CHAPTER – 1
INTRODUCTION

1.1. Introduction

1.2. Stress
   1.2.1 Meaning of Stress
   1.2.2 Types of Stress
   1.2.3 Causes of Stress
   1.2.4 Stages of Stress
   1.2.5 Stress Management
   1.2.6 Stress Theory

1.3. Depression
   1.3.1 Definition of Depression and its Symptoms
   1.3.2 Reactive Depression & Physical Depression
   1.3.3 Causes of Depression
   1.3.4 Treatment

1.4. Suicide
   1.4.1 Associated Factors of Suicide
   1.4.2 Causes of Suicide
   1.4.3 Treatment

1.5. Unemployment
   1.5.1 Types of Unemployment
   1.5.2 Causes of Unemployment
   1.5.3 Consequences of Unemployment
CHAPTER – 1
INTRODUCTION

1.1 Introduction

Modern human life, particularly in urban and semi-urban areas of India, is becoming full of challenges arising from various sources. Even an average person has become ambitious. He tends to set up high level goals for himself. But he seems to lack ability to develop attitudes and skills which would help him to overcome disappointment and frustration when he fails to achieve these goals.

In the school, his friends and co-students expect from him or challenge him to score very high marks in examination. At the higher educational level, his friends and family members expect him to get marks high enough to admission in attractive professional courses.

Even after completing his high level study, he faces a number of challenges in the job market. He may get marks which enable him to get only a very moderate or modest level of job. He may get marks which enable him to get only a very moderate or modest level of job. He may even fail to get a job in his own field of study, and so, may have to work in a job in a totally unrelated area.

At this juncture, if his friends and fails support and encourage him, he may feel relieved. But in many cases, his friends and family members begin to criticize him. This tends to arouse depression and stress may gradually decrease in some cases. But in many cases, such stress and depression go on increasing. It may lead to many undesirable negative thoughts in his subconscious or unconscious mind. He may get too emotional and sentimental and may start underrating himself, or may
become angry when facing even normal difficulties. He becomes rash and stars acting on the spur of moment.

Many of such young people are carried away by lightly expressed opinions of their co-students or co-workers, by watching stories depicted in TV serials or magazines, or films.

Stress arises due to conflicting demands of situation or by a negative interpretation of the situation. Depression may arise due to an unreasonable expectation of success.

In many cases, frustration arises when a young person instead of focusing on his study, develops a love affair, resulting in failure in examination. In some cases, frustration arises when, in spite of performing well in examination, a young person fails to get a job due to linguistic/ regional bias in selection procedure or reservation policy of government.

Some young people do get a chance in a conflict in family over selection of the course of study, his preparation or the young person’s love affair which is not accepted by parents. In some cases, a young person may think of suicide when his expectations from the marital partner are not fulfilled.

The present research takes up study of stress depression and suicidal tendency among the educated unemployed youth.

1.2 Stress

Physiological or biological stress is an organism's response to a stressor such as an environmental condition. Stress is a body's method of reacting to a challenge. According to the stressful event, the body's way to respond to stress is by sympathetic nervous system activation which results in the fight-or-flight response. Because the body cannot keep this state for long periods of time, the parasympathetic...
system returns the body's physiological conditions to normal (homeostasis). In humans, stress typically describes a negative condition or a positive condition that can have an impact on a person's mental and physical well-being.

There is likely a connection between stress and illness. Theories of the stress–illness link suggest that both acute and chronic stress can cause illness, and several studies found such a link. According to these theories, both kinds of stress can lead to changes in behavior and in physiology. Behavioral changes can be smoking and eating habits and physical activity. Physiological changes can be changes in sympathetic activation or hypothalamic pituitary adrenocorticoid activation, and immunological function. However, there is much variability in the link between stress and illness.

Selye demonstrated that stress decreases adaptability of an organism and proposed to describe the adaptability as a special resource, adaptation energy. Stress can make the individual more susceptible to physical illnesses like the common cold. Stressful events, such as job changes, may result in insomnia, impaired sleeping, and health complaints. Research indicates the type of stressor (whether it's acute or chronic) and individual characteristics such as age and physical well-being before the onset of the stressor can combine to determine the effect of stress on an individual. An individual's personality characteristics (such as level of neuroticism), genetics, and childhood experiences with major stressors and traumas may also dictate their response to stressors.

1.2.1 Meaning of Stress

The word stress is derived from the Latin word ‘stringi’, which means, ‘to be drawn tight’. Stress can be defined as follows:
In medical terms stress is described as, "a physical or psychological stimulus that can produce mental tension or physiological reactions that may lead to illness." When you are under stress, your adrenal gland releases corticosteroids, which are converted to cortisol in the blood stream. Cortisol have an immune suppressive effect in your body.

According to Richard S Lazarus, stress is a feeling experienced when a person thinks that "the demands exceed the personal and social resources the individual is able to mobilize."

Your body tries to adjust to different circumstances or continually changing environment around you. In this process, the body is put to extra work resulting in "wear and tear". In other words, your body is stressed. Stress disturbs the body's normal way of functioning.

Without stress, there would be no life. However, excessive or prolonged stress can be harmful. Stress is unique and personal. A situation may be stressful for someone but the same situation may be challenging for others. For example, arranging a world level symposium may be challenging for one person but stressful to another. Some persons have habit of worrying unnecessarily.

Stress is not always necessarily harmful. Stress is not necessarily something bad, it all depends on how you take it. The stress of exhilarating, creative successful work is beneficial, while that of failure, humiliation or infection is detrimental. Stress can be therefore negative, positive or neutral. Passing in an examination can be just stressful as failing.

Sometime we know in advance that doing a certain thing will be stressful, but we are willing to doing that. For example, while planning a vacation to a hill station you know that it would be stressful at certain times. But you are willing to face those challenges.
People often work well under certain stress leading to increased productivity. Many times you do not know in advance and the stress periods may be sudden. The situation may not be under your control. Too much stress is harmful. You should know your level of stress that allows you to perform optimally in your life.

1.2.2 Types of Stress

- **Acute stress**

  Acute stress is usually for short time and may be due to work pressure, meeting deadlines pressure or minor accident, over exertion, increased physical activity, searching something but you misplaced it, or similar things. Acute Stress Symptoms are headaches, back pain, stomach problems, rapid heartbeat, muscle aches or body pain. Acute stress is common in people who take too many responsibilities and are overloaded or overworked, disorganized, always in a hurry and never in time. These people are generally in positions of importance at their workplace and stressful lifestyle is inherent in them.

- **Chronic Stress**

  This type of stress is the most serious of all the stress types. Chronic stress is a prolonged stress that exists for weeks, months, or even years. This stress is due to poverty, broken or stressed families and marriages, chronic illness and successive failures in life.
1.1.3 Causes of Stress

- **Career Concern**: If an employee feels that he is very much behind in the corporate ladder, then he may experience stress. If he seems that there are no opportunities for self-growth, he may experience stress. Hence, unfulfilled career expectations are the significant source of stress.

- **Role Ambiguity**: It occurs when the person doesn't know what he is supposed to do, on the job. His tasks and responsibilities are not clear. The employee is not sure what he is expected to do. It creates confusion in the minds of the worker and results in stress.

- **Rotating Work Shifts**: Stress may occur in those individuals who work on different work shifts. Employees may be expected to work on day shift for some days and then on the night shift. That may create problems in adjusting to the shift timings, and it can affect not only personal life but also family life of the employee.

- **Role Conflict**: It takes place when people have different expectations from the person performing a particular role. It can also occur if the job is not as per expectation, or when a job
demands a certain type of behavior that is against the person's moral values.

- **Occupational Demands**: Some jobs are more demanding than others. Jobs that involve risk and danger are more stressful. Research findings indicate, job that cause stress needs constant monitoring of equipments and devices, unpleasant physical conditions, making decisions, etc.

- **Lack of Participation in Decision-making**: Many experienced employees feel that management should consult them on matters affecting their jobs. In reality, the superiors hardly ask the concerned employees before taking a decision. That develops a feeling of being neglected, which may lead to stress.

- **Work Overload**: Excessive workload leads to stress as it puts a person under tremendous pressure. Work overload may take two different forms: Qualitative work overload implies performing a job that is complicated or beyond the employee's capacity. Quantitative work overload is a result of many activities performed in a prescribed time.

- **Work Underload**: In this case, too little work or very easy work is expected on the part of the employee. Doing less work or jobs of routine and simple nature would lead to monotony and boredom, which can lead to stress.

- **Poor Working Conditions**: Employees may be subject to poor working conditions. It would include bad lighting and ventilation, unhygienic sanitation facilities, excessive noise, and dust, presence of toxic gasses and fumes, inadequate safety measures, etc. All these unpleasant conditions create physiological and psychological imbalance in humans thereby causing stress.
• **Lack of Group Cohesiveness:** Every group is characterized by its cohesiveness, although they differ widely in its degree. Individuals experience stress when there is no unity among work group members. There are mistrust, jealousy, frequent quarrels, etc., in groups and this lead to stress to employees.

• **Interpersonal and Intergroup Conflict:** These conflicts take place due to differences in perceptions, attitudes, values and beliefs between two or more individuals and groups. Such conflicts can be a source of stress for group members.

• **Organizational Changes:** When changes occur, people have to adapt to those changes, and this may cause stress. Stress is higher when changes are significant or unusual like transfer or adoption of new technology.

• **Lack of Social Support:** When individuals believe that they have the friendship and support of others at work, their ability to cope with the effects of stress increases. If this kind of social support is not available, then an employee experiences more stress.

### 1.2.4 Stages of Stress

There are three stages of stress: alarm, resistance and exhaustion. GAS (General Adaptation Syndrome) as termed by Hans Selve is another name of stress. He has given three stages of stress.

• **Alarm:** The first stage of stress is alarm wherein stressor mobilises the internal stress system. Many physiological and chemical reactions are observed under Alarm stage. Increased pituitary, adrenaline secretions, increased respiration, heart trouble and blood pressure are observed under alarm stage. Many employees prevent themselves from getting more stress through physiological and psychological treatment.
• **Resistance:** If the alarm stage is not prevented, resistance develops. The body organs make themselves resistant but it paves the way for development of other stressors. Nervousness and tension are increased making individuals unable to relax. Individuals develop conflicts, frustration and uneasiness. Illness and diseases attached with stress are developed under resistance. Apparently, individuals feel free from stress; but serious diseases are developed stealthily. It is essential to know the causes of stress and avoid them at the starting stage.

• **Exhaustion:** Resistance of resistant stress creates exhaustion. The immunity of body is reduced. Individuals feel fatigue and inability. Exhaustion develops moodiness, negative emotions and helplessness. The impact of stress is visible in physique, psychology and behavior of the employees in an organisation wherein stress has reached to the stage of exhaustion. Health and psychological depression reduces the effectiveness of employees. Consequently organizational success is adversely affected. Stressed employees cannot contribute significantly. A large number of organisations have started stress education to prevent stress from being negatively affecting the employees.

### 1.2.5 Stress Management

Stress is our body’s way of telling us that we’re struggling to cope with all of our demands or that we have to deal with a problem. When we feel stressed, our bodies react like we’re in physical danger: we get a burst of energy, our heart beats faster and our blood pressure rises.

