1.1 Introduction:

We all know that today rapid changes are being carried out in every walk in life. Due to the development of science and technology and industrialization, urbanization in modern age. We live in a world full of uncertainties. However, One thing is certain i.e., Stress, it is here to stay and cannot be ignored. The world of work is ever changing. There may be an emphasis on competition, pressure to achieve target and meet deadlines, or to keep up with the rapid advancements in the technology the threat of redundancy may be looming. So the changed life style has increased human needs due to blind running after the means of material happiness, the proportion of complication, conflict, depression, stress, anxiety, pressure have increased such situation produces stress. There are individual differences in coping style with such stressful situation. Some people face stressful situation quietly, while some people become the victim of behavioral disorders. So we see the actual meaning for psychosomatic disorder, Type D personality, Depression and Ego strength etc.

1.2 Psychosomatic disorders:

Today psychosomatic diseases word is famous for medical dictionary. We also know that most of diseases are affected to psychosomatic reason. So let’s now we see the history of psychosomatic.

1.2.1 A History of psychosomatics

In the medieval Islamic world the Persian Muslim psychologist-physicians Ahmed ibn Sahl al-Balkhi (d. 934) and Haly Abbas (d. 994) developed an early understanding of illness that was due to the interaction of the mind and the body. They realized how a patient's physiology and psychology can have an effect on one another. They found correlations between patients who were physically and mentally healthy and between those who were physically and mentally ill.

Franz Alexander led in the beginnings of the 20th century, the movement looking for the dynamic interrelation between mind and body. Sigmund Freud pursued a deep interest in psychosomatic illnesses following his correspondence with Georg...
Groddeck who was, at the time, researching the possibility of treating physical disorders through psychological processes.

Since the 1970s, due to the work of Thure von Uexküll and his colleagues in Germany and elsewhere, biosemiotic theory has been used as a theoretical basis for psychosomatic medicine. Particularly, the concept and the theory of organism by Jakob von Uexküll have been found useful as an approach to describe psychosomatic phenomena.

**Psychosomatic disorder**, also called Psycho physiological Disorder, condition in which psychological stresses adversely affect physiological (somatic) functioning to the point of distress. It is a condition of disfunction or structural damage in body organs through inappropriate activation of the involuntary nervous system and the glands of internal secretion. Thus, the psychosomatic symptom emerges as a physiological concomitant of an emotional state. In a state of rage, for example, the angry person’s blood pressure is likely to be elevated and his pulse and respiratory rate to be increased. When the anger passes, the heightened physiologic processes usually subside. If the person has a persistent inhibited aggression (chronic rage), however, which he is unable to express overtly, the emotional state remains unchanged, though unexpressed in the overt behavior, and the physiological symptoms associated with the angry state persist. With time, such a person becomes aware of the physiological dysfunction. Very often he develops concern over the resulting physical signs and symptoms, but he denies or is unaware of the emotions that have evoked the symptoms.

Psychosomatic disorders may affect almost any part of the body, though they are usually found in systems not under voluntary control. Research by psychiatrist Franz Alexander and his colleagues at the Chicago Institute of Psychoanalysis in the 1950s and 1960s suggested that specific personality traits and specific conflicts may create particular psychosomatic illnesses, but it is generally believed that the form a disorder takes is due to individual vulnerabilities. Emotional stress is assumed to aggravate existing illnesses, and there is some evidence that it may precipitate illnesses not usually considered to be psychosomatic (*e.g.*, cancer, diabetes) in individuals predisposed to them.
Psychosomatic disorders resulting from stress may include hypertension, respiratory ailments, gastrointestinal disturbances, migraine and tension headaches, pelvic pain, impotence, frigidity, dermatitis, and ulcers.

Many patients suffering from psychosomatic diseases respond to a combination of drug therapy, psychoanalysis, and behavior therapy. In less severe cases, patients can learn to manage stress without drugs.

Some physical diseases are believed to have a mental component derived from the stresses and strains of everyday living. This is the case, for example, of lower back pain and high blood pressure, which appear to be partly related to stresses in everyday life. Psychiatry has found it difficult until relatively recently to distinguish somatoform disorders, disorders in which mental factors are the sole cause of a physical illness, from psychosomatic disorders, disorders in which mental factors play a significant role in the development, expression, or resolution of a physical illness.

For instance, while peptic ulcer was once thought of as being purely caused by stress, later research revealed that *Helicobacter pylori* caused 80% of ulcers. However 4 out of 5 people colonized with *Helicobacter pylori* do not develop ulcers, and an expert panel convened by the Academy of Behavioral Medicine Research concluded that ulcers are not merely an infectious disease and that mental factors do play a significant role. One likelihood is that stress diverts energy away from the immune system thereby stress promotes *Helicobacter pylori* infection in the body.

It is still difficult to classify some disorders as purely physical, mixed psychosomatic, or purely somatoform. One example is Irritable Bowel Syndrome (IBS) that was considered formerly as having purely mental causes, while subsequent research showed significant differences in the behavior of the gut in IBS patients. On the other hand, there are no actual structural changes in IBS patients and research shows that stress and emotions are still significant factors in causing IBS. However, while it is necessary to identify if an illness has a physical basis, it is recognized more and more that the effort to identify disorders as purely physical or mixed psychosomatic is increasingly obsolete as almost all physical illness have mental factors that determine their onset, presentation, maintenance, susceptibility to treatment, and resolution.
Addressing such factors is the remit of the applied field of behavioral medicine in modern society; psychosomatic aspects of illness are often attributed to stress making the remediation of stress one important factor in the development, treatment, and prevention of psychosomatic illness.

1.2.2 Connotations of the term "psychosomatic illness"

Psychosomatic medicine is not to be confused with the demotic and scientifically incorrect use of the phrase "psychosomatic illness" to apply to illnesses that are now called somatoform disorders. Such illness is classified as neurotic, stress-related and somatoform disorders by the World Health Organization in the International Statistical Classification of Diseases and Related Health Problems. The field of psychosomatic medicine fell into disrepute clinically due to this incorrect use of this term, which was largely due to the influence of psychoanalytic theory on psychiatric physicians and the inaccurate application by non-specialists in the first part of the 20th century who considered this form of illness to be akin to malingering, thereby further harming the sufferer. For this reason, among others, the field of Behavioral Medicine has taken over much of the remit of Psychosomatic Medicine in practice and there exist large areas of overlap in the scientific research.

1.2.3 Treatment

Psychosomatic medicine is considered a subspecialty of the fields of psychiatry and neurology. Medical treatments and psychotherapy are used to treat psychosomatic disorders.

So we say that today psychosomatic diseases are burning issue, many key factors are affected like as Type D personality, Depression, Stress, Ego strength etc. so now we see the some key factors affected to psychosomatic illness. In the present main two classification assessment for psychosomatic diseases are DSM iv and I.C.D. so we see classification for I.C.D.
1.2.4 International Statistical Classification of Diseases and Related Health Problems

The International Classification of Diseases (most commonly known by the abbreviation ICD) is according to its publisher, the United Nations-sponsored World Health Organization "the standard diagnostic tool for epidemiology, health management and clinical purposes." It is known as a health care classification system that provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease. Under this system, every health condition can be assigned to a unique category and given a code, up to six characters long. Such categories can include a set of similar diseases.

The International Classification of Diseases is published by the World Health Organization (WHO) and used worldwide for morbidity and mortality statistics, reimbursement systems, and automated decision support in health care. This system is designed to promote international comparability in the collection, processing, classification, and presentation of these statistics. The ICD is a core classification of the WHO-FIC.

1.2.5 WHO Family of International Classifications (WHO-FIC)

The ICD is revised periodically and is currently in its tenth revision. The ICD-10, as it is therefore known, was developed in 1992 to track health statistics. ICD-11 is planned for 2015 and will be revised using Web 2.0 principles. Annual minor updates and triennial major updates are published by the WHO. The ICD is part of a "family" of guides that can be used to complement each other, including also the International Classification of Functioning, Disability and Health which focuses on the domains of functioning (disability) associated with health conditions, from both medical and social perspectives.

1.2.6 Historical synopsis

In 1893, a French physician, Jacques Bertillon, introduced the Bertillon Classification of Causes of Death at a congress of the International Statistical Institute in Chicago. A number of countries and cities adopted Dr. Bertillon’s system, which was based on the principle of distinguishing between general diseases and those localized to a particular organ or anatomical site, as used by the City of Paris for classifying deaths.
Subsequent revisions represented a synthesis of English, German and Swiss classifications, expanding from the original 44 titles to 161 titles. In 1898, the American Public Health Association (APHA) recommended that the registrars of Canada, Mexico, and the United States also adopt it. The APHA also recommended revising the system every ten-year to ensure the system remained current with medical practice advances. As a result, the first international conference to revise the International Classification of Causes of Death convened in 1900; with revisions occurring every ten-year thereafter. At that time the classification system was contained in one book, which included an Alphabetic Index as well as a Tabular List. The book was small compared with current coding texts.

The revisions that followed contained minor changes, until the sixth revision of the classification system. With the sixth revision, the classification system expanded to two volumes. The sixth revision included morbidity and mortality conditions, and its title was modified to reflect the changes: *International Statistical Classification of Diseases, Injuries and Causes of Death (ICD)*. Prior to the sixth revision, responsibility for ICD revisions fell to the Mixed Commission, a group composed of representatives from the International Statistical Institute and the Health Organization of the League of Nations. In 1948, the World Health Organization (WHO) assumed responsibility for preparing and publishing the revisions to the ICD every ten-year. WHO sponsored the seventh and eighth revisions in 1957 and 1968, respectively. It later becomes clear that the established ten-year interval between revisions was too short.

