skills. The lower an individual’s self-esteem, the more depressed that person feels.

**Creative Thinking**

Among the many varieties of human abilities, perhaps the greatest admiration is still reserved for thinking, especially the thinking that is regarded as creative. To understand the nature of creative thinking abilities
have expanded almost exponentially in recent years. There are varying opinions as to what constitutes creativity. This is because creativity has been studied from a wide variety of perspectives - philosophy, sociology, neurology, psychology and so on (Gulati, 1997). Guilford suggests that divergent thinking abilities are related to creativity. First of all, the ability to sense problems that call for solutions would result in increased opportunities to work on such problems and increased probability of coming with solutions. He said that higher the rate of production of words, ideas, associations and ways of expressing oneself (fluency), the more likely one would be arrive at an original solution. The greater the variety of ideas produced (original ideas) the greater also the likelihood of arriving at less common place solutions (Howes, 1990). Everyone has some creative potential, but it remains difficult to discern exactly how much potential one has or in what field or domain it may lie. Some psychologists and educators have been concerned with ways of enhancing creativity: one method is the idea of brainstorming and other one is behavioural reinforcement principles and procedures to promulgate creative responses.

Ideational fluency is a measure of divergent thinking. It relates significantly to physical, social and cognitive spontaneity as well as with indices of joy and humour (Liebermann, 1965).

Originality is a concept that applies to production of unique ideas. It pertains to innovate, novel and masterpiece ideas that are not previously
existing. It relates to the total creative endeavour, and depends on opportunity to re-examine possible relationships among associations and ideas generated.

**TREATMENT OF DEPRESSION**

Depression is the most treatable of all the mental illness. Individuals no longer have to suffer its debilitating symptoms. People with serious depression need encouragement from family and friends to seek the treatment that can ease their problem. Some people need even more help and must be taken for treatment.

When treatment is needed, help is available from physicians, mental health specialist, health maintenance organizations, community mental health centres, hospital department of psychiatry, university or medical school-affiliated programs etc. Some hospitals and universities have special research centres that study and treat depression. The common forms of treatment are: Drug therapy, Electroshock treatment, Psychotherapy, counselling and combinations of treatment etc (Bellack and Hersen, 1993).

**TREATMENT OF ADOLESCENT DEPRESSION**

Drug therapies do not seem to be very effective with adolescents. A recent double blind study found that fluoxetine reduced symptoms more than a placebo, but complete remission of symptoms was rare. Many other studies have shown that antidepressant drugs are no better than placebos in children and adolescents.
Most psychological interventions are modelled after clinical research with adults. For example: interpersonal therapy (IPT) has been modified for use with depressed adolescents, focusing on issues of concern of adolescents, such as peer pressure, separation from parents and authority issues.

A cognitive behavioural group intervention involving instruction in coping with depression was found to be effective with dressed adolescents, particularly when parents were involved in treatment. Social skills training can be expected to help depressed young people by providing them with the behavioural and verbal means to gain access to pleasant, reinforcing environments, such as making friends and getting along with peers. Stark, Napolitano, Swearer, Schmidt, Jaramillo and Hoile (1996) indicate that cognitive interventions and relaxation training, social skill training and problem solving techniques are very effective.

**PSYCHOLOGICAL MANAGEMENT OF ADOLESCENT PROBLEMS**

In recent years, psychological interventions for adolescent psychiatric disorders have become more efficacious in comparison to the traditional medical model of therapy, with the exception of treatment of psychosis and some forms of severe behaviour disturbances like depression and stresses. Drug management of psychiatric problems is still of great importance and can be practised only by qualified child psychiatrists, with adequate hospital and laboratory facilities. The drug management should be used with caution and only when absolutely necessary in psychiatric conditions because of the
unknown effects of drugs on the developing brain. So the psychosocial management should be the preferred mode of intervention for people’s wellness (Kapur, 1995).

Depression is widely recognised as a serious mental health concern among children and youth. It is clear that substantial number of children and adolescents experience symptoms of sadness, dysphoria and other characteristics associated with depression, whereas a smaller but still significant number of young people experience depression as a disorder as manifested in adults. The consequences of depressive symptoms and disorder during childhood and adolescence are significant as well including greatly increased risk for depression later in life as well as concurrent disruption in functioning in childhood and greatly increased risk for suicidal ideation and attempts. Finally, the importance of depression in young people is reflected in the pernicious tendency for depression to co-occur with a wide range of other problems and disorders; including anxiety, disruptive behaviour disorders and substance abuse (Weissberg and Gullotta, 1997). Depression that co-occurs with other problems or disorders greatly increase the level of associated social problems and impairment.

Despite the significance of depression as a mental health problem during childhood and adolescence, it received relatively little attention as a risk factor determining the potential of future generations. Research on risk reduction and those concerned with cognitive factors like stress, causes for
depression are limited to goals for adults. The absence of attention to depression in young people is especially noteworthy in light of the emphasis that it is a major health problem that lead to suicide in adolescents.

**INTerventions**

Once an adolescent has been diagnosed with either major depression or dysthymia, both psychotherapy and medication could be options. More and more doctors are realizing that chemical imbalance often account for mental illness, but at the same time, the importance of psychotherapy cannot be discounted. If an adolescent’s depression has been caused wholly or in part by psychological factors, medication may relieve the depression, but the underlying cause will not be cured by medication alone. Therapy can help the adolescent deal with his part in a healthy manner and also in learning ways to cope with the very difficult process of growing up.