Some stress isn’t a bad thing. It might give us the energy to finish a work project, for example. But too much stress is hard on our bodies. It can cause physical problems like headaches, stomach problems and sleep
problems. It affects the way our bodies fight infections like a cold or the flu, so we’re more likely to get sick when we’re stressed. It can also make health problems worse.

Too much stress is also bad for our mental health. It can leave us feeling tired, irritable, depressed and overwhelmed. It affects our ability to think, concentrate and react. Too much stress may even be a factor in our risk of developing a mental disorder, or having a relapse.

Everyone feels stress from time to time. We can’t always control the things that cause stress, but we can control how we cope with stress. This is called stress management.

1.2.6 Stress Theory

Theories of Stress Theories that focus on the specific relationship between external demands (stressors) and bodily processes (stress) can be grouped in two different categories: approaches to `systemic stress' based in physiology and psychobiology approaches to `psychological stress' developed within the field of cognitive psychology (Lazarus, 1991, Lazarus and Folkman 1984, McGrath 1982).

- **Systemic Stress**

  Selye's Theory The popularity of the stress concept in science and mass media stems largely from the work of the endocrinologist Hans Selye. In a series of animal studies he observed that a variety of stimulus events (e.g., heat, cold, toxic agents) applied intensely and long enough are capable of producing common effects, meaning not specific to either stimulus event. (Besides these nonspecific changes in the body, each stimulus produces, of course, its specific effect, heat, for example, produces vasodilatation, and cold vasoconstriction.) According to Selye, these nonspecifically caused changes constitute the stereotypical, i.e., specific, response pattern of systemic stress. Selye (1976) defines this
stress as `a state manifested by a syndrome which consists of all the nonspecifically induced changes in a biologic system.' This stereotypical response pattern, called the 'General Adaptation Syndrome' (GAS), proceeds in three stages. (a) The alarm reaction comprises an initial shock phase and a subsequent countershock phase. The shock phase exhibits autonomic excitability, an increased adrenaline discharge, and gastrointestinal ulcerations. The countershock phase marks the initial operation of defensive processes and is characterized by increased adrenocortical activity. (b) If noxious stimulation continues, the organism enters the stage of resistance. In this stage, the symptoms of the alarm reaction disappear, which seemingly indicates the organism's adaptation to the stressor. However, while resistance to the noxious stimulation increases, resistance to other kinds of stressors decreases at the same time. (c) If the aversive stimulation persists, resistance gives way to the stage of exhaustion. The organism's capability of adapting to the stressor is exhausted, the symptoms of stage (a) reappear, but resistance is no longer possible. Irreversible tissue damages appear, and, if the stimulation persists, the organism dies. Although Selye's work influenced a whole generation of stress researchers, marked weaknesses in his theory soon became obvious. First of all, Selye's conception of stress as a reaction to a multitude of different events had the fatal consequence that the stress concept became the melting pot for all kinds of approaches. Thus, by becoming a synonym for diverse terms such as, for example, anxiety, threat, conflict, or emotional arousal, the concept of stress was in danger of losing its scientific value (Engel 1985). Besides this general reservation, specific critical issues have been raised. One criticism was directed at the theory's core assumption of a nonspecific causation of the GAS. Mason (1971, 1975b) pointed out that the stressors observed as effective by Selye carried a common emotional meaning: they were
novel, strange, and unfamiliar to the animal. Thus, the animal's state could be described in terms of helplessness, uncertainty, and lack of control. Consequently, the hormonal GAS responses followed the (specific) emotional impact of such influences rather than the influences as such. In accordance with this assumption, Mason (1975b) demonstrated that in experiments where uncertainty had been eliminated no GAS was observed. This criticism lead to a second, more profound argument: unlike the physiological stress investigated by Selye, the stress experienced by humans is almost always the result of a cognitive mediation (Arnold 1960, Janis 1958, Lazarus 1966, 1974). Selye, however, fails to specify those mechanisms that may explain the cognitive transformation of objective' noxious events into the subjective experience of being distressed. In addition, Selye does not take into account coping mechanisms as important mediators of the stress–outcome relationship. Both topics are central to psychological stress theories as, for example, elaborated by the Lazarus group. A derivative of the systemic approach is the research on critical life events. An example is the influential hypothesis of Holmes and Rahe (1967), based on Selye's work, that changes in habits, rather than the threat or meaning of critical events, is involved in the genesis of disease. The authors assumed that critical life events, regardless of their specific (e.g., positive or negative) quality, stimulate change that produces challenge to the organism. Most of this research, however, has not been theoretically driven and exhibited little empirical support for this hypothesis (Thoits 1983).

- **Psychological Stress**

  The Lazarus Theory Two concepts are central to any psychological stress theory: appraisal, i.e., individuals' evaluation of the significance of what is happening for their well-being, and coping, i.e., individuals' efforts in thought and action to manage specific demands (Lazarus 1993).
Since its first presentation as a comprehensive theory (Lazarus 1966), the Lazarus stress theory has undergone several essential revisions (Lazarus 1991, Lazarus and Folkman 1984, Lazarus and Launier 1978). In the latest version (Lazarus 1991), stress is regarded as a relational concept, i.e., stress is not defined as a specific kind of external stimulation nor a specific pattern of physiological, behavioral, or subjective reactions. Instead, stress is viewed as a relationship ("transaction") between individuals and their environment. "Psychological stress refers to a relationship with the environment that the person appraises as significant for his or her well being and in which the demands tax or exceed available coping resources" (Lazarus and Folkman 1986). This definition points to two processes as central mediators within the person–environment transaction: cognitive appraisal and coping. The concept of appraisal, introduced into emotion research by Arnold (1960) and elaborated with respect to stress processes by Lazarus (1966, Lazarus and Launier 1978), is a key factor for understanding stress-relevant transactions. This concept is based on the idea that emotional processes (including stress) are dependent on actual expectancies that persons manifest with regard to the significance and outcome of a specific encounter. This concept is necessary to explain individual differences in quality, intensity, and duration of an elicited emotion in environments that are objectively equal for different individuals. It is generally assumed that the resulting state is generated, maintained, and eventually altered by a specific pattern of appraisals. These appraisals, in turn, are determined by a number of personal and situational factors. The most important factors on the personal side are motivational dispositions, goals, values, and generalized expectancies. Relevant situational parameters are predictability, controllability, and imminence of a potentially stressful event. In his monograph on emotion and adaptation, Lazarus (1991)
developed a comprehensive emotion theory that also includes a stress theory (Lazarus 1993). This theory distinguishes two basic forms of appraisal, primary and secondary appraisal (Lazarus 1966). These forms rely on different sources of information. Primary appraisal concerns whether something of relevance to the individual's well being occurs, whereas secondary appraisal concerns coping options. Within primary appraisal, three components are distinguished: goal relevance describes the extent to which an encounter refers to issues about which the person cares. Goal congruence defines the extent to which an episode proceeds in accordance with personal goals. Type of ego-involvement designates aspects of personal commitment such as self-esteem, moral values, ego-ideal, or ego-identity. Likewise, three secondary appraisal components are distinguished: blame or credit results from an individual's appraisal of who is responsible for a certain event. By coping potential Lazarus means a person's evaluation of the prospects for generating certain behavioral or cognitive operations that will positively influence a personally relevant encounter. Future expectations refer to the appraisal of the further course of an encounter with respect to goal congruence or incongruence. Specific patterns of primary and secondary appraisal lead to different kinds of stress. Three types are distinguished: harm, threat, and challenge (Lazarus and Folkman 1984). Harm refers to the (psychological) damage or loss that has already happened. Threat is the anticipation of harm that may be imminent. Challenge results from demands that a person feels confident about mastering. These different kinds of psychological stress are embedded in specific types of emotional reactions, thus illustrating the close conjunction of the fields of stress and emotions. Lazarus (1991) distinguishes 15 basic emotions. Nine of these are negative (anger, fright, anxiety, guilt, shame, sadness, envy, jealousy, and disgust), whereas four are positive (happiness, pride, relief, and love). (Two more emotions,
hope and compassion, have a mixed valence.) At a molecular level of analysis, the anxiety reaction, for example, is based on the following pattern of primary and secondary appraisals: there must be some goal relevance to the encounter. Furthermore, goal incongruence is high, i.e., personal goals are thwarted. Finally, ego- involvement concentrates on the protection of personal meaning or ego- identity against existential threats. At a more molar level, specific appraisal patterns related to stress or distinct emotional reactions are described as core relational themes. The theme of anxiety, for example, is the confrontation with uncertainty and existential threat. The core relational theme of relief, however, is `a distressing goal-incongruent condition that has changed for the better or gone away' (Lazarus 1991). Coping is intimately related to the concept of cognitive appraisal and, hence, to the stressrelevant person-environment transactions. Most approaches in coping research follow Folkman and Lazarus (1980), who define coping as `the cognitive and behavioral efforts made to master, tolerate, or reduce external and internal demands and conflicts among them.' This definition contains the following implications. (a) Coping actions are not classified according to their effects (e.g., as reality-distorting), but according to certain characteristics of the coping process. (b) This process encompasses behavioral as well as cognitive reactions in the individual. (c) In most cases, coping consists of different single acts and is organized sequentially, forming a coping episode. In this sense, coping is often characterized by the simultaneous occurrence of different action sequences and, hence, an interconnection of coping episodes. (d) Coping actions can be distinguished by their focus on different elements of a stressful encounter (Lazarus and Folkman 1984). They can attempt to change the person–environment realities behind negative emotions or stress (problem-focused coping). They can also relate to internal elements and try to reduce a negative emotional
state, or change the appraisal of the demanding situation (emotion-focused coping).

- **Resource Theories of Stress**

  A Bridge between Systemic and Cognitive Viewpoints Unlike approaches discussed so far, resource theories of stress are not primarily concerned with factors that create stress, but with resources that preserve well being in the face of stressful encounters. Several social and personal constructs have been proposed, such as social support (Schwarzer and Leppin 1991), sense of coherence (Antonovsky 1979), hardiness (Kobasa 1979), self-efficacy (Bandura 1977), or optimism (Scheier and Carver 1992). Whereas self-efficacy and optimism are single protective factors, hardiness and sense of coherence represent tripartite approaches. Hardiness is an amalgam of three components: internal control, commitment, and a sense of challenge as opposed to threat. Similarly, sense of coherence consists of believing that the world is meaningful, predictable, and basically benevolent. Within the social support field, several types have been investigated, such as instrumental, informational, appraisal, and emotional support. The recently offered conservation of resources (COR) theory (Hobfoll 1989, Hobfoll et al. 1996) assumes that stress occurs in any of three contexts: when people experience loss of resources, when resources are threatened, or when people invest their resources without subsequent gain. Four categories of resources are proposed: object resources (i.e., physical objects such as home, clothing, or access to transportation), condition resources (e.g., employment, personal relationships), personal resources (e.g., skills or self-efficacy), and energy resources (means that facilitate the attainment of other resources, for example, money, credit, or knowledge). Hobfoll and co-workers outlined a number of testable hypotheses (called principles) derived from basic assumptions of COR (Hobfoll et al. 1996). 1. Loss of
resources is the primary source of stress. This principle contradicts the fundamental assumption of approaches on critical life events (Holmes and Rahe 1967) that stress occurs whenever individuals are forced to readjust themselves to situational circumstances, may these circumstances be positive (e.g., marriage) or negative (e.g., loss of a beloved person). In an empirical test of this basic principle, Hobfoll and Lilly (1993) found that only loss of resources was related to distress. 2. Resources act to preserve and protect other resources. Self-esteem is an important resource that may be beneficial for other resources. Hobfoll and Leiberman (1987), for example, observed that women who were high in self-esteem made good use of social support when confronted with stress, whereas those who lacked self-esteem interpreted social support as an indication of personal inadequacy and, consequently, misused support. 3. Following stressful circumstances, individuals have an increasingly depleted resource pool to combat further stress. This depletion impairs individuals' capability of coping with further stress, thus resulting in a loss spiral. This process view of resource investment requires to focus on how the interplay between resources and situational demands changes over time as stressor sequences unfold. In addition, this principle shows that it is important to investigate not only the effect of resources on outcome, but also of outcome on resources.