The ICD is currently the most widely used statistical classification system for diseases in the world. International health statistics using this system are available at the Global Health Observatory (GHO). In addition, some countries—including Australia, Canada and the United States—have developed their own adaptations of ICD, with more procedure codes for classification of operative or diagnostic procedures.

### 1.2.7 Versions of ICD

#### 1.2.7.1 ICD-6

The ICD-6, published in 1949, was the first to be shaped to become suitable for morbidity reporting. Accordingly the name changed from International List of Causes of
Death to International Statistical Classification of Diseases. The combined codes for injury and causing accident were split into a chapter for injuries, and in one for the external causes. With use for morbidity there was a need for coding mental conditions and for the first time a section on mental disorders was added.

1.2.7.2 ICD-7

The International Conference for the Seventh Revision of the International Classification of Diseases was held in Paris under the auspices of WHO, in February 1955. In accordance with a recommendation of the WHO Expert Committee on Health Statistics, this revision was limited to essential changes and amendments of errors and inconsistencies.

1.2.7.3 ICD-8

The Eighth Revision Conference convened by WHO met in Geneva, from 6 to 12 July 1965. This revision was more radical than the Seventh but left unchanged the basic structure of the Classification and the general philosophy of classifying diseases, whenever possible, according to their etiology rather than a particular manifestation. During the years that the Seventh and Eighth Revisions of the ICD were in force, the use of the ICD for indexing hospital medical records increased rapidly and some countries prepared national adaptations which provided the additional detail needed for this application of the ICD. In the USA, a group of consultants was asked to study the 8th revision of ICD (ICD-8) for its applicability to various users in the United States. This group recommended that further detail be provided for coding hospital and morbidity data. The American Hospital Association’s “Advisory Committee to the Central Office on ICDA” developed the needed adaptation proposals, resulting in the publication of the International Classification of Diseases, Adapted (ICDA). In 1968, the United States Public Health Service published the International Classification of Diseases, Adapted, 8th Revision for use in the United States (ICDA-8). Beginning in 1968, ICDA-8 served as the basis for coding diagnostic data for both official morbidity statistics in the United States.
1.2.7.4 ICD-9

The International Conference for the Ninth Revision of the International Classification of Diseases, convened by WHO, met in Geneva from 30 September to 6 October 1975. In the discussions leading up to the conference, it had originally been intended that there should be little change other than updating of the classification. This was mainly because of the expense of adapting data processing systems each time the classification was revised. There had been an enormous growth of interest in the ICD and ways had to be found of responding to this, partly by modifying the classification itself and partly by introducing special coding provisions. A number of representations were made by specialist bodies which had become interested in using the ICD for their own statistics. Some subject areas in the classification were regarded as inappropriately arranged and there was considerable pressure for more detail and for adaptation of the classification to make it more relevant for the evaluation of medical care, by classifying conditions to the chapters concerned with the part of the body affected rather than to those dealing with the underlying generalized disease. At the other end of the scale, there were representations from countries and areas where a detailed and sophisticated classification was irrelevant, but which nevertheless needed a classification based on the ICD in order to assess their progress in health care and in the control of disease. A field test with a bi-axial classification approach - one axis for anatomy, another for etiology - showed the impracticability of such approach for routine use. The final proposals presented to and accepted by the Conference retained the basic structure of the ICD, although with much additional detail at the level of the four digit subcategories, and some optional five digit subdivisions. For the benefit of users not requiring such detail, care was taken to ensure that the categories at the three digit level were appropriate. For the benefit of users wishing to produce statistics and indexes oriented towards medical care, the Ninth Revision included an optional alternative method of classifying diagnostic statements, including information about both an underlying general disease and a manifestation in a particular organ or site. This system became known as the dagger and asterisk system and is retained in the Tenth Revision. A number of other technical innovations were included in the Ninth Revision, aimed at increasing its flexibility for use in a variety of situations. It was eventually replaced by ICD-10, the version currently in use by the WHO and most countries. Given the widespread expansion in the tenth
revision, it is not possible to convert ICD-9 data sets directly into ICD-10 data sets, although some tools are available to help guide users. Publication of ICD-9 without IP restrictions in a world with evolving electronic data systems lead to a range of products that are based on ICD-9, as MeDRA or the Read directory.

1.2.7.5 ICPM

When ICD-9 was published by the World Health Organization (WHO), the International Classification of Procedures in Medicine (ICPM) was also developed (1975) and published (1978). The ICPM surgical procedures fascicle was originally created by the United States, based on its adaptations of ICD (called ICDA), which had contained a procedure classification since 1962. ICPM is published separately from the ICD disease classification as a series of supplementary documents called fascicles (bundles or groups of items). Each fascicle contains a classification of modes of laboratory, radiology, surgery, therapy, and other diagnostic procedures. Many countries have adapted and translated the ICPM in parts or as a whole and are using it with amendments since then.

1.2.7.6 ICD-9-CM

*International Classification of Diseases, Clinical Modification (ICD-9-CM)* is an adoption created by the U.S. National Center for Health Statistics (NCHS) and used in assigning diagnostic and procedure codes associated with inpatient, outpatient, and physician office utilization in the United States. The ICD-9-CM is based on the ICD-9 but provides for additional *morbidity* detail. It is updated annually on October 1. It consists of two or three volumes:

- **Volumes 1 and 2 contain, diagnosis codes** (Volume 1 is a tabular listing, and volume 2 is an index.) Extended for ICD-9-CM
- **Volume 3 contains procedure codes.** ICD-9-CM only

The NCHS and the Centers for Medicare and Medicaid Services are the U.S. governmental agencies responsible for overseeing all changes and modifications to the ICD-9-CM.
1.2.7.7 ICD-10

Work on ICD-10 began in 1983 and the new revision was endorsed by the Forty-third World Health Assembly in May 1990. The latest version came into use in WHO Member States starting in 1994. The classification system allows more than 155,000 different codes and permits tracking of many new diagnoses and procedures, a significant expansion on the 17,000 codes available in ICD-9. Adoption was relatively swift in most of the world. Several materials are made available online by WHO to facilitate its use, including a manual, training guidelines, a browser, and files for download. Some countries have adapted the international standard, such as the "ICD-10-AM" published in Australia in 1998 (also used in New Zealand), and the "ICD-10-CA" introduced in Canada in 2000.

1.2.7.8 ICD-10-CM

Adoption of ICD-10 has been slow in the United States. Since 1979, the USA had required ICD-9-CM codes for Medicare and Medicaid claims, and most of the rest of the American medical industry followed suit. On 1 January 1999 the ICD-10 (without clinical extensions) was adopted for reporting mortality, but ICD-9-CM was still used for morbidity. Meanwhile, NCHS received permission from the WHO to create a clinical modification of the ICD-10, and has production of all these systems:

- ICD-10-CM, for diagnosis codes, is intended to replace volumes 1 and 2. Annual updates are provided.
- ICD-10-PCS, for procedure codes, is intended to replace volume 3. Annual updates are provided.

On August 21, 2008, the US Department of Health and Human Services (HHS) proposed new code sets to be used for reporting diagnoses and procedures on health care transactions. Under the proposal, the ICD-9-CM code sets would be replaced with the ICD-10-CM code sets, effective October 1, and 2013. On April 17, 2012 the Department of Health and Human Services (HHS) published a proposed rule that would delay, from October 1, 2013 to October 1, 2014, the compliance date for the ICD-10-CM and PCS.
1.2.7.9 ICD-10-CA

ICD-10-CA is a clinical modification of ICD-10 developed by the Canadian Institute for Health Information for morbidity classification in Canada. ICD-10-CA applies beyond acute hospital care, and includes conditions and situations that are not diseases but represent risk factors to health, such as occupational and environmental factors, lifestyle and psycho-social circumstances.

1.2.7.10 ICD-11

The World Health Organization is currently revising the International Classification of Diseases (ICD) towards the ICD-11. The development is taking place on an internet-based workspace, called CAT (Collaborative Authoring Tool) Platform, somewhat similar to Wikipedia –yet it requires more structure and peer review process. The WHO collaborates through this platform with all interested parties.

The final draft of the ICD-11 system is expected to be submitted to WHO's World Health Assembly (WHA) for official endorsement by 2015. The beta draft was made available online in May 2012 for initial consultation and commenting.

1.2.7.11 In ICD-11

Each disease entity will have definitions that give key descriptions and guidance on what the meaning of the entity/category is in human readable terms - to guide users. This is advancement over ICD-10. Because in ICD-10 there were only title headings. The Definitions have a standard structure according to a template with standard definition templates and further features exemplified in a “Content Model”. The Content Model is a structured framework that captures the knowledge that underpins the definition of an ICD entity. The Content Model therefore allows computerization with links to ontologism and SNOMED CT. Each ICD entity can be seen from different dimensions or “parameters”. E.g. there are currently 13 defined main parameters in the Content Model (see below) to describe a category in ICD.

1.3 TYPE D PERSONALITY

Type D personality, a concept used in the field of medical psychology, is defined as the joint tendency towards negative affectivity (e.g. worry, irritability,
gloom) and social inhibition (e.g. reticence and a lack of self-assurance). The letter D stands for 'distressed'.

Individuals with a Type D personality have the tendency to experience increased negative emotions across time and situations and tend not to share these emotions with others, because of fear of rejection or disapproval. Johan Denollet, professor of Medical Psychology at Tilburg University, Tilburg, the Netherlands, developed the construct based on clinical observations in cardiac patients, empirical evidence, and existing theories of personality. The prevalence of Type D personality is 21% in the general population and ranges between 18 to 53% in cardiac patients.

Research has shown that CHD patients with a Type D personality have a worse prognosis following a myocardial infarction (MI) as compared to patients without a Type D personality. Type D is associated with a 4-fold increased risk of mortality, recurrent MI, or sudden cardiac death, independently of traditional risk factors, such as disease severity.