Antidepressant medication for adolescent is a controversial topic. There are no long term studies that show what kind of impact thus medication will have on an adolescents development a most professional’s will recommend therapy as a first line of defence for adolescent with depression, except in cases where the adolescent is severely depressed or suicidal. The decision of whether to treat an adolescent depending on the severity of the adolescent’s depression and parents should educate themselves as much as possible in order to make as informed decision.
Introduction

The promotion of healthy adolescent development has become a major focus of world attention. Cognitive theories of depression emphasize the role of negative thinking and maladaptive attributional style in the development of depression. Based on this theoretical view it is assumed that onset of depression may be prevented by changing the dysfunctional cognitive processes of adolescents. Thus in the present study an effort is made to see whether changing of negative thinking will bring about depressive symptom reduction. The efficacy of creativity training in altering cognitive functions and generating alternative solutions is well recorded. Aniljose’s Creative tasks like brainstorming, assertiveness training, relaxation, techniques (positive imagery) and general counselling are used to train adolescents at risk of depression to think constructively and positively and thereby manage depressive reactions.

The psychological factors tend to have a two dimensional effect on mental development and health of the adolescents (1) Direct effect which provide the resources for physical development an expose them to appropriate stimulations for the mastery of various developmental tasks determines the relative social status and sense of completion and satisfaction in terms of the quality of life are aspires for. Dissatisfaction with the immediate social environment and quality of life is reflected as a sense of deprivation. Possibility for such sense of deprivation is dependent on the person’s exposure to or awareness of various status of life or people with
different quality of life. The physical deprivation and psychological deprivation and psychological sense of deprivation have different effects; the latter lead to tendencies of depression.

**Psychological Interventions**

Psychological interventions have been gaining more attention, because it plays an important role as well. It appears that strategies used for reducing anxiety, stress and depression by cognitive psychotherapy, reduce the frequency and severity of fear and anxiety by systematic desensitisation (Peterson, 1996). Adolescence is the period of stress and strain during that period the occurrence of unexpected lose or failure leads to irrational fear and hopeless thinking may become the causes of depression. Operant conditioning techniques in which children are rewarded for not having to be hospitalised are also found to reduce the frequency of such hospitalisation (Edlin, et al, 1998). Cognitive restructuring, Positive thinking, Biofeedback, Laughing therapy, Exercises like running, walking are effective techniques for reducing depressive symptoms in individuals.

In the light of the theoretical literature so far presented it can be assumed that the psychosocial environment and different types of psychotherapies are effective for managing child/adolescent depression. For further classification the empirical studies conducted in these directions are referred and the relevant ones are presented in the second chapter.
OPERATIONAL DEFINITIONS

Stress

Stress is defined as mental tension that depends largely on individuals interpretation of the events and its meaning for their own life.

Perceptions and evaluations of ongoing events may alter the life of the individuals with consequences for how stress reactions are produced.

Coping Styles

Coping is the cognitive and behavioural efforts used to manage specific external or internal demands and conflicts between them.

The adaptive value of a coping technique depends on how individuals perceive the exact nature of the situation.

Frustration Tolerance

Frustration tolerance means how an individual perceives and tolerates the frustration producing situations.

Frustration arises when one has to choose one alternative and give up the other and this leads to cognitive strain.

Personal Belief

Personal belief is defined as individuals’ belie in his/her qualities and attributes. It mainly depends on one’s perception about the self and the environment.
Creative Thinking

Ability to become sensitive to problems, deficiencies, gaps in knowledge, missing elements, disharmonies and so on, identifying the difficulty, searching for solutions, making guesses, testing them and finally communicating the results.

Ideation Fluency

Ability to be fluent with ideas, generate large number of associations and alternate solutions to problems.

Originality

Ability to generate innovative, infrequent and unique ideas that are not previously existing.

SIGNIFICANCE OF THE PRESENT STUDY

Adolescent depression is a very prominent dread in the society today. Therefore there is growing interest among psychologists to study this problem from various dimensions.

An adolescent experiences biological as well as psychological changes within him/her during this stage, which is their gateway from child to an adult. Biologically their bodies pass through puberty, which comprises of changes in their body from head to foot. Psychologically the interaction of their family and society also is different as a result of their transition from childhood to adulthood.
Adolescents today face many challenges like denial of individuality, broken families, absence of parents (physical or emotional), death of loved ones, nuclear families and sexual exploitations. Besides familial problems social factors like school and media are also responsible in creating depression in adolescents. Challenges like academic excellence, comparison with fellow students by parents and teachers, harassment by teachers and from senior students are seen to cause depression in adolescents. Exaggerated portrayal of violence, aggression and sex, in media and cinema and especially in the case of Kerala, the highly emotional depiction of sad events create a feeling of insecurity and helplessness which may induce depressive thoughts in them.

Depressed adolescents cannot face stressful situations and challenges in their daily life and will find it difficult to cope with these situations. This may tend to make them great failures in life and may at times lead to suicide and similar other serious problems.

From a developmental perspective a child may be prone to immature and inadequate appraisals of future dangers and disturbances. Hence it is important to develop in them an enhanced age appropriate understanding of the circumstances and meaning of the traumatic experiences. This may be achieved by formulating constructive prevention and intervention strategies in relation to what has occurred and to future situations. Attempted emotional reprocessing can represent efforts to understand the content of emotional
reactions generated by experience so as to increase tolerance, diminish self punishing attributions and maintain or repair the subjective sense of well being.

In the light of the afore mentioned the present study investigate the role of cognitive factors in depression among adolescents and examines the efficacy of a package of intervention for use with adolescent children with high risk of depression.

It is expected that the findings of the research may be used to help adolescents to cope with the daily challenges of the society, be strong willed, competent and mentally healthy that may aid their transition to a successful life.

The present study reads as “Cognitive Factors In Depression and Efficacy of Intervention In Managing Depression: A Study Among Adolescents At Risk of Depression”.

Introduction 56