Because stress is one of the most interesting and mysterious subjects we have since the beginning of time, its study is not only limited to what happens to the body during a stressful situation, but also to what occurs in the psyche of an individual. In this article, we will discuss the different psychological theories of stress proposed by James & Lange, Cannon & Brad, and Schachter & Singer.

In 1884 and in 1885, theorists William James and Carl Lange might have separately proposed their respective theories on the
correlation of stress and emotion, but they had a unified idea on this relationship - emotions do not immediately succeed the perception of the stressor or the stressful event; they become present after the body’s response to the stress. For instance, when you see a growling dog, your heart starts to race, your breath begins to go faster, then your eyes become wide open. According to James and Lange, the feeling of fear or any other emotion only begins after you experience these bodily changes. This means that the emotional behavior is not possible to occur unless it is connected to one’s brain.

- **Cannon-Bard: The Emergency Theory**

  This theory is quite the opposite of what James and Lange proposed. According to theorist Walter Cannon, emotion in response to stress can actually occur even when the bodily changes are not present. Cannon said that the visceral or internal physiologic response of one’s body is more slowly recognized by the brain as compared with its function to release emotional response. He attempted to prove his theory by means of creating the so-called “decorticated cats”, wherein the neural connections of the body are separated from the cortex in the brain of the cats. When faced with a stressful response, the decorticated cats showed emotional behavior which meant feelings of aggression and rage. This emotion was then manifested by bodily changes such as baring of teeth, growling and erect hair.

  To further enhance Cannon’s theory, theorist Philip Bard expanded the ideals of Cannon by arguing that a lower brain stem structure called the thalamus is important in the production of emotional responses. According to Bard, the emotional response is released first, and then sent as signals by the thalamus to the brain cortex for the interpretation alongside with the sending of signals to the sympathetic nervous system or SNS to begin the physiologic response to stress. Therefore, this theory
argues that emotional response to stress is not a product of the physiologic response; rather, they occur simultaneously.

- **The Schachter-Singer Theory**

  Theorists Stanley Schachter and Jerome Singer argued that the appropriate identification of the emotion requires both cognitive activity and emotional arousal in order to experience an emotion. Attribution or the process wherein the brain can identify the stress stimulus producing an emotion is also proposed by Schachter and Singer. The theory explains that we become aware of the reason behind the emotional response, and when we the reason is not obvious, we start to look for environmental clues for the proper interpretation of the emotion to occur.

### 1.3. Depression

The statistics are staggering. An estimated 10 million people in the United States suffer from clinical depression each year (Comer, 1992). An estimated 15 percent of American adults will experience depression at some point in their lives (Comer, 1992). In 1980 depression was estimated to have cost Americans $2.1 billion in therapies and care costs, and another $14 billion in lost productivity (Schwartz & Schwartz, 1993).

Depression can be a lonely illness for those who suffer from it. At times it can be frustrating for friends and relatives of depressives. Depression can last as short a period of time as two weeks, or it can last many years. But it can be treated effectively to cure most and help others to get back on their feet again.

In the following pages, I will describe what depression is, the various explanations given for the existence of depression and the various therapies associated with them.
1.3.1 Definition of Depression and its Symptoms

Depression is an affective, or mood disorder. It is an illness that immerses its sufferers in a world of self-blame, confusion, and hopelessness. It is an illness of the mind and the body. Some could argue depression is a way of coping with life’s pressures (Schwartz & Schwartz, 1993).

When most people think of the word depression they think of feeling sad, feeling down. If you do poorly on your physics exam you may feel disappointed and tell your friend, “I’m depressed. I didn’t do well on my physics test today.”

While you may feel depressed about doing poorly on your exam, chances are your depression isn’t overwhelming to a point where your daily functioning hampered.

Clinical depression is a serious illness that affects most, if not all, facts of a depressive’s life. The major component of depression is a loss of interest in activities once found pleasurable. In fact, in order for a person to be diagnosed with having major depression, a loss of interest in activities once found pleasurable must be present (Schwartz & Schwartz, 1993).

For some depressives, there is even a loss of interest in life itself. Each year an average of 5,000 American take their lives. How many of these people were suffering from depression is not known, but it is believed a vast majority of them were depressed.

Depression can be disabling to the point where the depressive can be no longer function in the daily rigors of life. Absence from work or school is common, for the severely depressed individual does not have enough energy or motivation to get out of bed. Many a depressive will describe his or her illness to having a large and heavy weight on his or
her back. Often that heavy weight is an accumulation of stressors, and sometimes the weight is unexplainable.

Physically, a depressive is sluggish. His or her speech is noticeably slow, and motor skills are retarded (Comer, 1992). The depressive may complain of headaches or other ailments that have no explanation (Schwartz & Schwartz, 1993). Cognitively, depressives exhibit confusion and find it difficult to make even what may seem to many people to be the simplest of decisions (Schwartz & Schwartz, 1993). Memory is also impaired.

Depressives are often agitated and irritable. They may perform repetitive motor tasks, like pacing or rubbing their hands together. They may exert a poor disposition and become “aggressively hostile” to others (Wetzel, 1984).

Life can be a lonely experience for depressives. Their sense of humor is lost and they are seldom seen smiling. They are often tired from either too little or too much sleep. Intense feelings of shame and guilt because they believe that everything that goes wrong is their fault are often harbored (Schwartz & Schwartz, 1993). Feelings of inadequacy may lead a depressive to attempt to withdraw from family and friends. Feelings of inferiority may eventually lead to feelings of hopelessness. Nothing can go right and nothing will ever improve, they believe. Often times feelings of inferiority are a result of the depressive’s demanding expectations of him or herself (Schwartz & Schwartz, 1993).

While some depressives may shy away from family and friends, some display an overdependence on others. When they are shunned by those they depend on, they become even more depressed. Their world becomes that much more lonely and hopeless.
1.3.2 Reactive Depression & Physical Depression

There are two major subcategories of unipolar depression: reactive and physical. Formerly known as exogenous depression, meaning depression from the environment, reactive depression is a response to a particularly stressful or emotionally traumatic event. The death of a loved one, being rejected, divorce, or serious illness can bring about its onset.

Physical depression, formerly known as endogenous depression, meaning depression from within, is the result of deficiencies in neuron communication in the brain (Biomedical information corporation, 1985).

- Reactive & Physical Depression: Differences

A side from the obvious difference between reactive depression and physical depression, there are certain characteristics of each type that can lead doctors and their patients to the underlying cause of the depression.

To begin physical depression’s average age of onset is 40 (Biomedical Information Corporation, 1985). Reactive depression can occur at time. Physical depression tends to run in families and isn’t necessarily triggered by a stressful or traumatic event (Biomedical Information Corporation, 1985). Physical depressives are more likely to experience the effects of their depression in the morning than reactive depressives (Biomedical Information Corporation, 1985). Physical depression tends to be more debilitating to the depressive in that its patients are more likely to have their daily functioning hindered (Biomedical Information Corporation, 1985). Physical depressive are also more likely than reactive depressives to experience a loss of self-esteem (Biomedical Information Corporation, 1985). They are also more likely to have suicidal tendencies than reactive depressives (Biomedical Information, 1985).
1.3.3 Causes of Depression

There are four major views as to what causes depression. They are: the psychoanalytic theory, behavioural theory, cognitive-behavioural theory, and the biological theory.

- The psychodynamic View

The psychodynamic view of depression, authored by Freud, anchors on the principle of loss. Therapists privy to this view of depression believe the root of all depression lies in the loss of something loved, whether it be a person or an object. The loss can be real or it can be imagined (Lowry, 1984).

In a study done by P.J. Clayton in the late 1970s, widows and widowers were studied for a year after the death of their spouses. While depression brought about by the death of a loved one is excluded as being a depressive episode by the psychological community, Clayton found that 45 percent of his subjects fit the criteria for a diagnosis of depression (Lowry, 1984).

But what about depression in people who haven’t lost a loved one?

Freud’s definition of what constituted a loss was broad. He deemed depression that didn’t evolve in reaction to the loss of a loved one to be the result of “symbolic loss.” Thus, rejection for a date could cause a depressive episode because the depressive has “lost” something, even if he or she never had it to begin with.

In reaction to losing the object, Freud believed the depressive then develops feelings of self-hatred (Comer, 1992). The depressive begins to believe he or she is responsible for the loss. Freud also believed feelings of self-hatred develop from the depressive’s thoughts about unresolved conflicts (Comer, 1992). As a result of feelings of self-hatred, the depressive feels worthless and loses his or her self-esteem.
It is the loss of self-esteem, many psychodynamic theorists claim, that starts a person down the path of depression (Comer, 1992). Melanie Klein, a neo-Freudian, claims that whether an individual loses his or her self-esteem depends on the quality of the individual’s relationship as an infant with his or her mother during the first year of life (Wetzel, 1984). If an individual doesn’t have positive experiences with his or her mother during the first year of life, then a predisposition to depression may be planted (Wetzel, 1984).

Klein’s interpretation to the origin of depression closely resembles that of Freud’s theory that an individual can develop a predisposition for the illness.

Freud also believed too many positive experiences during the first year of life could set an individual up for developing depression later on in life (Comer, 1992). Freud believed that if an individual is nurtured too much as an infant, he or she won’t develop beyond the oral stage of development because there was never a need to. The individual runs into problems in adult life because he or she is used to receiving excessive amounts of attention (Comer, 1992). If an individual is used to receiving 10 points of attention he or she did when he or she was young, and he or she only receives 6 points of attention, then he or she will feel rejected, unloved, and the inferior.

The primary criticism of the psychodynamic theory of depression is the same as it is for other psychodynamic theories: there is no way to prove its assumptions. Freud’s stages of development occur at an unconscious level. There is no way to tell if an individual is stuck at the oral stage because the psychodynamic theory hinges on subjective interpretations. What is too much or too little nurturing (Comer, 1992)? How can it be measured?
• **The Behavioural View**

  Behaviourist theorists and clinicians believe depression is learned. Charles Ferster, one of the first researchers to suggest a link between depression and behaviour, hypothesized depression develops as a result of a lack of positive reinforcement for the depressive’s actions (Wetzel, 1984).

  Ferster hypothesized depressives lack motivation and control and as a result receive negative feedback from others (Wetzel, 1984). Other behaviourists tend to agree with this view and see the presence of negative reinforcements as compounding the depression by causing more and more self-esteem to be lost (Wetzel, 1984) Other behaviourists, like Peter Lewinsohn, believe there may not even by any reinforcements in a depressive’s life (Wetzel, 1984).