Type D personality can be assessed by means of a valid and reliable 14-item questionnaire, the Type D Scale (DS14). Seven items refer to negative affectivity, and seven items refer to social inhibition. People who score 10 points or more on both dimensions are classified as Type D. The DS14 can be applied in clinical practise for the risk stratification of cardiac patients.

Type D has also been addressed with respect to common somatic complaints in childhood.

1.3.1 Type D characteristics

Type D individuals score highly on negative affectivity and social inhibition personality dimensions. Negative affectivity is defined as the ‘tendency to experience negative emotions,’ including depressed mood, anxiety, anger, and hostile feelings. Individuals scoring high on negative affectivity are not only dysphoric but have a negative view of self, report more somatic symptoms, and have an attention bias towards adverse stimuli. As Denollet astutely notes, individuals who score high on negative affectivity seem to scan the world for signs of impending trouble.
Social inhibition is described as ‘the avoidance of potential ‘dangers’ involved in social interactions such as disapproval or non-reward by others.’ Individuals scoring high on social inhibition frequently feel inhibited, tense, uncomfortable, and insecure when encounter with other people. Both negative affectivity and social inhibition are associated with the perception of a socially unsupportive environment.

Type D is defined as the interaction of negative affectivity (which is closely related to neuroticism) and social inhibition. Social inhibition is a moderator: the prevalence of cardiac events for individuals who score high in negative affectivity but low in social inhibition is less than for that for individuals scoring highly in both components. In other words, the type D concept suggests that the way people cope with negative emotions may be as important as the experience of negative emotions per se.

**Personality type D is assessed** with a scale that measures negative affectivity and social inhibition. Each item is rated according to a 5-point Likert scale from 0 (false) to 4 (true). Patients, who score high on both negative affectivity and social inhibition, as determined by a median split, are classified as type D. The psychometric qualities and prognostic power of the scale have been proved satisfactory in Belgian cardiac patients with Cronbach’s α of 0.89 and 0.82 and test–retest reliability of 0.78 and 0.87 for the Negative Affectivity and Social Inhibition subscales, respectively. The two-factor structure and the internal consistency of the Negative Affectivity and Social Inhibition subscales were recently confirmed in studies of Danish and German cardiac patients.

The data on the relation of type D personality with mood and anxiety disorders are limited. There is evidence that type D personality is associated with depressive and anxiety symptoms, and with post-traumatic stress disorder. Type D personality may be related to social phobia and panic disorder, because its clinical and biological correlates could be thus attributed. Type D individuals may also have a predis position to develop avoidant personality disorder.

**1.3.2 Final words about Type D personality**

Your current personality is the result of the past experiences you have been through and your coping skills. By changing your coping skills you can change your
personality or get rid of the unwanted traits that you dislike. In short, if you are a Type D you can certainly change that.

To know myself is not a complicated medical website nor a boring online encyclopedia but rather a place where you will find simple, to the point and effective information that is backed by psychology and presented in a simple way that you can understand and apply. If you think that this is some kind of marketing type then see what other visitors say about to know myself. The Solid confidence program was launched by to know myself.com; the program will either help you become more confident or give you your money back.

1.3.3 The D stands for distressed

The new report, published in the September 14, 2010 issue of Circulation: Cardiovascular Quality and Outcomes, attempts to provide an estimate of the prognostic risk associated with type-D personality. In this meta-analysis of nine studies published from 1995 to 2009, including patients with coronary artery disease, previous MI, congestive heart failure, recent heart transplantation, and peripheral artery disease, type-D personality was associated with a 3.7-fold increased risk of poor long-term prognosis, including an increased risk of mortality, cardiac death, and MI.

To heart wire, Denollet said the follow-up in the individual studies examining the link between the distressed personality type and cardiac events ranged from one year to six to 10 years.

"Most of the studies went to three, four, or five years, so this is more about the mid-term risk of events," he said. "It's not about the immediate risk in patients who were just diagnosed, but more what happens in the years to come when patients have been diagnosed and treated with invasive treatments or with drugs."

Denollet said that biological mediating mechanisms, such as stress hormones like cortisol, potentially play a role in the increased risk of cardiovascular events. In an unrelated study published last week in the Journal of Clinical Endocrinology and Metabolism, researchers, led by Dr Nicole Vogelzangs (VU University Medical Center, Amsterdam, and the Netherlands) provided further support for the harmful role of cortisol
on the heart. In the study of 861 individuals 65 years and older, higher urinary cortisol levels were associated with an increased risk of cardiovascular death.

Continuing, Denollet said that there is also evidence showing an increase in proinflammatory cytokines in type-D patients with chronic heart failure, which in turn increases risk of cardiovascular events. Importantly, these distressed individuals might also possess critical behavioral characteristics, such as being less likely to quit smoking, participate in physical activity, or comply with medical therapy, that increase their risk of cardiovascular events.

"In terms of treatment, it's important to get these patients involved in cardiac rehabilitation programs, including exercise training," Denollet told heart wire. "I would also advise doctors to more closely monitor these patients, maybe by getting them into the office for a more regular checkup or even by telephone to see how they're doing and to pay particular attention to things like quitting smoking." An analysis of 11 studies also showed that type-D personality was associated with a threefold increased risk of emotional distress, including poor mental health, anxiety, and depression.

Many studies have demonstrated the role of psychosocial and behavioral risk factors in the etiology and pathogenesis of cardiovascular disorders. The most well known of these factors is type A behavior pattern, which includes ambitiousness, aggressiveness, competitiveness, impatience, muscle tenseness, alertness, rapid and empathic vocal style, irritation, cynicism, hostility, and increased potential for anger. Type A individuals are at increased risk for developing coronary heart disease.

Recently, a new personality construct, the type D or ‘distressed’ personality, has been proposed. This construct is a result of an investigation of coping styles in men with coronary heart disease. Type D personality subtype is characterized by the joint tendency to experience negative emotions and to inhibit these emotions while avoiding social contacts with others. In other words, the type D personality is a gloomy, anxious, and socially inept worrier. Type D individuals generally have fewer personal ties with other people and tend to feel less comfortable with strangers.
1.3.4 Type D and cardiac events

The inhibition of emotions has been associated with higher cardiovascular reactivity, lower cardiovascular recovery, lower heart rate variability, and, in the long term, carotid atherosclerosis, incidence of coronary heart disease, and cardiac mortality. In a sample of patients undergoing cardiac rehabilitation, deaths from cardiac causes were increased four-fold in those with type D personality, even after controlling for conventional risk factors. This observation was later replicated in an independent sample of more than 300 patients with coronary heart disease. Type D was an independent predictor of cardiac mortality and non-fatal myocardial infarction, and also of a composite endpoint of cardiac mortality, non-fatal myocardial infarction, coronary artery bypass surgery, and percutaneous transluminal coronary angioplasty.

A study of cardiac patients with a decreased left ventricular ejection fraction demonstrated that type D personality was an independent predictor of a composite endpoint of mortality due to cardiac causes together with a decreased left ventricular ejection fraction. In this study, type B behavior, depression, anxiety, and anger did not add to the predictive power of type D personality. Appels et al. investigated the effect of type D behaviour on sudden cardiac death. Next-of-kin of the sudden cardiac death victims were interviewed. Patients scoring high on negative affectivity and social inhibition were at seven-fold increased risk of sudden cardiac death, after controlling for biomedical risk factors. Type D personality and older age were independent predictors of the development of cancer in patients with coronary heart disease.

A recent study suggests that type D personality is associated with increased depressive and anxiety symptoms in patients with an implantable cardioverter defibrillator. Another recent study investigated the effect of type D personality on the occurrence of adverse events at 9 months in patients with ischemic heart disease after percutaneous coronary intervention with sirolimus-eluting stents or bare stents. Type D patients were at a cumulative increased risk of adverse outcome, compared with non-type D subjects.

Type D personality (whether as a biological construct of temperament or a constellation of habitual behaviours) is a risk factor at least equivalent in importance to
the other, ‘conventional’ coronary heart disease prognostic factors. Importantly, major depression is a very significant risk factor for cardiovascular disorders. That cardiac patients with the type D personality are at increased risk for cardiovascular morbidity and mortality, underlines the importance of examining both acute (e.g. major depression) and chronic (e.g. certain personality features) factors in people who are at risk for coronary events. We need to adopt a personality approach in the early identification of those coronary patients who are at risk for stress-related cardiac events. Psychological risk factors tend to cluster together, and clustering of these factors, in turn, considerably elevates the risk for cardiac events.