  Behaviourists use the learned helplessness model to explain depression. In a theory much in line with Freud’s theory of nurturing, many behaviourists believe that some individuals develop depressing because they were overprotected when they were younger (Wetzel, 1984). The pressures and stressors of life out in the “real world” are just too much for them to handle. they have been taught by their parents to be passive because there was always someone looking out for them. The stressors mount and they feel inferior because they believe they are incapable of fending for themselves.

• **The Cognitive-Behavioural View**

  An offshoot of the behavioural model is Aaron Beck’s cognitive-behavioural view of depression. Beck believes “depressives suffer from a kind of basic thinking that distorts reality” (Papalia & Olds, 1988).

  Depressives, according to Beck, distorts reality by harboring negative feelings about anything and everything. They tend to take things too personality and believe the future is bleak and dim (Papalia & Olds,
1988). These inferior feelings, Beck believes, lead to more negative experiences for the depressive. In turn, the depressive develops more thoughts of worthlessness and inferiority (Schwartz & Schwartz, 1993). Often a depressive expects too much of him or herself, Beck believes (Papalia & Olds, 1988). Failure is an accepted way of life and the depressive believes there is nothing he or she can do about it (Papalia & Olds, 1988). Learned helplessness is the result.

To demonstrate the learned helplessness theory, Martin Seligman conducted an experiment using two sets of dogs and a shuttle box. The shuttle box was constructed so there were two parts. One half of the box contained electrodes on the floor to emit electricity, while the other half of the box was normal. In the middle of the box a barrier was placed.

The first set of dogs was placed in the box and administered shocks. Initially they would react by jumping around. Eventually they jumped over the barrier to the safe zone. After awhile Seligman installed a warning device for the dogs, such as a light that would dim. The dogs learned that when the light dimmed, the electricity was coming. They were able to jump over the barrier to the other side without getting shocked.

The second set of dogs was also placed in the box, but they were unable to escape the shocks. Seligman then gave them an opportunity to avoid the shocks, but these dogs didn’t learn that when the light dimmed they were going to be shocked. Instead, they lied dormant and whimpered when the electricity was turned on.

The second set of dogs, Seligman concluded, had been taught helplessness. They believed that no matter how much they tried to escape the shocks, the shocks were still going to be present (Comer, 1992).
**Biological View:**

Evidence that depression is related to genetics has been growing recently, as more and research is being done to examine the role the brain and heredity play in the likelihood and individual will develop depression.

For the time in the early 1980s visible evidence of depression having a biological tie showed up in laboratory tests that examined the brain’s functioning in depressives (Lowry, 1984).

Other medical evidence that supports the biological model of depression are the documentation of higher than normal amounts of cortical discharges in the adrenal glands of depressives, and eccentric brain wave patterns as recorded by electroencephalograms (EEGs) (Lowry, 1984).

Research has also shown depression has a tendency to run in families. Most published research covers bipolar depression, but researchers have concluded there is reason to believe unipolar depression can be inherited and it thus a biological illness (Schwartz & Schwartz, 1993).

In twin studies done examining bipolar depression, researchers have found the likelihood to be 80 percent both twins will develop bipolar depression if at least one has it (Schwartz & Schwartz, 1993).

Criticisms of the biological model are it ignores environmental factors when looking at the relationship of depression in family studies, and the concordance rate in identical twin studies is not 100 percent. If depression can be inherited, critics argue, and then both identical twins should inherit it (Schwartz & Schwartz, 1993). Proponents of the biological model, however, point out it is the predisposition of depression inherited, not the illness itself (Schwartz, Schwartz, 1993). Even identical twins don’t experience the same life events.
Other View on Depression

In addition to the three major views of what causes depression, the psychological community has explored other potential causes. One avenue researchers are looking at is effect an individual’s diet has on his or her mood.

Studies have shown there is a correlation between the amount of caffeine and carbohydrates a person consumes and how well his or her affect is. While caffeine stimulates the nervous system, too much of it may depress the nervous system (Schwartz & Schwartz, 1993).

The explanation for caffeine’s depressive effect on a person’s affects lies in what caffeine stimulates. If consume just before bed time, caffeine alters an individual’s sleep/wake cycle by delaying sleep, or preventing an individual from achieving the full benefit of sleep (Schwartz, 1993).

Another explanation for depression and one that’s attracting more and attention deal with the chronobiological principle. Studies have shown there may be a correlation between a person’s daily schedule in terms of his or her sleep/wake cycle, and affect (Schwartz & Schwartz, 1993). The chronobiological principle centres on the hormone melatonin. A light-sensitive hormone, melatonin is released at night when the body senses darkness. In the morning when light reappears, melatonin levels drop. A high level of melatonin during the day may cause individuals to be fatigued and subsequently depressed. A low level of melatonin at night might disrupt an individual’s sleep/wake cycle to the point where the individual doesn’t enough sleep (Schwartz & Schwartz, 1993).

There are two categories of SAD: Winter SAD and Summer SAD. The annual onset of Winter SAD occurs in the fall as the days become shorter. It becomes more prominent in the winter months when there is less sunlight. Chronobiologists believe that as the days grow shorter and
shorter and sun the sun rises later in the day, some people’s bodies’ biological clocks may not be able to synchronize melatonin’s release with the sleep/wake cycle (Schwartz & Schwartz, 1993). This belief has not been proven (Schwartz & Schwartz, 1993). As many as 89 percent of Winter SAD patients in one study reported experiencing hypomania when spring rolled around (Schwartz & Schwartz, 1993).

The explanation for Summer SAD is quite different than the explanation for Winter SAD, for melatonin plays no role.

Temperature is the main character in Summer SAD (Schwartz & Schwartz, 1993). Summer SAD patients have reported relief from their depression when in an air-conditioned environment (Schwartz & Schwartz, 1993). Ironically, some Summer SAD patients have reported relief also when placed in a darkened environment (Schwartz & Schwartz, 1993).

Other ways in which Summer SAD differs from Winter SAD is the tendency for its patients to display symptoms more favorable to endogenous depression, in regards of frequent thoughts of death and suicide (Schwartz & Schwartz, 1993).

1.3.4 Treatment of Depression

While depression can be a debilitating illness, the odds of successfully treating it are encouragingly high as many as 85 percent to 90 percent of depressives who seek treatment get better (Hegg, 1991). Unfortunately, only approximately 30 percent of the estimated 10 million depressives in the United States receive therapy (Hegg, 1991). Overall, it is believed 64 percent of all depressives in the United States recover within six month, many without receiving treatment (Comer, 1992).

There are essentially two types of treatment for depression: psychotherapy and drug therapy.
Psychotherapy has the clinician acting as a confidant to the depressive. The psychotherapist will often employ counselling techniques from each of the three major views of depression, rather than rely on one technique, like psychoanalysis. Some patients respond better to behavioural therapy while others may respond better to psychoanalysis. The key to successful therapy is using the right mix of techniques from the different models.

- **Psychodynamic Techniques**

  Because psychodynamic theorists contend depression develops in response to a loss—often a loss at the unconscious level—psychodynamic clinicians make extensive use of free association (Comer, 1992). The hope is that by having the depressive talk about whatever is on his or her mind the identity of the lost object will be revealed, or at least hints of what the objects is will come to the surface. The therapist and patient discuss events that may have led to a loss or losses and attempt to interpret the events. The interpretations are intended to provide the patient with some insight into his or her self-anger that Freud believed is present with a loss that precipitates a depressive episode.

  Sometimes, however, a patient is so depressed he or she is unable to motivate him or herself to think of things to talk about. When this happens the therapist will usually take an active role in the therapy by introducing different topics, with the hope the patient will be sparked enough to want to talk about things (Comer, 1992).

  Psychodynamic theorists also like to interpret dreams depressives experience as a means of unlocking the unconscious mind. By gaining insight from the interpretation of free association and dreams, the goals of the psychodynamic technique is to have the patient understand what his or her loss is and how it and future losses can be confronted now and in the future.
If there is a drawback to psychodynamic therapy, it is its nature of being a slow moving approach. By nature, depressives are often frustrated and this technique may lead some to give up on therapy altogether (Comer, 1992).

- **Behavioural & Cognitive-Behaviour Techniques**

  Followers of the behavioural and cognitive-behavioural schools believe depression is learned and then negatively reinforced because there are little or no positive reinforcements available to depressives. Because of this, depressives are likely to a deficiency in social skills. As a result, behaviourist clinicians focus on positive reinforcement as a means of treating depressives.

  Beck encourages patients to get involved with their therapy (Schwartz & Schwartz, 1993). Having the patient talk about present events, Beck believes, is the key to determining the cause of the depression. Past events are discussed only to the extent of their relationships with present events. The therapist and the patient then collaborate to develop homework assignments that will hopefully provide the patient with positive reinforcements in his or her development of social skills (Wetzel, 1984).

  For example, if the patient is depressed because he or she doesn’t have many friends or the patient is socially withdrawn, the therapist will work with the patient to develop a schedule for the patient to follow in the patient quest to get out, be with, and meet people. The first step in meeting new people would be for the patients to put him or herself in a situation where potential friends could be made. If the patient likes to run, he or she might plan to go to a track the first day. The second day the patient might make it a goal to introduce him or herself to another runner, and so on.
As each item on the schedule is reached, the patient comments in a log, which is then brought to the next therapy session for, review by the therapist and discussion.

Similar to Beck’s treatment technique is Peter Lewinsohn’s technique for promoting positive experiences through role playing (Comer, 1992). Used primarily in group settings, role playing allows the patient an opportunity to learn how to be assertive in social situations (Comer, 1992). The patient’s own non-assertiveness is also demonstrated. While the role plays take place, the therapist takes notes on each patient’s strengths and weakness, allowing for the patient to see what he or she needs to work on (Comer, 1992).

Lewinsohn has even gone so far as to develop a class for depressives, complete with text books and all. One study found an 80 percent success rate in treating patient’s depression this way (Comer, 1992).

- **Electroconvulsive Therapy (ECT)**

  Electroconvulsive therapy, also known as shock treatment, is the most controversial form therapy in treating depression. First used in 1938, ECT calls for the patient to be administered low-voltage shocks to the brain ECT was widely used in the 1950s and 1960s, but today it is used only as a last resort to treat the severely depressed who have demonstrated suicidal tendencies.

  How ECT works isn’t clear, but it has proven to be a quick and effective means of treatment (Comer, 1992). It is believed that be administering shocks to the brain, chemical imbalances are affected. Another theory for ECT’s effectiveness is it helps the patient eliminate destructive thoughts that may prompt depression. The shocks to the brain render the patient unconscious and with recollection of the treatment.
When a patient undergoes ECT, he or she is administered sedatives or tranquilizers first to alleviate anxiety and resistance. In its infancy, ECT did not use sedatives or tranquilizers and the frequent result was patients suffering from fractured bones.

The patient is then strapped onto a padded table, given a mouthpiece to prevent broken teeth, and administered anaesthesia to block out plain. It is then electrodes are attached to the head and the shocks given. Some therapists use two electrodes to administer shock to both sides of the brain, and some use one electrode to administer shock to only one side of the brain. The shocks prompt the brain to go into convulsion for a few minutes, and the treatment is done. ECT is usually administered for two weeks, spread out over three to six sessions (Papalia & Olds, 1988).