1.3.5 Type D, stress, and cortisol

Type D individuals tend to experience negative emotions such as depressed mood, anxiety, anger, hostile feelings, and to inhibit these emotions while avoiding social contacts. Situations involving fear, anxiety, helplessness, and loss of control result in release of cortisol. The relationship between negative affect and cortisol activity has been documented in several studies using structured laboratory stressors, such as public speaking and mental arithmetic and aversive stimulation, and in the scientific literature related to changes in the hypothalamic-pituitary-adrenal (HPA) axis in depressed patients. A recent study has documented relationships among negative affect, positive affect and cortisol in response to naturalistic stressors. Both the experience of a current stressor and anticipating a stressor were associated with increased salivary cortisol levels. Negative affect was associated with higher cortisol levels and positive affect was associated with lower cortisol levels. Another study also found that stressful daily events were associated with increased cortisol secretion in healthy volunteers. Distress, as reflected by the mood states ‘negative affect’ and ‘agitation’, was associated with higher cortisol levels. Mood plays a mediating role in the relationship between stressful events and cortisol secretion. Negative affectivity is not just a confounder, but is related to elevated cortisol secretion during normal daily activities. In a recent study, both type D dimensions (negative affectivity and social inhibition) were associated with greater cortisol reactivity to stress, although the results were not significant in more stringent regression analyses. However, it is reasonable to suggest that there is a difference in HPA regulation in type D individuals and in people with other personality types.
1.3.6 Elevated cortisol and medical illness

Depression appears to be an independent risk factor for the development of coronary heart disease and osteoporosis, and affects the prognosis of these and other medical disorders. Considerable evidence suggests an association between depression and hypertension, peptic ulcers, and diabetes. Elevated cortisol may be a mediating factor in these relationships. Cortisol has many effects that promote coronary heart disease. For example, cortisol inhibits the growth hormone and Gonadal axes. Growth hormone deficiency is associated with higher relative risk for premature cardiovascular disease in adults. Cortisol is a potent stimulus to visceral fat. Inhibition of the growth hormone and gonadal axes exacerbates visceral fat accumulation. Excess visceral fat leads to dyslipidaemia and, along with hypercortisolism, to insulin resistance, hyperinsulinism, and their squeal. Similar mechanisms may increase the vulnerability of type D individuals to cardiac and other medical illnesses. Elevated cortisol may be a mediating factor in the association between type D personality and the increased risk for coronary heart disease and, possibly, other medical disorders. It is important to note that cortisol is not the only mediating factor in this association. A recent study suggests that type D personality is associated with increased circulating levels of cytokine tumour necrosis factor α and its soluble receptors 1 and 2, which are predictors of mortality in chronic heart failure.

1.3.7 HPA function, ageing, and type D personality

Depression is associated with impairment in feedback control of the HPA axis, contributing to higher cortisol levels during episodes of depression. Prolonged exposure to elevated cortisol levels may be neurotoxin, especially for brain regions rich in corticosteroid receptors, and may mediate neuronal vulnerability to stressors. Recurrent depression is associated with atrophy of the hippocampus and amygdale, as well as the prefrontal cortex. A gradual deterioration of hippocampus feedback inhibition of the HPA axis due to down-regulation of glucocorticoid receptors from repeated stress has been demonstrated. Evidence suggests that age and/or length of depression and/or the number of depressive episodes affect HPA regulation in depressed patients. The potentiating or additive effect of age in conjunction with depression on pituitary
adrenocortical activity was suggested by a number of studies. Mean 24-h cortisol level increases with age in depression.

Elderly depressives who are cortisol non-suppressors after dexamethasone need more time for pituitary adrenocortical normalization to occur than do younger subjects. An increase in post-dexamethasone cortisol levels with age has been reported in major depressive disorder. A significant effect of age on cortisol release in depressed patients has been observed during the combined dexamethasone-corticotrophin-releasing hormone test: older patients had higher post-dexamethasone cortisol levels. In patients with endogenous depression, advancing age leads to higher baseline cortisol and a greater likelihood of being a dexamethasone non-suppressor. Cortisol responses to fenfluramine administration in depressed patients increased with the number of major depressive episodes. Other authors have reported similar observations.

However, a number of authors suggest that age does affect HPA regulation in healthy humans. Differences in the results of studies have been be explained by differences in a sample size, screening criteria, and some other factors, such as differences in sleeping patterns. Equivocal results of these studies may be, in part, related to a different prevalence of type D individuals in study samples: i.e. some type D individuals may have alterations within the HPA axis that are similar to HPA axis changes in depressed patients. Future studies of HPA function should control for the presence of type D individuals. Type D individuals should perhaps not participate in psychobiological studies as healthy controls. Studies of HPA function should also control for other personality traits that may affect the HPA axis. For example, individuals with borderline or antisocial personality features may have HPA axis abnormalities.

1.3.8 "Distressed"-personality heart-disease patients at increased risk of future events

Tilburg, the Netherlands - Heart-disease patients with a general propensity to psychological distress are at a significantly higher risk of adverse cardiovascular events, according to the results of a new analysis. In identifying individuals with the type-D personality construct, physicians might be able to better identify high-risk patients at risk for future events, say researchers.
"This is the type of patient that tells you everything is okay, that there are no problems, but you can sense that something is going on, something is not quite right," explained lead investigator Dr Johan Denollet (Tilburg University, the Netherlands).

Speaking with heartwire, Denollet said that type-D personality, a relatively new construct, is a combination of two fairly normal personality traits. It is not to be confused with depression, he said, noting that while there is some overlap between type D and depression, many type-D patients do not meet the clinical criteria for depressive illness.

"On the one hand, type-D people have the tendency to experience negative emotions, such as anxiety, depression, stress, and so on," he said. "At the same time, they also score higher [on tests] measuring social inhibition. Type-D patients are more closed in social interactions and are more unlikely to disclose their personal feelings toward others and tend to feel a bit insecure. This combination makes them more liable to chronic forms of psychological distress."

1.3.9 What to do if you have a Type D personality

The first thing you must understand about personality types is that they have nothing to do with genes. This means that if you have a Type D personality then this doesn't mean that you can't change it.

The problem with personality type quizzes that people find on the internet is that they make them believe that the result of the quiz determines their destiny rather than letting them know that according to psychology any personality trait can be changed.

Here is how to change if you are a Type D personality:

1.3.9.1 Learn how to control your emotions: Contrary to common beliefs almost everyone can control his emotions even if he was a Type D. Read this guide to know how to control your emotions.

1.3.9.2 Control your thoughts: What's even better than controlling emotions is preventing them from being triggered by learning how to control your thoughts. Read this guide to know how to control your thoughts.

1.3.9.3 Get over fear of rejection: In the Solid Self confidence program I said that fear of rejection is caused by low self esteem. Because the person fears that others
find out that he is less worthy than them he fears rejection. If you are a Type D personality then this is an essential step you must take to heal yourself.

1.3.9.4 Learn to open up: This step was mentioned right after the last one because it can't happen before the previous one happens. You won't be able to open up to others before you get over your fear of rejection.

1.3.10 How is the treatment for Type D Personality?

Type D personality is a term used in medical psychology to refer to a person who has negative tendencies such as irritability, worry, gloomy, distressed among others. Further he suffers from social inhibitions such as being aloof and lacks self-confidence and assurance. The letter “D” in Type D personality stands for the tendency of being ‘distressed’. Ongoing research in the medical world has proved that heart patients with Type D personality are more prone to cardiovascular problems.

1.3.10.1 Type D personality can be combated effectively by using a range of therapeutic techniques. Regular therapy sessions involving detailed discussions about threatening issues can alleviate the symptoms to a great extent. The person can be helped to restructure his social life so as to promote healthy interaction with others and form meaningful relationships. Heart patients can be tested for Type D personality traits enabling early intervention in the form of behavioral and psychological counseling leading to improved treatment for cardiovascular issues.

1.3.10.2 Type D personality in the framework of four temperaments

While describing personalities in the A, B, C, D framework, a Type D personality describes a person who lacks creativity and motivation though he may be very dependable. He shuns change and is content to follow a set of rules and doing things repeatedly in the same manner. It may be a boon to have Type D personalities in the workplace as they enjoy having a structured and orderly routine at home and office. They are compassionate and supportive so hence other personality types turn to them for help.
Psychosomatic medicine is an interdisciplinary medical field studying the relationships of social, psychological, and behavioral factors on bodily processes and quality of life in humans and animals. The influence that the mind has over physical processes — including the manifestations of disabilities that are based on intellectual infirmities, rather than actual injuries or physical limitations — is manifested in treatment by phrases such as the power of suggestion, the use of "positive thinking" and concepts like "mind over matter".

The academic forebear of the modern field of behavioral medicine and a part of the practice of consultation-liaison psychiatry, psychosomatic medicine integrates interdisciplinary evaluation and management involving diverse specialties including psychiatry, psychology, neurology, surgery, allergy, dermatology and psychoneuroimmunology. Clinical situations where mental processes act as a major factor affecting medical outcomes are areas where psychosomatic medicine has competence.

1.4 DEPRESSION

Depression is a state of low mood and aversion to activity that can have a negative effect on a person's thoughts, behavior, feelings, world view and physical well-being. Depressed people may feel sad, anxious, empty, hopeless, worried, helpless, worthless, guilty, irritable, hurt or restless. They may lose interest in activities that once were pleasurable, experience loss of appetite or overeating, have problems concentrating, remembering details, or making decisions and may contemplate or attempt suicide. Insomnia, excessive sleeping, fatigue, loss of energy, or aches, pains or digestive problems that are resistant to treatment may also be present.

Depressed mood is not necessarily a psychiatric disorder. It is a normal reaction to certain life events, a symptom of some medical conditions and a side effect of some medical treatments. Depressed mood is also a primary or associated feature of certain psychiatric syndromes such as clinical depression.
1.4.1 A History of Depression

The Ancient Greek physician Hippocrates described a syndrome of melancholia as a distinct disease with particular mental and physical symptoms; he characterized all "fears and despondencies, if they last a long time" as being symptomatic of the ailment. It was a similar but far broader concept than today's depression; prominence was given to a clustering of the symptoms of sadness, dejection, and despondency, and often fears, anger, delusions and obsessions were included.

The term depression itself was derived from the Latin verb deprimere, "to press down". From the 14th century, "to depress" meant to subjugate or to bring down in spirits. It was used in 1665 in English author Richard Baker's Chronicle to refer to someone having "a great depression of spirit", and by English author Samuel Johnson in a similar sense in 1753. The term also came in to use in physiology and economics. An early usage referring to a psychiatric symptom was by French psychiatrist Louis Delasiauve in 1856, and by the 1860s it was appearing in medical dictionaries to refer to a physiological and metaphorical lowering of emotional function. Since Aristotle, melancholia had been associated with men of learning and intellectual brilliance, a hazard of contemplation and creativity. The newer concept abandoned these associations and through the 19th century, became more associated with women.