**Drug Therapy**

In the 1950s, drug therapy has come to the forefront as a major means of fighting depression. The success of drug therapy has also boosted the belief depression results from chemical imbalances in the brain (Papalia & Olds 1988). There are two types of drugs used to treat depression: tricyclics and monoamine oxidize inhibitors.

**Monoamine Oxidize Inhibitors**

Monoamine oxidize Inhibitors, or MAO inhibitors, work on monoamine oxidize, an enzyme the body yeses to regulate the body’s blood pressure by breaking down tramline, a chemical found in fermented and aged foods, and foods containing cheese (Comer, 1992). When MAO levels get too high, the neurotransmitters nor epinephrine and serotonin are destroyed (Comer, 1992). Low levels of nor epinephrine or serotonin are believed to be responsible for physical depression.

MAO inhibitors break down the production of MAOs, but this leaves the patient susceptible to dangerous level of high blood pressure.
As a result, patients of MAO inhibitors must adhere to a diet to prevent much tramline from entering the body and causing high blood pressure (Comer, 1992).

Because of the dietary restrictions MAO inhibitors place on patients, clinicians tend to prescribe tricycles more often (Comer, 1992).

- **Tricyclics**

  Imipramine became the first anti-depressant drug when Swiss researchers looking for a drug to treat schizophrenia discovered it boosted people’s affects by increasing the uptake of the neurotransmitter nor-epinephrine.

  Tricyclics, named because of their three-ring chemical structure, work by improving communication amongst brain cells. Researchers believe that tricyclics work by neither blocking the reuptake of nor-epinephrine, increasing its uptake in receiving neuron. Neither when a neuron releases nor epinephrine, it immediately tries to retrieve (reuptake) the neurotransmitter or prevent overstimulation of the receiving neuron. It is believed that in depressives, too much of the neurotransmitter is reuptake, resulting in a chemical imbalance that causes brain activity to become stunted, or more appropriately, depressed (Comer, 1992).

  Some critics questions why it takes as long as two weeks for tricyclics to kick into action (Comer, 1992). One theory is tricyclics work on the sensitivity of neuron receptors themselves, not the neurotransmitters

  A deficiency in serotonin, another neurotransmitter, has also been shown to be related to depression. Fluoxetine hydrochloride, or Prozac, has been shown to be quite effective in increasing serotonin levels in neuron receptors. A second generation tricyclic, Prozac works specifically on serotonin. Since its introduction in the late 1980s Prozac...
has been hailed by many as a “miracle” drug because of its few and less severe side effects. Others claim the drug causes depressives to become suicidal. The Food & Drug Administration has found no such evidence.

The introduction of drugs in the fight against depression has brought a better understanding to researchers studying the biological roots of the disease. Researchers have found that decreased levels of norepinephrine coincide with lethargy, inattentiveness, and loss of appetite. A decrease in serotonin, on the other hand coincides with agitation, lack of confidence and self-esteem, and an increased susceptibility to suicide (Comer, 1992).

• **Hope**

For depressives, life is a struggle. They are psychologically paralyzed trapped in a dark tunnel, with the end seemingly too far away. Some depressives see the light at the end of the tunnel, but they cannot run or walk. Frustration reigns and self-blame is a way of life. While research to unlock the mysteries of the disease is an ongoing process and treatments are being refined, there are some basic principles depressives and their family and friends should keep in mind.

Depression is not a sign of weakness. While many depressives tend to keep their illness to themselves, the Biological Information Corporation encourages depressives to “Get it out in the open and treat [sic] it like any other disease. “Psychologists also encourage depressives to get out and relax and not try to do too much too soon. Depressives shouldn’t hesitate to consult with family and friends when faced with important decisions that must be made immediately.

Family and friends of depressives should be supportive and non-judgmental. A person can’t “snap out of it.” For many depressives, the difference between a good day and a bad day is as little as a friend or family member taking a walk with them or listening to their frustrations.
Depression may not be preventable, but its effects can be alleviated.

1.4. Suicide

Suicide is intentional self-inflicted death. Edwin Schneidman defined Suicide as “the conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the act is perceived as the best solution.” Suicide is not a random or pointless act. On the contrary, it is a way out of a problem or a crisis that is invariably causing intense suffering. Suicide is associated with thwarted or unfulfilled needs, feelings of hopelessness and helplessness, ambivalent conflicts between survival and unbreakable stress, a narrowing of perceived options, and need for escape; the suicidal persons sends out signals of distress.

1.4.1 Associated Factors of Suicide

- **Sex**
  
  Men commit suicide more than three times as often as do women, a rate that is stable over all ages. Women, however, are four times as likely to attempt Suicide as are men.

- **Methods**
  
  The higher rate successful suicide for men is related to the method they use. Men use firearms, hanging, or jumping from high places. Women are more likely to take a overdose of psychoactive substances or a poison, but they are beginning to use firearms more often than in the past. The use of guns has decreased as a method of suicide in those states with gun control laws.

- **Age**
  
  Suicide rates increase with age. The significance of the midlife crisis is underscored by suicide rates. Among men, suicides peak after
age 45; among women, the greatest number of completed suicides occurs after age 55. Rates of 40 per 100,000 populations are found in men aged 65 and older. The elderly attempt suicide less often than do younger people but are successful more often. The elderly account for 25 percent of suicides, although they make up only 10 percent of the total population. The rate for those 75 or older is more than three times the rate among the young.

The suicide rate is rising most rapidly in young people. For males 15 to 24 years old, the rate increased 40 percent between 1970 and 1980, and the rate is still rising. The suicide rate for females in the same age group showed only a slight increase. Among men 25 to 34 years old, the suicide rate increased almost 30 percent. Suicide is the third leading cause of death in the 15 to 24 years-old age group after accidents and homicides. Attempted suicide in the age group number between 1 million and 2 million annually. The majority of suicides now occur among those 15 to 44.

- **Race**

The rate suicide among whites is nearly twice that among nonwhites, but the figures are being questioned, as the suicide rate among blacks is increasing. In 1989 the suicide rate for white males (19.6 per 100,000 persons) was 1.6 times that for black males (12.5), 4 times that for white females (4.8), and 8.2 times that for black females (2.4). Among ghetto youth and certain Native American and Alaskan Indian groups, suicide rate have greatly exceeded the national rate. Suicide among immigrants is higher than in the native-born population. Two out of every three suicides are white males.

- **Religion**

Historically, suicide rates among Catholic populations have been lower than the rates among Protestants and Jews. It may be that a
religion’s degree of orthodoxy and integration is a more accurate measure of risk in this category than is simple institutional religious affiliation.

- **Marital Status**

  Marriage reinforced by children seems to significantly lessen the risk of suicide. Among married persons, the rate is 11 per 100,000. The overall rate for never-married persons is nearly double the rate for married persons. However, previously married persons show sharply higher rates than do never-married persons: 24 per 100,000 among the widowed; 40 per 100,000 among divorced persons, with divorced men registering 69 suicides per 100,000, as compared with 18 per 100,000 for divorced women. Suicide is more common in persons who have a history of suicide (attempted or real) in the family and who are socially isolated than in the general population. So-called anniversary suicides are suicide by persons who take their lives on the same day as did a member of their families.

- **Occupation**

  The higher a person’s social status is, the greater is the suicide risk, but a fall in social status also increases the risk. Work, in general, protects against suicide.

  Among occupational rankings, professionals, particularly physicians, have traditionally been considered to be at the greatest risk for suicide. However, the best recent studies have found no increased suicide risk for male physicians in the United States. Their annual suicide rate is about 36 per 100,000, which is the same as that for white men over 25. Recent British and Scandinavian data, by contrast, show that the suicide rate for male physicians is two to three times the rate found in the general male population of the same age.

  Studies agree that female physicians have a higher risk of suicide than do other women. In the United States the annual suicide rate for
female physicians are about 41 per 100,000, compared with the rate of 12 per 100,000 among all white women over 25 years of age. Similarly, in England and Wales the suicide rate for unmarried female physicians is 2.5 times greater than the rate among unmarried women in the general population, although it is comparable to that found among other groups of professional women.

Studies show that the physician who commits suicide has a mental disorder. The most common mental disorders found among physicians and among physician suicide victims are depressive disorders and substance dependence. Often, the physician who commits suicide has experienced recent professional, personal, or family difficulties. Both male and female physicians commits suicide significantly more often by substance overdoses and less often by firearms than do person in the general population; drug availability and knowledge about toxicity are important factors in physician suicides. Some evidence indicates that female physicians have an unusually high lifetime risk for mood disorders. This may be the major determinant of the elevated suicide risk.

Among physicians, psychiatrists are considered to be at greatest risk, followed by ophthalmologists and anesthesiologists, but the trend is toward equalization among all specialties. Special at-risk populations are musicians, dentists, law enforcement officers, lawyers, and insurance agents. Suicide is higher among unemployed persons than among employed persons. During economic recessions and depressions and times of high unemployment, the suicide rate increases. During times of high employment and during war, the rate decreases.

- **Climate**

  No seasonal correlation with suicide has been found. The spring and the fall see a slight increase in suicides, but contrary to popular belief, suicides do not increase during December and holiday periods.
**Physical Health**

The relation of physical and illness to suicide is significant. Prior medical care appears to be a positively correlated risk indicator of suicide: 32 percent of all people who commit suicide have had medical attention with six months of death. Postmortem studies show that a physical illness is present in some 25 to 75 percent of all suicide victims: a physical illness is estimated to be an important contributing factor in 11 to 51 percent of all suicides. In each instance the percentage increases with age.

Some endocrine conditions are associated with increased suicide risk: Cushing’s disease, Klinefelter’s syndrome, and porphyries. Mood disorders also attend those disorders. The two gastrointestinal disorders with an increased suicide risk are peptic ulcer and cirrhosis, both physical disorders found among alcohol-dependents persons. The two urogenital problem with an increased suicide risk are prostatic hypertrophy and renal disease treated with hemodialysis, both problems in which changes in mood occur.

Factors associated with illness and contributing to both suicides and suicide attempts are loss of mobility among persons to whom physical activity is occupationally or recreationally important; disfigurement, particularly among women: and chronic, intractable pain. In addition to the direct effects of illness, the secondary effects of illness-for example, disruption of relationships and loss of occupational status- are prognostic factors.

Certain drugs can produce depression, which may lead to suicide in some cases. Among those drugs are reserpine (Serpasil), corticosteroids, antihypertensive (for example, propranolol (Inderal), and some anticancer agents.
• **Mental Health**

Highly significant psychiatric factors in suicide include substance abuse, depressive disorders, schizophrenia, and other mental disorders. Almost 95 percent of all patients who commit or attempt suicide have diagnosed mental disorders. Depressive disorders account for 80 percent of that figure, schizophrenia accounts for 10 percent, and dementia or delirium accounts for 5 percent. Among all mentally disordered persons, 25 percent are also alcohol-dependent and have dual diagnoses. Patients who suffer from delusional depression are at the highest risk for suicide. The risk of suicide in patients with depressive disorders is about 15 percent. Twenty-five percent of all patients with a history of impulsive behavior violent acts are also at high risk for suicide. Previous psychiatric hospitalization for any reason increases the risk for suicide.