Although melancholia remained the dominant diagnostic term, depression gained increasing currency in medical treatises and was a synonym by the end of the century; German psychiatrist Emil Kraepelin may have been the first to use it as the overarching term, referring to different kinds of melancholia as depressive states.

Sigmund Freud likened the state of melancholia to mourning in his 1917 paper Mourning and Melancholia. He theorized that objective loss, such as the loss of a valued relationship through death or a romantic break-up, results in subjective loss as well; the depressed individual has identified with the object of affection through an unconscious, narcissistic process called the libidinal cathexis of the ego. Such loss results in severe melancholic symptoms more profound than mourning; not only is the outside world viewed negatively but the ego itself is compromised. The patient's decline of self-perception is revealed in his belief of his own blame, inferiority, and unworthiness. He
also emphasized early life experiences as a predisposing factor. Meyer put forward a mixed social and biological framework emphasizing reactions in the context of an individual's life, and argued that the term depression should be used instead of melancholia. The first version of the DSM (DSM-I, 1952) contained depressive reaction and the DSM-II (1968) depressive neurosis, defined as an excessive reaction to internal conflict or an identifiable event, and also included a depressive type of manic-depressive psychosis within Major affective disorders.

In the mid-20th century, researchers theorized that depression was caused by a chemical imbalance in neurotransmitters in the brain, a theory based on observations made in the 1950s of the effects of reserpine and isoniazid in altering monoamine neurotransmitter levels and affecting depressive symptoms.

The term Major depressive disorder was introduced by a group of US clinicians in the mid-1970s as part of proposals for diagnostic criteria based on patterns of symptoms (called the "Research Diagnostic Criteria", building on earlier Feighner Criteria), and was incorporated into the DSM-III in 1980. To maintain consistency the ICD-10 used the same criteria, with only minor alterations, but using the DSM diagnostic threshold to mark a mild depressive episode, adding higher threshold categories for moderate and severe episodes. The ancient idea of melancholia still survives in the notion of a melancholic subtype.

The new definitions of depression were widely accepted, albeit with some conflicting findings and views. There have been some continued empirically based arguments for a return to the diagnosis of melancholia. There has been some criticism of the expansion of coverage of the diagnosis, related to the development and promotion of antidepressants and the biological model since the late 1950s

1.4.2 Major depressive disorder (MDD)

Major depressive disorder (also known as recurrent depressive disorder, clinical depression, major depression, unipolar depression, or unipolar disorder) is a mental disorder characterized by an all-encompassing low mood accompanied by low self-esteem, and by loss of interest or pleasure in normally enjoyable activities. This cluster of symptoms (syndrome) was named, described and classified as one of the mood
disorders in the 1980 edition of the American Psychiatric Association's diagnostic manual. The term "depression" is ambiguous. It is often used to denote this syndrome but may refer to other mood disorders or to lower mood states lacking clinical significance. Major depressive disorder is a disabling condition that adversely affects a person's family, work or school life, sleeping and eating habits, and general health. In the United States, around 3.4% of people with major depression commit suicide, and up to 60% of people who commit suicide had depression or another mood disorder.

The diagnosis of major depressive disorder is based on the patient's self-reported experiences, behavior reported by relatives or friends, and a mental status examination. There is no laboratory test for major depression, although physicians generally request tests for physical conditions that may cause similar symptoms. The most common time of onset is between the ages of 20 and 30 years, with a later peak between 30 and 40 years.

Typically, patients are treated with antidepressant medication and, in many cases, also receive psychotherapy or counseling, although the effectiveness of medication for mild or moderate cases is questionable. Hospitalization may be necessary in cases with associated self-neglect or a significant risk of harm to self or others. A minority are treated with electroconvulsive therapy (ECT). The course of the disorder varies widely, from one episode lasting weeks to a lifelong disorder with recurrent major depressive episodes. Depressed individuals have shorter life expectancies than those without depression, in part because of greater susceptibility to medical illnesses and suicide. It is unclear whether or not medications affect the risk of suicide. Current and former patients may be stigmatized.

The understanding of the nature and causes of depression has evolved over the centuries, though this understanding is incomplete and has left many aspects of depression as the subject of discussion and research. Proposed causes include psychological, psycho-social, hereditary, evolutionary and biological factors. Certain types of long-term drug use can both cause and worsen depressive symptoms. Psychological treatments are based on theories of personality, interpersonal communication, and learning. Most biological theories focus on the monoamine
chemicals serotonin, nor epinephrine and dopamine, which are naturally present in the brain and assist communication between nerve cells.

1.4.3 Symptoms and signs

Major depression significantly affects a person's family and personal relationships, work or school life, sleeping and eating habits, and general health. Its impact on functioning and well-being has been compared to that of chronic medical conditions such as diabetes.

A person having a major depressive episode usually exhibits a very low mood, which pervades all aspects of life, and an inability to experience pleasure in activities that were formerly enjoyed. Depressed people may be preoccupied with, or ruminate over, thoughts and feelings of worthlessness, inappropriate guilt or regret, helplessness, hopelessness, and self-hatred. In severe cases, depressed people may have symptoms of psychosis. These symptoms include delusions or, less commonly, hallucinations, usually unpleasant. Other symptoms of depression include poor concentration and memory (especially in those with melancholic or psychotic features), withdrawal from social situations and activities, reduced sex drive, and thoughts of death or suicide. Insomnia is common among the depressed. In the typical pattern, a person wakes very early and cannot get back to sleep. Insomnia affects at least 80% of depressed people. Hypersomnia, or oversleeping, can also happen. Some antidepressants may also cause insomnia due to their stimulating effect.

A depressed person may report multiple physical symptoms such as fatigue, headaches, or digestive problems; physical complaints are the most common presenting problem in developing countries, according to the World Health Organization's criteria for depression. Appetite often decreases, with resulting weight loss, although increased appetite and weight gain occasionally occur. Family and friends may notice that the person's behavior is either agitated or lethargic. Older depressed people may have cognitive symptoms of recent onset, such as forgetfulness, and a more noticeable slowing of movements. Depression often coexists with physical disorders common among the elderly, such as stroke, other cardiovascular diseases, Parkinson's disease, and chronic obstructive pulmonary disease.
Depressed children may often display an irritable mood rather than a depressed mood, and show varying symptoms depending on age and situation. Most lose interest in school and show a decline in academic performance. They may be described as clingy, demanding, dependent, or insecure. Diagnosis may be delayed or missed when symptoms are interpreted as normal moodiness. Depression may also coexist with attention-deficit hyperactivity disorder (ADHD), complicating the diagnosis and treatment of both.

1.4.4 Causes of Depression

The bio psychosocial model proposes that biological, psychological, and social factors all play a role in causing depression. The diathesis–stress model specifies that depression results when a preexisting vulnerability, or diathesis, is activated by stressful life events. The preexisting vulnerability can be either genetic, implying an interaction between nature and nurture, or schematic, resulting from views of the world learned in childhood.

1.4.5 Biological

A picture for monoamine hypothesis defines for neurotransmitters. So first we see the Biology of depression.
Of approx. 30 neurotransmitters that have been identified, researchers have discovered associations between clinical depression and the function of three major neurochemicals. These substances are serotonin, nor epinephrine, and dopamine. Antidepressants influence the overall balance of these three neurotransmitters within structures of the brain that regulate emotion, reactions to stress, and the physical drives of sleep, appetite, and sexuality.

Most antidepressant medications increase the levels of one or more of the monoamines the neurotransmitters serotonin, nor epinephrine and dopamine in the synaptic cleft between neurons in the brain. Some medications affect the monoamine receptors directly.

**Serotonin** is hypothesized to regulate other neurotransmitter systems; decreased serotonin activity may allow these systems to act in unusual and erratic ways. According to this "permissive hypothesis", depression arises when low serotonin levels promote low levels of nor epinephrine, another monoamine neurotransmitter. Some antidepressants enhance the levels of nor epinephrine directly, whereas others raise the levels of dopamine, a third monoamine neurotransmitter. These observations gave rise to the monoamine hypothesis of depression. In its contemporary formulation, the monoamine hypothesis postulates that a deficiency of certain neurotransmitters is responsible for the corresponding features of depression: "Nor epinephrine may be related to alertness and energy as well as anxiety, attention, and interest in life; [lack of] serotonin to anxiety, obsessions, and compulsions; and dopamine to attention, motivation, pleasure, and reward, as well as interest in life." The proponents of this theory recommend the choice of an antidepressant with mechanism of action that impacts the most prominent symptoms. Anxious and irritable patients should be treated with SSRIs or nor epinephrine reuptake inhibitors, and those experiencing a loss of energy and enjoyment of life with nor epinephrine- and dopamine-enhancing drugs.

1.4.5.1 Psychological

Various aspects of personality and its development appear to be integral to the occurrence and persistence of depression, with negative emotionality as a common precursor. Although depressive episodes are strongly correlated with adverse events, a
person's characteristic style of coping may be correlated with his or her resilience. In addition, low self-esteem and self-defeating or distorted thinking are related to depression. Depression is less likely to occur, as well as quicker to remit, among those who are religious. It is not always clear which factors are causes and which are effects of depression; however, depressed persons who are able to reflect upon and challenge their thinking patterns often show improved mood and self-esteem.

American psychiatrist Aaron T. Beck, following on from the earlier work of George Kelly and Albert Ellis, developed what is now known as a cognitive model of depression in the early 1960s. He proposed that three concepts underlie depression: a triad of negative thoughts composed of cognitive errors about oneself, one's world, and one's future; recurrent patterns of depressive thinking, or schemas; and distorted information processing. From these principles, he developed the structured technique of cognitive behavioral therapy (CBT). According to American psychologist Martin Seligman, depression in humans is similar to learned helplessness in laboratory animals, which remain in unpleasant situations when they are able to escape, but do not because they initially learned they had no control.

Attachment theory, which was developed by English psychiatrist John Bowlby in the 1960s, predicts a relationship between depressive disorder in adulthood and the quality of the earlier bond between the infant and the adult caregiver. In particular, it is thought that "the experiences of early loss, separation and rejection by the parent or caregiver (conveying the message that the child is unlovable) may all lead to insecure internal working models ... Internal cognitive representations of the self as unlovable and of attachment figures as unloving [or] untrustworthy would be consistent with parts of Beck’s cognitive triad". While a wide variety of studies has upheld the basic tenets of attachment theory, research has been inconclusive as to whether self-reported early attachment and later depression are demonstrably related.

Depressed individuals often blame themselves for negative events, and, as shown in a 1993 study of hospitalized adolescents with self-reported depression, those who blame themselves for negative occurrences may not take credit for positive outcomes. This tendency is characteristic of a depressive attribution, or pessimistic explanatory style. According to Albert Bandura, a Canadian social psychologist
associated with social cognitive theory, depressed individuals have negative beliefs about themselves, based on experiences of failure, observing the failure of social models, a lack of social persuasion that they can succeed, and their own somatic and emotional states including tension and stress. These influences may result in a negative self-concept and a lack of self-efficacy; that is, they do not believe they can influence events or achieve personal goals.

An examination of depression in women indicates that vulnerability factors—such as early maternal loss, lack of a confiding relationship, responsibility for the care of several young children at home, and unemployment—can interact with life stressors to increase the risk of depression. For older adults, the factors are often health problems, changes in relationships with a spouse or adult children due to the transition to a caregiving or care-needing role, the death of a significant other, or a change in the availability or quality of social relationships with older friends because of their own health-related life changes.

The understanding of depression has also received contributions from the psychoanalytic and humanistic branches of psychology. From the classical psychoanalytic perspective of Austrian psychiatrist Sigmund Freud, depression, or melancholia, may be related to interpersonal loss and early life experiences. Existential therapists have connected depression to the lack of both meaning in the present and a vision of the future. The founder of humanistic psychology, American psychologist Abraham Maslow, suggested that depression could arise when people are unable to attain their needs or to self-actualize (to realize their full potential).

1.4.5.2 Social

Poverty and social isolation are associated with increased risk of mental health problems in general. Child abuse (physical, emotional, sexual, or neglect) is also associated with increased risk of developing depressive disorders later in life. Such a link has good face validity given that it is during the years of development that a child is learning how to become a social being. Abuse of the child by the caregiver is bound to distort the developing personality and create a much greater risk for depression and many other debilitating mental and emotional states. Disturbances in family functioning, such
as parental (particularly maternal) depression, severe marital conflict or divorce, death of a parent, or other disturbances in parenting are additional risk factors. In adulthood, stressful life events are strongly associated with the onset of major depressive episodes. In this context, life events connected to social rejection appear to be particularly related to depression. Evidence that a first episode of depression is more likely to be immediately preceded by stressful life events than are recurrent ones is consistent with the hypothesis that people may become increasingly sensitized to life stress over successive recurrences of depression.

The relationship between stressful life events and social support has been a matter of some debate; the lack of social support may increase the likelihood that life stress will lead to depression, or the absence of social support may constitute a form of strain that leads to depression directly. There is evidence that neighborhood social disorder, for example, due to crime or illicit drugs, is a risk factor, and that a high neighborhood socioeconomic status, with better amenities, is a protective factor. Adverse conditions at work, particularly demanding jobs with little scope for decision-making, are associated with depression, although diversity and confounding factors make it difficult to confirm that the relationship is causal.

Depression can be caused by prejudice. This can occur when people hold negative self-stereotypes about them. This "deprejudice" can be related to a group membership (e.g., Me-Gay-Bad) or not (Me-Bad). If someone has prejudicial beliefs about a stigmatized group and then becomes a member of that group, they may internalize their prejudice and develop depression. For example, a boy growing up in the United States may learn the negative stereotype that gay men are immoral. When he grows up and realizes he is gay, he may direct this prejudice inward on himself and become depressed. People may also show prejudice internalization through self-stereotyping because of negative childhood experiences such as verbal and physical abuse.

### 1.4.5.3 Major depressive episode

A major depressive episode is characterized by the presence of a severely depressed mood that persists for at least two weeks. Episodes may be isolated or
recurrent and are categorized as mild (few symptoms in excess of minimum criteria), moderate, or severe (marked impact on social or occupational functioning). An episode with psychotic features — commonly referred to as *psychotic depression* — is automatically rated as severe. If the patient has had an episode of mania or markedly elevated mood, a diagnosis of bipolar disorder is made instead. Depression without mania is sometimes referred to as *unipolar* because the mood remains at one emotional state or "pole".

**DSM-IV-TR** excludes cases where the symptoms are a result of bereavement, although it is possible for normal bereavement to evolve into a depressive episode if the mood persists and the characteristic features of a major depressive episode develop. The criteria have been criticized because they do not take into account any other aspects of the personal and social context in which depression can occur. In addition, some studies have found little empirical support for the DSM-IV cut-off criteria, indicating they are a diagnostic convention imposed on a continuum of depressive symptoms of varying severity and duration: Excluded are a range of related diagnoses, including dysthymia, which involves a chronic but milder mood disturbance; recurrent brief depression, consisting of briefer depressive episodes; minor depressive disorder, whereby only some of the symptoms of major depression are present; and adjustment disorder with depressed mood, which denotes low mood resulting from a psychological response to an identifiable event or stressor.

### 1.4.6 Subtypes for Depression

The DSM-IV-TR recognizes five further subtypes of MDD, called *specifies*, in addition to noting the length, severity and presence of psychotic features:

**1.4.6.1 Melancholic depression** is characterized by a loss of pleasure in most or all activities, a failure of reactivity to pleasurable stimuli, a quality of depressed mood more pronounced than that of grief or loss, a worsening of symptoms in the morning hours, early-morning waking, psychomotor retardation, excessive weight loss (not to be confused with anorexia nervosa), or excessive guilt.

**1.4.6.2 Atypical depression** is characterized by mood reactivity (paradoxical anhedonia) and positivity, significant weight gain or increased appetite (comfort
eating), excessive sleep or sleepiness (hypersomnia), a sensation of heaviness in limbs known as leaden paralysis, and significant social impairment as a consequence of hypersensitivity to perceived interpersonal rejection.

1.4.6.3 **Catatonic depression** is a rare and severe form of major depression involving disturbances of motor behavior and other symptoms. Here the person is mute and almost stuporous, and either remains immobile or exhibits purposeless or even bizarre movements. Catatonic symptoms also occur in schizophrenia or in manic episodes, or may be caused by neuroleptic malignant syndrome.

1.4.6.4 **Postpartum depression**, or mental and behavioural disorders associated with the puerperium, not elsewhere classified, refers to the intense, sustained and sometimes disabling depression experienced by women after giving birth. Postpartum depression has an incidence rate of 10–15% among new mothers. The DSM-IV mandates that, in order to qualify as postpartum depression, onset occur within one month of delivery. It has been said that postpartum depression can last as long as three months.

1.4.6.5 **Seasonal affective disorder** (SAD) is a form of depression in which depressive episodes come on in the autumn or winter, and resolve in spring. The diagnosis is made if at least two episodes have occurred in colder months with none at other times, over a two-year period or longer.

1.4.7 **Differential diagnoses**

To confer major depressive disorder as the most likely diagnosis, other potential diagnoses must be considered, including dysthymia, adjustment disorder with depressed mood or bipolar disorder. Dysthymia is a chronic, milder mood disturbance in which a person reports a low mood almost daily over a span of at least two years. The symptoms are not as severe as those for major depression, although people with dysthymia are vulnerable to secondary episodes of major depression (sometimes referred to as *double depression*). Adjustment disorder with depressed mood is a mood disturbance appearing as a psychological response to an identifiable event or stressor, in which the resulting emotional or behavioral symptoms are significant but do not meet the criteria for a major depressive episode. Bipolar disorder, also known as manic-depressive disorder, is a
condition in which depressive phases alternate with periods of mania or hypomania. Although depression is currently categorized as a separate disorder, there is ongoing debate because individuals diagnosed with major depression often experience some hypomanic symptoms, indicating a mood disorder continuum.

Other disorders need to be ruled out before diagnosing major depressive disorder. They include depressions due to physical illness, medications, and substance abuse. Depression due to physical illness is diagnosed as a mood disorder due to a general medical condition. This condition is determined based on history, laboratory findings, or physical examination. When the depression is caused by a substance abused including a drug of abuse, a medication, or exposure to a toxin, it is then diagnosed as a substance-induced mood disorder. In such cases, a substance is judged to be etiologically related to the mood disturbance.

1.4.8 Prevention for Depression

Behavioral interventions, such as interpersonal therapy, are effective at preventing new onset depression. Because such interventions appear to be most effective when delivered to individuals or small groups, it has been suggested that they may be able to reach their large target audience most efficiently through the Internet. However, an earlier meta-analysis found preventive programs with a competence-enhancing component to be superior to behaviorally oriented programs overall, and found behavioral programs to be particularly unhelpful for older people, for whom social support programs were uniquely beneficial. In addition, the programs that best prevented depression comprised more than eight sessions, each lasting between 60 and 90 minutes, were provided by a combination of lay and professional workers, had a high-quality research design, reported attrition rates, and had a well-defined intervention. The "Coping with Depression" course (CWD) is claimed to be the most successful of psychoeducational interventions for the treatment and prevention of depression (both for its adaptability to various populations and its results), with a risk reduction of 38% in major depression and an efficacy as a treatment comparing favorably to other psychotherapies.
1.4.9  Management for Depression

The three most common treatments for depression are psychotherapy, medication, and electroconvulsive therapy. Psychotherapy is the treatment of choice for people under 18, while electroconvulsive therapy is used only as a last resort. Care is usually given on an outpatient basis, whereas treatment in an inpatient unit is considered if there is a significant risk to self or others.