Among adult suicide victims, differences between the young and the old are significant for both psychiatric diagnoses and antecedent stressors. A study in San Diego showed that diagnoses of substance abuse and antisocial personality disorder were found most often among suicide victims under 30 years of age, and diagnoses of mood disorders and cognitive disorders of age, and diagnoses of mood disorders and cognitive disorders were found most often among suicides aged 30 and over. Stressors associated with suicide in those under 30 were separation, rejection, unemployment, and legal troubles; illness stressors were found most often among suicide victims over 30.

• **Previous Suicide Behavior**

A past suicide attempt is perhaps the best indicator that a patient is at increased risk for suicide. Studies show that about 40 percent of depressed patients who commit suicide have made a previous attempt. The risk of a patient’s making a second suicide attempt is highest within three months of the first attempt.
1.4.2 Causes of Suicide

- Sociological Factors

Durkheim’s Theory The first major contribution to the study of the social and cultural influences on suicide was made at the end of the last century by the French sociologist Emile Durkheim. In an attempt to explain statistical patterns, Durkheim divided suicides into three social categories: egoistic, altruistic, and anomic. Egoistic suicide applies to those who are not strongly integrated into any social group. The lack of family integration can be used to explain why the unmarried are more vulnerable to suicide than are the married and why couples with children are the best-protected group of all. Rural communities have more social integration than do urban areas and, thus, less suicide. Protestantism is a less-cohesive religion than Catholicism is, and so Protestants have a higher suicide rate than do Catholics.

Altruistic suicide applies to those whose proneness to suicide stems from their excessive integration into a group, with suicide being the outgrowth of that integration—for example, the Japanese soldier who sacrifices his life in battle.

Anomic suicide applies to those persons whose integration into society is disturbed, thereby depriving them of the customary norms of behavior. Anomie can explain why those whose economic situation has changed drastically are more vulnerable than they were before their change in fortune. Anomie also refers to social instability, with a breakdown of society’s standards and values.

- Psychological Factors

Freud’s Theory The first important Psychological insight into Theory came from Sigmund Freud. He described only one patient who made a suicide attempt, but he saw many depressed patients.
In his paper, “Mourning and Melancholia” Freud stated his belief that suicide represents aggression turned inward against an introjected, ambivalently cathected love object. Freud doubted that there would be a suicide without the earlier repressed desire to kill someone else.

**Menninger’s Theory** Building on Freud’s concepts, Karl Menninger in Man against Himself conceives of suicide as a retroflexed murder, inverted homicide as a result of the patient’s anger toward another person, which is either turned inward or used as an excuse for punishment. He also described a self-directed death instinct (Freud’s concept of Thanatos). He described three components of hostility in suicide: the wish to kill, the wish to be killed, and the wish to die.

**Recent Theory** Contemporary suicidologists are not persuaded that a specific psychodynamic or personality structure is associated with suicide. However, they have written that much can be learned about the psychodynamic of suicidal patients from their fantasies as to what would happen and what the consequences would be if they were to commit suicide. Such fantasies often include wishes for revenge, power, control, or punishment; for atonement, sacrifice, or restitution; for escape or sleep; or for rescue, rebirth, and reunion with the dead, or a new life. The suicidal patients who are most likely to act out suicidal fantasies may be those who have suffered the loss of a love object or had a narcissistic injury, who experience overwhelming affects like rage and guilt, or who identify with a suicide victim. Group dynamics underlie mass suicides like those at Masada and Jonestown.

Depressed persons may attempt suicide just as they appear to be recovering from their depression. And a suicide attempt can cause a long-standing depression to disappear, especially if it fulfills the patient’s need for punishment of equal relevance, many suicide patients use a preoccupation with suicide as a way of fighting off intolerable depression.
and a sense of hopelessness. In fact, hopelessness was found, in a study by Aaron Beck, to be one of the most accurate indicators of long-term suicidal risks.

- **Genetics**

  A genetics factors in suicide has been suggested. Studies show that suicide tends to run in families. For example, at all stages of the life cycle, a family history of suicide is present significantly more often among person who have attempted suicide than among those who have not. One major study found that the suicide risk for first-degree relatives of psychiatric patient was almost eight times greater than that for the relatives of controls. Furthermore, the suicide risk among the first-degree relatives of the psychiatric patients who had committed suicide was four times greater than that found among the relatives of patient who had not committed suicide. In some situations, particularly among adolescents, the family member who has committed suicide may serve as a role model with whom to identify when the option of committing suicide become one possible solution to intolerable psychological pain.

- **Neurochemistry**

  A serotonin deficiency, measured as a decrease in the metabolism of 5 hydroxyindoleacetic acid (5-HIAA), was found in a group of depressed patients who attempted suicide by violent means (for example, guns or jumping) had a lower 5-HIAA level in the cerebrospinal fluid (CSF) than did those depressed patients who were not suicide or who attempted suicide in a less violent manner (for example, a substance overdose).

  Some animal and human studies have indicated an association between a deficiency in the central serotonin system and poor impulse control. Some workers have viewed suicide as one type of impulse behavior. Furthermore, a significant negative correlation between CSF5-
HIAA levels and lifetime aggression scores has been reported among personality disorder patients. Other patient groups thought to have problems with impulse control include violent offenders, arsonists and those with alcohol dependence, groups who have also been noted to have lower CSF5-HIAA levels than do controls.

Possible peripheral markers of suicidal behavior have also been examined. High outputs of urinary free cortisol, non-suppression of plasma cortisol after the administration of dexamethasone, an exaggerated plasma cortisol response to the infusion of 5-hydroxtryptophan, a blunted plasma thyroid stimulating hormone (TSH) response to the infusion of thyrotropin releasing hormone (TRH), skin conductance abnormalities, altered urinary catechol ratios, and decreases in platelet serotonin uptake or titrated imipramine (Tofranil) binding number have all been associated with suicidal behavior among depressed patients.

A few studies have found ventricular enlargement and abnormal electroencephalograms (EEGs) in some suicidal patients.

Blood samples analyzed for platelet monoamine oxidase (MAO) from a group of normal volunteers revealed that those persons with the lowest level of the enzyme in their platelets had eight times the prevalence of suicide in their families, compared with persons with high levels of the enzyme. There is strong evidence for an alteration of platelet MAO activity in depressive disorders.

• Self-Injury

Studies show that about 4 percent of all patients in psychiatric hospitals have cut themselves; the female-to-male ratio is almost 3 to 1. The incidence of self-injury in psychiatric patients is estimated to be more than 50 times greater than in the general population. Cutters presenting to psychiatrists tend to have cut themselves chronically over
several years. Self-injury is found in about 30 percent of all abusers of oral substances and 10 percent of all intravenous users admitted to substances-treatment units.

The patients are usually in their 20s and may be single or married. Most cut delicately, not coarsely. Cutting is usually done in private with a razor blade, a knife, broken glass, or a mirror. The wrists, arms, thighs, and legs are the most common site cut; the face, breasts, and abdomen are cut infrequently. Most cutters claim to experience no pain. The reasons given include anger at themselves or others, relief of tension, and the wish to die. The great majorities of cutters are classified as those with personality disorders and are significantly more introverted, neurotic, and hostile than are controls. Alcohol abuse and other substances abuse are common, and majority of cutters have attempted suicide.

Self-mutilation has been viewed as localized self-destruction, with mishandling of aggressive impulses caused by an unconscious wish to punish either oneself or interjected object. Some have referred to cutters as pseudosuicidal.

• **Prediction**

The clinician must assess an individual patient’s risk for suicide on the basis of the clinical examination. The most predictive items associated with suicide risk. Among the high risk characteristics are age over 45, male sex, alcohol dependence (the suicide rate is 50 times higher in alcohol dependent person than in those who are not alcohol dependent), violent behavior, prior suicide behavior, and previous psychiatric hospitalization.
Factors Associated with Suicide Risk

<table>
<thead>
<tr>
<th>Rank order</th>
<th>Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Age (45 and older)</td>
</tr>
<tr>
<td>2</td>
<td>Alcohol dependence</td>
</tr>
<tr>
<td>3</td>
<td>Irritation, rage, violence</td>
</tr>
<tr>
<td>4</td>
<td>Prior suicidal behavior</td>
</tr>
<tr>
<td>5</td>
<td>Male</td>
</tr>
<tr>
<td>6</td>
<td>Unwilling to accept help</td>
</tr>
<tr>
<td>7</td>
<td>Long than usual duration of current episode of depression</td>
</tr>
<tr>
<td>8</td>
<td>Prior inpatient psychiatric treatment</td>
</tr>
<tr>
<td>9</td>
<td>Recent loss or separation</td>
</tr>
<tr>
<td>10</td>
<td>Depression</td>
</tr>
<tr>
<td>11</td>
<td>Loss of physical health</td>
</tr>
<tr>
<td>12</td>
<td>Unemployed or retired</td>
</tr>
<tr>
<td>13</td>
<td>Single, widowed, or divorced</td>
</tr>
</tbody>
</table>

The clinician should always ask about suicide ideation as part of every mental status examination, especially if the patient is depressed. The patient should be asked directly: “Are you or have you ever been suicidal. Do you want to die?” Eight out of 10 persons who eventually kill themselves give warnings of their intent. Fifty percent say openly that they want to die. If the patient admits to a plan of action that is a particularly dangerous sign. Also, if a patient who has been threatening suicide becomes quiet and less agitated than in the past, that may be an ominous sign.

1.4.3 Treatment

The great majority of suicide among psychiatric patients are preventable. Some patients experience suffering so great and intense or so chronic and unresponsive to treatment that their eventual suicides may be perceived as inevitable; fortunately, such patients are relatively
uncommon. Some other patients have severe personality disorders, are highly impulsive and apparently commit suicide impulsively, often when dysphonic or intoxicated or both. The evidence that inadequate assessment or treatment is associated with suicide indicates that the great majority of suicide of psychiatric patients is probably preventable.

- **Inpatient Versus Outpatient Treatment**

  Whether to hospitalize patients with suicide ideation in the most important clinical decision to be made. Not all such patients require hospitalization; some may be treated as outpatients. But the absence of a strong social support system, a history of impulsive behavior, and a suicidal plan of action are indications for hospitalization. To determine whether outpatient treatment is feasible-asking patients considered should use a straightforward clinical approach-asking patients considered suicidal to agree to call when reaching a point beyond which they are uncertain of their ability to control their suicidal impulses. Patients who can make such an agreement reaffirm the belief that they have sufficient strength to control such impulses and to seek help.

  In return for the patient’s commitment, the clinician should be available to the patient 24 hours a day. If a patient who is considered seriously suicidal cannot make the commitment, immediate emergency hospitalization is indicated, and both the patient and the patient’s family should be so advised. If, however, the patient is to be treated as an outpatient, the therapist should note the patient’s home and work telephone numbers for emergency reference; occasionally, a patient hangs up unexpectedly during a late night call or gives only a name to the answering service. If the patient refuses hospitalization, the family must take the responsibility to be with the patient 24 hours a day.

  In the hospital the patient can receive antidepressant or antipsychotic medications as indicated; individual therapy, group therapy,
and family therapy are available; and the patient receives the hospital’s social support and sense of security. Other therapeutic measures depend on the patient’s underlying diagnosis. For example, if alcohol dependence is an associated problem, treatment must be directed toward alleviating that condition.