Treatment options are much more limited in developing countries, where access to mental health staff, medication, and psychotherapy is often difficult. Development of mental health services is minimal in many countries; depression is viewed as a phenomenon of the developed world despite evidence to the contrary, and not as an inherently life-threatening condition. Physical exercise is recommended for management of mild depression, but it has only a moderate, statistically insignificant effect on symptoms in most cases of major depressive disorder.

1.4.10  Psychotherapy

Psychotherapy can be delivered, to individuals, groups, or families by mental health professionals, including psychotherapists, psychiatrists, psychologists, clinical social workers, counselors, and suitably trained psychiatric nurses. With more complex and chronic forms of depression, a combination of medication and psychotherapy may be used.

1.4.10.1 Cognitive behavioral therapy (CBT) currently has the most research evidence for the treatment of depression in children and adolescents, and CBT and interpersonal psychotherapy (IPT) are preferred therapies for adolescent depression. In people under 18, according to the National Institute for Health and Clinical Excellence, medication should be offered only in conjunction with a psychological therapy, such as CBT, interpersonal therapy, or family therapy.

Psychotherapy has been shown to be effective in older people. Successful psychotherapy appears to reduce the recurrence of depression even after it has been terminated or replaced by occasional booster sessions.
The most-studied form of psychotherapy for depression is CBT, which teaches clients to challenge self-defeating, but enduring ways of thinking (cognitions) and change counter-productive behaviors. Research beginning in the mid-1990s suggested that CBT could perform as well or better than antidepressants in patients with moderate to severe depression. CBT may be effective in depressed adolescents, although its effects on severe episodes are not definitively known. Several variables predict success for cognitive behavioral therapy in adolescents: higher levels of rational thoughts, less hopelessness, fewer negative thoughts, and fewer cognitive distortions. CBT is particularly beneficial in preventing relapse. Several variants of cognitive behavior therapy have been used in depressed patients, the most notable being rational emotive behavior therapy and more recently mindfulness-based cognitive therapy.

Psychoanalysis is a school of thought, founded by Sigmund Freud, which emphasizes the resolution of unconscious mental conflicts. Psychoanalytic techniques are used by some practitioners to treat clients presenting with major depression. A more widely practiced, eclectic technique, called psychodynamic psychotherapy, is loosely based on psychoanalysis and has an additional social and interpersonal focus. In a meta-analysis of three controlled trials of Short Psychodynamic Supportive Psychotherapy, this modification was found to be as effective as medication for mild to moderate depression.

1.4.10.2 **Logo therapy**, a form of existential psychotherapy developed by Austrian psychiatrist Viktor Frankl, addresses the filling of an "existential vacuum" associated with feelings of futility and meaninglessness. It is posited that this type of psychotherapy may be useful for depression in older adolescents.

1.4.11 **Anti-Depressants**

The effectiveness of antidepressants is none to minimal in those with mild or moderate depression but significant in those with very severe disease. The effects of antidepressants are somewhat superior to those of psychotherapy, especially in cases of chronic major depression, although in short-term trials more patients — especially those with less serious forms of depression — cease medication than cease psychotherapy,
most likely due to adverse effects from the medication and to patients' preferences for psychological therapies over pharmacological treatments.

To find the most effective antidepressant medication with minimal side-effects, the dosages can be adjusted, and if necessary, combinations of different classes of antidepressants can be tried. Response rates to the first antidepressant administered range from 50–75%, and it can take at least six to eight weeks from the start of medication to remission, when the patient is back to their normal self. Antidepressant medication treatment is usually continued for 16 to 20 weeks after remission, to minimize the chance of recurrence, and even up to one year of continuation is recommended. People with chronic depression may need to take medication indefinitely to avoid relapse.

1.4.11.1 Selective serotonin reuptake inhibitors:

(SSRIs) are the primary medications prescribed owing to their relatively mild side-effects, and because they are less toxic in overdose than other antidepressants. Patients who do not respond to one SSRI can be switched to another antidepressant, and these results in improvement in almost 50% of cases. Another option is to switch to the atypical antidepressant bupropion. Venlafaxine, an antidepressant with a different mechanism of action, may be modestly more effective than SSRIs. However, venlafaxine is not recommended in the UK as a first-line treatment because of evidence suggesting its risks may outweigh benefits, and it is specifically discouraged in children and adolescents. For adolescent depression, fluoxetine and escitalopram are the two recommended choices. Antidepressants have not been found to be beneficial in children. There is also insufficient evidence to determine effectiveness in those with depression complicated by dementia. Any antidepressant can cause low serum sodium levels (also called hyponatremia) nevertheless, it has been reported more often with SSRIs. It is not uncommon for SSRIs to cause or worsen insomnia; the sedating antidepressant mirtazapine can be used in such cases.

Irreversible monoamine oxidize inhibitors, an older class of antidepressants, has been plagued by potentially life-threatening dietary and drug interactions. They
are still used only rarely, although newer and better tolerated agents of this class have been developed. The safety profile is different with reversible monoamine oxidase inhibitors such as moclobemide where the risk of serious dietary interactions is negligible and dietary restrictions are less strict.

1.4.11.2 The terms "refractory depression" and "treatment-resistant depression" are used to describe cases that do not respond to adequate courses of at least two antidepressants. In many major studies, only about 35% of patients respond well to medical treatment. It may be difficult for a doctor to decide when someone has treatment-resistant depression or whether the problem is due to coexisting disorders, which are common among patients with major depression.

A team of psychologists from multiple American universities found that antidepressant drugs hardly have better effects than a placebo in cases of mild or moderate depression. The study focused on paroxetine and imipramine.

For children, adolescents, and probably young adults between 18 and 24 years old, there is a higher risk of both suicidal ideations and suicidal behavior in those treated with SSRIs. For adults, it is unclear whether or not SSRIs affect the risk of suicidality. One review found no connection another an increased risk and a third no risk in those 25–65 years old and a decrease risk in those more than 65. Epidemiological data has found that the widespread use of antidepressants in the new "SSRI-era" is associated with a significant decline in suicide rates in most countries with traditionally high baseline suicide rates. The causality of the relationship is inconclusive. A black box warning was introduced in the United States in 2007 on SSRI and other antidepressant medications due to increased risk of suicide in patients younger than 24 years old. Similar precautionary notice revisions were implemented by the Japanese Ministry of Health.

1.4.11.3 There is some evidence that fish oil supplements containing high levels of eicosapentaenoic acid to docosaxaenoic acid may be effective in major depression, but other meta-analysis of the research conclude that positive effects
may be due to publication bias. There is some preliminary evidence that COX-2 inhibitors have a beneficial effect on major depression.

1.4.12 Electroconvulsive therapy

Electroconvulsive therapy (ECT) is a procedure whereby pulses of electricity are sent through the brain via two electrodes, usually one on each temple, to induce a seizure while the patient is under a brief period of general anesthesia. Hospital psychiatrists may recommend ECT for cases of severe major depression that have not responded to antidepressant medication or, less often, psychotherapy or supportive interventions. ECT can have a quicker effect than antidepressant therapy and thus may be the treatment of choice in emergencies such as catatonic depression where the patient has stopped eating and drinking, or where a patient is severely suicidal. ECT is probably more effective than pharmacotherapy for depression in the immediate short-term, although a landmark community-based study found much lower remission rates in routine practice. When ECT is used on its own, the relapse rate within the first six months is very high; early studies put the rate at around 50%, while a more recent controlled trial found rates of 84% even with placebos. The early relapse rate may be reduced by the use of psychiatric medications or further ECT (although the latter is not recommended by some authorities) but remains high. Common initial adverse effects from ECT include short and long-term memory loss, disorientation and headache. Although memory disturbance after ECT usually resolves within one month, ECT remains a controversial treatment, and debate on its efficacy and safety continues.

1.4.13 Prognosis

Major depressive episodes often resolve over time whether or not they are treated. Outpatients on a waiting list show a 10–15% reduction in symptoms within a few months, with approximately 20% no longer meeting the full criteria for a depressive disorder. The median duration of an episode has been estimated to be 23 weeks, with the highest rate of recovery in the first three months.

Studies have shown that 80% of those suffering from their first major depressive episode will suffer from at least 1 more during their life, with a lifetime average of 4 episodes. Other general population studies indicate around half those who
have an episode (whether treated or not) recover and remain well, while the other half will have at least one more, and around 15% of those experience chronic recurrence. Studies recruiting from selective inpatient sources suggest lower recovery and higher chronicity, while studies of mostly outpatients show that nearly all recover, with a median episode duration of 11 months. Around 90% of those with severe or psychotic depression, most of whom also meet criteria for other mental disorders, experience recurrence.

Recurrence is more likely if symptoms have not fully resolved with treatment. Current guidelines recommend continuing antidepressants for four to six months after remission to prevent relapse. Evidence from many randomized controlled trials indicates continuing antidepressant medications after recovery can reduce the chance of relapse by 70% (41% on placebo vs. 18% on antidepressant). The preventive effect probably lasts for at least the first 36 months of use.

Those people who experience repeated episodes of depression require ongoing treatment in order to prevent more severe, long-term depression. In some cases, people need to take medications for long periods of time or for the rest of their lives. Cases when outcome is poor are associated with inappropriate treatment, severe initial symptoms that may include psychosis, early age of onset, more previous episodes, incomplete recovery after 1 year, pre-existing severe mental or medical disorder, and family dysfunction as well.