Although patient classified as acutely suicidal may have favorable prognoses, chronically suicidal patient are difficult to treat and they exhaust the caretakers. Constant observation by special nurses, seclusion and restraints cannot prevent suicide if the patient is resolute. Electroconvulsive therapy (ECT) may be necessary for some severely depressed patients, who may require several treatment courses.

Useful measures for the treatment of the depressed suicidal inpatient include searching the patient’s belongings and person on arrival in the ward for objects that may be used for suicide and repeating the search at times of exacerbation of the suicidal ideation. Ideally, the suicidal depressed inpatient should be treated on a locked ward where the windows are shatterproof, and the patient’s room should be located near the nursing station to maximize observation by nursing staff. The treating team has to assess how much to restrict the patient and whether to make regular checks or continued direct observation. Vigorous treatment with antidepressant medication should be initiated.

Supportive psychotherapy by the psychiatrist show concern and may alleviate some of the patient’s intense suffering. Some patients may be able to accept the idea that they are suffering from a recognized illness and that they will probably make a complete recovery. Patients should be dissuaded from making major life decisions while they are suicidal depressed, because such decisions are often morbidly determined and may be irrevocable. The consequences of such bad decisions can cause further anguish and misery when the patient has recovered.
Patients recovering from a suicidal depression are at particular risk. As the depression lifts, patients become energized and are thus able to put their suicidal plans into action. Sometimes depressed patients, with or without treatment, suddenly appear to be at peace with themselves, because they have reached a secret decision to commit suicide. The clinician should be especially suspicious of such a dramatic clinical change, which may portend a suicidal attempt.

A patient may commit suicide even when in the hospital. According to one survey, about 1 percent of all suicides were committed by patients who were being treated in general medical-surgical or psychiatric hospitals; however, the annual suicide rate in psychiatric hospitals is only 0.003 percent.

**Legal and Ethical Considerations**

Liability issues stemming from suicides in psychiatric hospitals frequently involve questions about the patient’s rate of deterioration, the presence during hospitalization of clinical signs indicating risk, and the psychiatrist’s and the staff members’ awareness of and response to those clinical signs.

About half of cases of suicide while the patient is on psychiatric unit result in a lawsuit. What the courts require is not that suicide never occur but that the patients be periodically evaluated for suicidal risk, that a treatment plan with a high level of security be formulated and that the staff members follow that treatment plan.

At present, suicide and attempted suicide are variously viewed as a felony and a misdemeanor, respectively; in some states the act are considered not crimes but unlawful under common law and statutes. The role of an aider and abettor in suicide adds another dimension to the legal morass; some court decisions have held that, although neither suicide nor
attempted suicide is punishable, anyone who assists in the act may be punished.

- **Community Organizations**
  
  Community organizations seem to have fewer problems than do individual therapists with the ethics and the legalities of helping suicidal people. Prevention centers, crisis listening posts, and suicide hot lines are clear attempts to intervene and diminish the isolation, withdrawal and loneliness of the suicidal patient. Outreach programs enable highly motivated laypersons to respond to cries for help in a variety of ways. But such responses do no more than just diminish an acute crisis; highly suicidal people place fewer than 10 percent of such calls. Two studies in the United State have failed to find that suicide prevention centers had an effect on suicide rates. Nevertheless suicide prevention centers are important mental health resources for persons in distress.

1.5. **Unemployment**

A man has to perform many roles in his life, the most crucial of which is that of an earning member. It is crucial not because a man spends approximately one-third of his lifetime performing this role but because it determines both livelihood and status and also enables the individual to support his family and fulfill his social obligations to the family and society. It also enables him to achieve power. If a person, with a capacity and potential to work, refuses to work or fails to obtain work, he not only does not gain any status in the society but also comes to suffer from several emotional and social problems. His plight affects not only himself but his family and society too. No wonder, unemployment has been described as the most significant sociological problem in the society. Opportunities for employment then become a must in all such cultures which claim to be democracies. Equal employment opportunity
is a prerequisite for equal accessibility to achieved status. Attempts to deal with unemployment have hitherto been two-pronged, one, to alleviate the status of the unemployed and two, to abolish unemployment itself. Since local communities have proved unequal to cope up with the problem, the governments—both central and state—have taken the problem into their hands after Independence. However, the government has remained ineffective in tackling this problem and in providing assistance to persons unable to support themselves. It still views unemployment as an economic phenomenon rather than a social phenomenon.

What is unemployment? If a man with a Ph.D. degree works as a petty clerk in an office, he will not be considered an unemployed person. At most, he would be viewed as an ‘underemployed’ person.

An unemployed person is “one who having potentialities and willingness to earn, is unable to find a remunerative work”. Sociologically, it has been defined as “forced or involuntary separation from remunerative work of a member of the normal working force (that is, of 15-59 age group) during normal working time at normal wages and under normal conditions”. A condition in which an individual is not in a state of remunerative occupation despite his desire to do so. Naba Gopal Das explained unemployment as “condition of involuntary idleness”. The Planning Commission of India has described a person as ‘unemployed’ when he/she remains without work for one day in a week. Against this, the ILO considers that person as ‘unemployed’ who remains with work for 15 hours (about two days) in a week (of five days). This definition may be accepted in a developed country which provides social security to the unemployed but it cannot be accepted in a developing country like India which has no Unemployment Insurance Scheme.
Unemployment has three elements: (i) the individual should be capable of working, (ii) the individual should be willing to work, and (iii) the individual must make an effort to find work. On this basis, a person who is physically and/or mentally disabled, or who is chronically ill and unable to work, or a Sadhu who because of his status as an in charge of a Math, considers it below dignity to work, or a beggar who does not want to work, cannot be included in the definition of unemployed persons. A society is believed to be in a ‘condition of full employment’ if the period of enforced idleness remains minimum. A society with full employment has four characteristics: (i) the individual takes very little time to find remunerative work according to his capabilities and qualification, (ii) he is sure of finding remunerative work, (iii) the number of vacant jobs in the society exceeds the number of job seekers, and (iv) the work is available on ‘adequate remuneration’.

1.5.1 Types of Unemployment

Unemployment may either be classified as rural and urban, or it may be classified as seasonal, cyclical, and technological. Urban unemployment has been sub-classified as educational and industrial.

- **Seasonal Unemployment**

  Seasonal unemployment is inherent in the agricultural sector and certain manufacturing units like sugar and ice factories. The nature of work in a sugar factory or an ice factory is such that the workers have to remain out of work for about six months in a year.

- **Agricultural Unemployment**

  Agricultural unemployment is caused because of a number of factors. First, the land-holdings are so small that even the family members of the working age-groups are not absorbed by the land. Second, the nature of work is seasonal. Broadly speaking, a cultivator in
India remains unemployed for about four to six months in a year. According to one Land revenue Commission appointed in Bengal, a cultivator (in Bengal) remains unemployed for about six months in a year. Keatings in Rural Economy of Bombay Deccan describes that a cultivator in Maharashtra works for 180 to 190 days in a year. Calvert its of the opinion that in Punjab, a cultivator does not work for more than 150 days in a year. R.K.Mukerjee in Rural Economy of India has said that an average cultivator in north India does not remain busy for more than 200 days in a year. Slater in Some Indian Villages maintains that in southern India, Cultivators remain busy only for five and half months in a year. Jack in Economic Life of a Bengal District explains that a jute worker remains unemployed for nine months and a rice-manufactured for seven and a half months in a year. All these are example of seasonal unemployment which is caused because of the nature of work involved. Of the total population in the rural areas, only 29.4% people are self-supporting, 59.0% are non-earning dependents, and 11.6% are earning dependents. This means that 29.4% people not only support themselves but they also support the reaming 70.6% people as well.

- **Cyclical Unemployment**

  Cyclical unemployment is caused because of the ups and downs in trade and business. When the entrepreneurs earn high profits, they invest them in business which increases employment, but when they get less profits of suffer from losses or their products remains unsold and pile up, they reduce the number of workers in their industries which causes unemployment. A boom is generated when investments exceed savings, and similarly a depression results when savings exceed investment. This is probably an over simplification of the concept of cyclical unemployment but it is still basically true.
• **Industrial Unemployment**

Industrial unemployment is caused because of a large scale migration of people from rural to urban areas, losses incurred by industries, slow growth of industries, competition with foreign industries, unplanned industrialization, defective industrial policies, labour strikes or employer’s lock-outs, rationalization, and so on.

• **Technological Unemployment**

Technological unemployment is caused due to the introduction of automation or other technological changes in industry or other work places. It is also caused due to the reduction of man power necessary to produce a finished article. Throughout the course of economic development, particularly since the industrial revolution, man has been forced to adjust himself to the processes of mechanization. An increase in mechanical skills has both its advantages as well as its disadvantages. Machine production has multiplied the number of commodities consumed by average man. This has meant a constantly rising standard of material comfort and a concomitant increase in the consumption of luxury goods. Certain items which were at one time considered as luxury items for one class of people have today become items of necessity for them. On the other hand, the industry has diminished the average man’s economic security since every advance in technology has meant a displacement of human labour. In fact, new inventions do more than merely displace labour. They create poverty which results from the destruction of old investments and, therefore, restrict the market for new productions. A vicious circle is thus created. In the long run, it is true that technological improvements may increase employment in related service industries (Elliott & Merill, 1950). Nevertheless, continued improvements in mechanical devices mean that employment opportunities have to increase proportionately or there will be an added residue of unemployment.
• **Educational Unemployment**

Educational unemployment is caused because the system of education is largely unrelated to life. In fact, one of the University Grants Commission (UGC) Annual Reports laid out clearly that the present system of education is generating much waste and stagnation. The (education) system is irrelevant because of the stress it lays on higher education which can be given only to a small minority, most of whom would in any case be unemployed or unemployable once they graduate. The education is of little relevance to the needs of the nation. The Kothari Commission (1964-66) also admitted that there is a wide gulf between the contents of the present education and purposes and the concerns of national development. According to a study made by the UGC in 1977, a majority of the courses taught in the universities have not been revised for the last 30 years and are obsolete. Scores of expert committees-in fact more than 50 panels appointed after independence have delved into the problems and churned out tones of pompous reports and memoranda, but nothing seems to have really changed.

The main obstacles to a radical reform of the curriculum in higher education are the university teachers. Such changes would require teachers to constantly update their education and keep abreast of the latest developments in their respective fields. A good number of teachers remain indifferent to studies or are so bogged down in tuitions, part-time business, and university/college politics that education has become a business rather than a profession for them.

The irrelevance of the educational system is also manifest in the rise in the rate of unemployment among the educated youth. During 1965-77 the number of unemployment graduates rose at the rate of 21.0% annually (from 9 lakh in 1965 to 5.6 million in 1977). Then during
1980-88, their number rose at the rate of 23.0% every year, and between January, 1988 and January, 1989, the percentage increased by 19.2.

The highest number of unemployed degree holders is found in the state of West Bengal (27.21% of the total unemployed), followed by Bihar (24.85%), Kerala (21.10%), Karnataka (18.49%), Punjab (13.7%), Tamil Nadu (12.96%), Uttar Pradesh (9.96%), Gujarat (9.23%), Maharashtra (7.68%), Rajasthan (6.54%) and Nagaland (4.42%).

The expansion of the various faculties of the universities bears no relationship to the needs of the economy. While the number of arts graduates between 1980 and 1988 increased by 13.0% a year, the rate of unemployment among them increased by 26.0%. In the case of science graduates, the corresponding percentage were 12.9 and 33.0; for commerce graduates 16.4 and 27.4; for engineering graduates 4.6 and 29.0; and for medical graduates 12.2 and 37.0.

1.5.2 Causes of Unemployment

Economists have explained unemployment in terms of lack of capital and lack of investment, and high production. Some believe that unemployment has its roots in the decline in the business cycle following
a period of industrial prosperity. A few hold that dislocations in the industries and an inability to forecast the market have put a sizeable proportion of men out of work. Yet others are of the opinion that sudden economic deflation and impersonal forces of economic competition cause loss of work. Improvements in machine technology, over-production, falsely stimulated speculation, social emphasis upon monetary success and the inevitable depressions—all these make for crippling disruption in the demand of labour. The classical school of thought places the essential cause of unemployment on the ‘Wage Fund theory’, according to which the wages of the workers are fixed in advance but because of lack of capital the manufacturers engage only a small number of workers which results in unemployment. The new classical school believes unemployment to be the result of ‘over production’. Over production reduces the prices of the commodities which necessitates reducing the workers, which in turn increases unemployment. Keynes (1952) has talked of the ‘desire for saving’ as the cause of unemployment. People invest little because they want to save more. Small investments cause low production which causes more unemployment. Some economists have referred to the imbalance between demand and supply as the cause of unemployment. When effective demand declines for the products of industry, prices drop, factories close down, wages stop, and men are shifted from the employed to the unemployed status through no fault of their own. Less demand is the result of slow rate of development in early years, or postponing investments due to poor trade and commerce, and/or shift (or investment) from the industrial to the non-industries sector. Unemployment is caused by the disruption of the economic structure. Elliott and Merill (1950) have said that unemployment is primarily a result of the decline in the business cycle following a period of industrial prosperity. Advances in technical skills and highly specialized division of
labour also make it impossible for able bodied and capable men to secure jobs. Bartlett (1949) has said that the virtually monopolistic industries, like iron and steel industry, have been major factors in producing depressions. These industries, he charges, do not lower their price sufficiently during the period of declining price level in other industries to make it possible to keep up their production.

Several scholars have now maintained that unemployment cannot be ascribed only to economic factors. Social and personal factors equally contribute to unemployment. In sociological terms, unemployment can be described as the product of a combination of social factors like degrading social status, geographical immobility, rapid growth of population and defective educational system; and personal factors like lack of experience, vocational unfitness and illness and disability.

- **Social or Work Status**

  Degrading social or work status causes unemployment in the sense that some people consider it below their dignity to take up certain jobs and prefer to remain unemployed. For example, the youth considers the IAS, IPS and teaching in the university to be prestigious jobs and teaching in schools, salesmanship, and typing to be low-status and low-profile. They prefer to remain unemployed rather than accept the latter. Many students though uninterested in doing research and working for a Ph.D degree prefer to accept scholarships of Rs. 400, Rs. 600 or Rs. 800 per month for two or three years rather than accepting a clerical or a typist’s job only because it gives them social acceptance and the status of a ‘research scholar’. They stall their friends and relatives by claiming that they are “preparing for the competitive examinations” knowing fully well that they neither have the necessary potential nor the interest to undertake such examinations. Sometimes young person’s refuse to accept certain jobs because they consider their family’s position higher to the job they
have been offered. In a public opinion survey conducted in four metropolitan cities on the occupational aspirations of the youth, 52.0% of the respondents gave preferences to government jobs and college lecturership (Career Aspiration (1968). It is good to have high aspirations and a growing desire for a high standard of living but it is unwise to refuse to accept substitute interests and preferences.

- **Repid Growth of Population**

  The upsurge in the birth rate or the rapid growth of population is the factor which immensely affects the availability of work. Gunnar Myrdal (1940), the eminent Swedish sociologist and an authority on population, considered the problem of population from the standpoint of the weal of democratic nations and said: “To my mind, no other factor—not even that of peace or war—is so tremendously fatal for the long time destinies of democracies as the factor of population. Democracy, not only as a political form but with all its content of civic ideals and human life, must either solve this problem or perish”. The greater the number of unemployed children in the family, the greater is the dependency to be borne by the parents; the greater the number of unemployed persons in the society, the greater is the responsibility to be assumed by the government. For a number of reasons, the pattern of responsibility to be borne by the joint family system has been changing. Maintaining unemployed dependents by nuclear families is not economically feasible for most families. This detachment not only weakens the family ties but also creates many problems for the society. The increasing unemployment due to the unchecked growth of population, thus not only increases the responsibilities of the society but also leads to degradation as well as loss of social esteem for the unemployed individual.
• **Geographical Immobility**

Unemployment is triggered off by geographical immobility too. There is surplus labour in one place and inadequate labour in another place, when people refuse to move from one region to other. The immobility may also be due to the lack of information regarding the availability of jobs in other cities or because of the language problem or family responsibilities.

Last, unemployment is also a result of the defective educational system. The educational system introduced more than 150 years ago by the British to train babus for their burgeoning bureaucracy, can no longer be described as ‘purposeful’ today. The education system is inadequate because it does not give due priority to primary education and what it imparts at the higher levels, at a great cost to the exchequer, does not instill attitudes needed for nation building; The education industry is truly gigantic. Its annual budget of 2,500 crore is second only to that of defense. The benefit of education is confined to a small middle a and high income group and has not been able to help young persons find employment. Ironically perhaps, it even makes them unemployable by turning their minds into a duffle-bag crammed with text book theories which are out of date and inappropriate for India’s development.

As regards the personal factors, the lack of experience of the person (seeking a job) because of his young age, old age affecting one’s capacity to work, lack of vocational training, physical disabilities and illness all go against the unemployed and the unemployable.

**1.5.3 Consequences of Unemployment**

Unemployment affects the individual, family, as well as the society, or it may be said that unemployment causes personal disorganization, family disorganization and social disorganization.
• **Personal Disorganization**

From the point of view of personal disorganization, the unemployed person faces disillusionment and cynicism. Having no outlet to release their depression, the young persons tune their creative energies into wrong channels which explain the rise of the number of youthful bandits, highway robberies and bank holdups. These antisocial activities offer a chance to the indiscipline and recalcitrant youth to extract a living. Most of the criminals are undoubtedly recruited from boys with a history of earlier delinquencies but there has been an increase in the number of daring criminals with the decrease in work opportunities. On the other hand, the plight of an earning person who loses his job is equally sad. Ex-wage earners are more liable to physical illness, tension, suicide and crime, because the lack of working opportunities makes it impossible for them to support their dependents. Their own dependency on others is very often morally sapping because of the humiliation that follows. Some people in this state are even known to turn to illegal occupation like smuggling and drug trafficking rather than facing up to the true situation. During economic depressions, the reduction in wages and the increase in part-time jobs is further frustrating. Wages are often unbelievably low because of the competition for jobs, and the increase in unemployment further reduces the chance of finding a job and depreciates the wages. The underemployed and underpaid are subjected to nearly as many difficult adjustments as those who are completely out of work (Wight Bakke, 1940).

• **Family Disorganization**

Family disorganization because of unemployment is easier to measure. Unemployment affects the unity of interests of family members, the unity of objectives as well as the unity of personal ambitions. The disharmonious functioning of the members creates discord within the
family, which means that not only do the tensions between the unemployed husband and wife increase but conflicts between parents and children also arise. Sometimes the wife of an unemployed person wants to take up a job but the idea of a wife taking up a job irritates the husband with traditional and conservative values so much that there is tremendous conflict within the home. Many husbands object to any substantial assumption of authority by their wives in the field which they (the husbands) consider traditionally their own. On the other hand, the conflict between husband and wife may arise when the unemployed husband wants his wife to take up job and the wife is reluctant to do so because of the presence of small children at home.

- **Social Disorganization**

  Social disorganization caused by unemployment is harder to measure. Social disorganization is a breakdown of the social structure, or change because, of which old forms of social control no longer function effectively, or a process by which social relationship between members of a group are broken or dissolved. The activities of the unemployed are so restricted and their attitudes so bitter that in this phase disillusionment and discouragement, they lose their desire to work and their skill may deteriorate with a resultant loss to the whole community. In a brave effort to manage the family with a little saving and/or borrowing in cash or kind, many families suffer slow starvation by resorting to unbelievable economy in food and other necessities of life.

**1.5.5 Measures Taken to Control Unemployment**

Our policy planners have brought employment generation into focus in the Eighth Five year Plan with other parameters so set so as to achieve a 3.0% growth a year in employment. The overall magnitude of employment to be generated in the Seventh Plan (1985-90) was estimated
at 48.58 million which included the backlog of 9.2 million at the outset of the Plan. The plan envisaged that the overall employment would grow from 186.7 million standard person year (SPY) in 1984-85 to 227.06 million SPY in 1989-90, implying a growth of 3.99%. In particular, the plan envisaged that the special employment programmers of the NREP and RLEGP would generate 2.26 million SPY of employment in 1989-90. Similarly, the IRDP was envisaged to generate 3.0 million mandays, concentrating mainly on agriculture.

The uttar Pradesh Government has recently taken some innovative steps to solve the pressing problem of unemployment. These steps will not only help the rural people get jobs in different regions but will also reclaim most of the large areas of barren and uncultivable land, making it possible to distribute this reclaimed land among the landless villagers. Towards this end, a land army called ‘Bhoomi Sena’ has been organized. The ‘Bhoomi Sainiks’ are given funds by the state government in the form of bank loans for the forestation of land. If a loan is repaid within two years, the liability to pay 10.5% annual interest on such loans does not operate. It costs nearly Rs. 10,000 on the forestation of one hectare of land. The belief is that the accumulation of salt above and under the land makes it barren. By a year-long accumulation of water, the land is washed and then made even. The salt settles down and ceases to affect the roots of plants, it is said. The barren piece of land is, thus, rendered cultivable. Likewise, land lying along rivers remains uncultivable because of the overflowing river water. By checking the overflow of river water, this land could be made useful for planting trees and raising crops. Similarly by preventing soil erosion, the land could be reclaimed for intensive cultivation. The ‘Bhoomi Sena’ has been organized in the state (Uttar Pradesh) to create work and help landless labourers to lead a life of economic self-sufficiency. The state government has earmarked 52.0% of
the state budget for the development of the rural sector. Of this, Rs. 38 crore was spent in 1990-91 and Rs. 27 crore are to be spent in 1991-92 on the ‘Bhoomi sena’ alone. It has been estimated that Rs. 219 crore will be spent on land reclamation schemes during the Eighth Plan period, benefiting nearly 1,80,000 landless labourers. Till now, nearly 14,370 hectare barren land has been identified for reclamation and the reclamation work is going in 12 district including Varanasi, Kanpur, Etawah, Ghaziabad, Raibareli, unnao, Sultanpur and Fatehpur. One sainik gets one hectare of land for afforestation. Till February, 1991, about one thousand hectare land was distributed for afforestation to about one thousand sainiks. This is besides a provision of Rs.6.3 crore made under the Adarsh Gram Yojna to remove unemployment in every district in the state.