Depressed individuals have a shorter life expectancy than those without depression, in part because depressed patients are at risk of dying by suicide. However, they also have a higher rate of dying from other causes, being more susceptible to medical conditions such as heart disease. Up to 60% of people who commit suicide have a mood disorder such as major depression, and the risk is especially high if a person has a marked sense of hopelessness or has both depression and borderline personality disorder. The lifetime risk of suicide associated with a diagnosis of major depression in the US is estimated at 3.4%, which averages two highly disparate figures of almost 7% for men and 1% for women (although suicide attempts are more frequent in women). The
estimate is substantially lower than a previously accepted figure of 15%, which had been derived from older studies of hospitalized patients.

Depression is often associated with unemployment and poverty. Major depression is currently the leading cause of disease burden in North America and other high-income countries, and the fourth-leading cause worldwide. In the year 2030, it is predicted to be the second-leading cause of disease burden worldwide after HIV, according to the World Health Organization. Delay or failure in seeking treatment after relapse, and the failure of health professionals to provide treatment, are two barriers to reducing disability.

1.4.14 Diagnosis for Depression (Clinical assessment)

A diagnostic assessment may be conducted by a suitably trained general practitioner, or by a psychiatrist or psychologist, who records the person's current circumstances, biographical history, current symptoms and family history. The broad clinical aim is to formulate the relevant biological, psychological and social factors that may be impacting on the individual's mood. The assessor may also discuss the person's current ways of regulating their mood (healthy or otherwise) such as alcohol and drug use. The assessment also includes a mental state examination, which is an assessment of the person's current mood and thought content, in particular the presence of themes of hopelessness or pessimism, self-harm or suicide, and an absence of positive thoughts or plans. Specialist mental health services are rare in rural areas, and thus diagnosis and management is left largely to primary-care clinicians. This issue is even more marked in developing countries. The score on a rating scale alone is insufficient to diagnose depression to the satisfaction of the DSM or ICD, but it provides an indication of the severity of symptoms for a time period, so a person who scores above a given cut-off point can be more thoroughly evaluated for a depressive disorder diagnosis. Several rating scales are used for this purpose. Screening programs have been advocated to improve detection of depression, but there is evidence that they do not improve detection rates, treatment, or outcome.

Primary care physicians and other non-psychiatrist physicians have difficulty diagnosing depression, in part because they are trained to recognize and treat physical symptoms,
and depression can cause a myriad of physical (psychosomatic) symptoms. Non-psychiatrists miss two-thirds of cases and unnecessarily treat other patients.

Before diagnosing a major depressive disorder, in general a doctor performs a medical examination and selected investigations to rule out other causes of symptoms. These include blood tests measuring TSH and thyroxin to exclude hypothyroidism; basic electrolytes and serum calcium to rule out a metabolic disturbance; and a full blood count including ESR to rule out a systemic infection or chronic disease. Adverse affective reactions to medications or alcohol misuse are often ruled out, as well. Testosterone levels may be evaluated to diagnose hypogonadism, a cause of depression in men.

Subjective cognitive complaints appear in older depressed people, but they can also be indicative of the onset of a dementing disorder, such as Alzheimer's disease. Cognitive testing and brain imaging can help distinguish depression from dementia. A CT scan can exclude brain pathology in those with psychotic, rapid-onset or otherwise unusual symptoms. No biological tests confirm major depression. In general, investigations are not repeated for a subsequent episode unless there is a medical indication.

Biomarkers of depression have been sought to provide an objective method of diagnosis. There are several potential biomarkers, including Brain-Derived Neurotrophic Factor and various functional MRI techniques. One study developed a decision tree model of interpreting a series of fMRI scans taken during various activities. In their subjects, the authors of that study were able to achieve a sensitivity of 80% and a sensitivity of 87%, corresponding to a negative predictive value of 98% and a positive predictive value of 32% (positive and negative likelihood ratios were 6.15, 0.23, respectively). However, much more research is needed before these tests could be used clinically.

1.4.14.1 DSM-IV-TR and ICD-10 criteria

The most widely used criteria for diagnosing depressive conditions are found in the American Psychiatric Association’s revised fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), and the World Health Organization's International Statistical Classification of Diseases and
Related Health Problems (ICD-10), which uses the name *recurrent depressive disorder*. The latter system is typically used in European countries, while the former is used in the US and many other non-European nations, and the authors of both have worked towards conforming one to the other.

Both DSM-IV-TR and ICD-10 mark out typical (main) depressive symptoms. ICD-10 defines three typical depressive symptoms (depressed mood, anhedonia, and reduced energy), two of which should be present to determine depressive disorder diagnosis. According to DSM-IV-TR, there are two main depressive symptoms—depressed mood and anhedonia. At least one of these must be present to make a diagnosis of major depressive episode.

Major depressive disorder is classified as a mood disorder in DSM-IV-TR. The diagnosis hinges on the presence of single or recurrent major depressive episodes. Further qualifiers are used to classify both the episode itself and the course of the disorder. The category Depressive Disorder Not Otherwise Specified is diagnosed if the depressive episode's manifestation does not meet the criteria for a major depressive episode. The ICD-10 system does not use the term *major depressive disorder*, but lists very similar criteria for the diagnosis of a depressive episode (mild, moderate or severe); the term *recurrent* may be added if there have been multiple episodes without mania.

1.5 Ego strength:

In Sigmund Freud's psychoanalytic theory of personality, ego strength is the ability of the ego to effectively deal with the demands of the id, the superego and reality. Those with little ego strength may feel torn between these competing demands, while those with too much ego strength can become too unyielding and rigid. Ego strength helps us maintain emotional stability and cope with internal and external stress.

According to Sigmund Freud, personality is composed of three elements: the id, the ego and the super-ego. The id is composed of all the primal urges and desires and is the only part of personality present at birth. The super-ego is the part of personality that is composed of the internalized standards and rules that we acquire from our parents.
and from society. The ego is the part of personality that mediates between the demands of reality, the urges of the id and the idealistic standards of the super-ego.

In situations involving psychological disorders, ego strength is often used to describe a patient’s ability to maintain their identity and sense of self in the face of pain, distress and conflict. Researchers have also suggested that acquiring new defenses and coping mechanisms is an important component of ego strength.

Ego-strength" is a much used and useful term, though the concept is not easy to define. According to Wolberg (1977) it connotes the positive personality assets that will enable the individual to overcome his anxieties, to yield secondary gains of his illness, and to acquire new, more adequate defenses." Ego-strength is also the patient's capacity to hold on to his own identity despite psychic pain, distress, turmoil and conflict between opposing internal forces as well as the demands of reality (Brown et al., 1979). The patient needs to have sufficient ego-strength to be able to give up his neurotic defences when confronted with them in BDP. Conversely, each successful challenge or confrontation of a transference reaction increases the ego-strength.

1.5.1 High Ego Strength

An individual with strong ego-strength approaches challenges with a sense that he or she can overcome the problem and even grow as a result. By having strong ego-strength, the individual feels that he or she can cope with the problem and find new ways of dealing with struggles. These people can handle whatever life throws at them without losing their sense of self.

1.5.2 Low Ego Strength

On the other hand, those with weak ego-strength view challenges as something to avoid. In many cases, reality can seem too overwhelming to deal with. These individuals struggle to cope in the face of problems, and may try to avoid reality through wishful thinking, substance use and fantasies.
1.5.3 Why a healthy Ego is essential to health and happiness?

A healthy ego gives you the needed ego-strength to navigate challenging moments, and emotions of vulnerability rooted in fear and anxiety, with ease and resilience – which is an essential skill in the formation of healthy emotional intimacy.

Unlike weak ego-strength, you are less likely to personalize what others say or do, and more likely to accept yourself and others as human beings who have a right to make mistakes, and to grow their own problem solving abilities in the process – by making and learning from mistakes. It’s very basic to how healthy human beings learn.

Many of the major psychological theorists associated a healthy ego and ego-strength with a healthy exercise of personal power, one’s freedom and ability to choose to act in responsible ways with regard to self and other. Here’s what a few of them had to say on the subject:

1.5.3.1 Alfred Adler (1870-1937)

Alfred Adler one of the first to associate the striving for personal power, or ego-strength, as a universal drive that is not only normal, but a healthy human need. He believed persons are social beings with universal needs to belong, to exercise personal power, to find value in their relationships, and to contribute to the betterment of humankind. In a 1927 fourth edition of *The Neurotic Character*, he described an unhealthy lust for ‘neurotic power’ over others, as characterized by self-absorption and the use of aggression to dominate others. Adler believed this was rooted in harsh parenting practices that unwittingly thwarted a child’s needs for healthy power. He regarded parental love and involvement as the most important elements to healthy human development.

1.5.3.2 Rollo May (1909 – 1994)

Rollo May define power as an interpersonal process of growing a sense of self as free to act within socially responsible limits. He viewed a low level of anxiety as essential to growth, and ‘neurotic anxiety’ as product of not facing ‘normal anxiety’ in life. May identified five types of power, each in terms of its highest intention: (1) integrative power, which seeks to attain win-win
interactions with others; (2) nutrient power, which focuses on taking care of other human beings; (4) competitive power, which consists of choices to use either fair or unfair means of winning; (4) manipulative power, which seeks to get others to do something against their will or without their knowledge; and (5) exploitive power, which aims to exploit others destructively for own purposes and gain.

1.5.3.3 Abraham Maslow (1908 – 1970)

Abraham Maslow described a healthy need for power as part of the universal human need for self-esteem. He believed that human beings were intrinsically motivated to find meaning in life by fulfilling five intrinsic needs as an integral aspect of their personal and relational growth. Maslow developed a Hierarchy of Needs that separated the 5 needs into two levels: (1) one high level need for self-actualization; and (2) four lower basic needs for physiological sustenance, emotional safety, belonging and self-esteem. He also identified two types of esteem needs that develop ego-strength; one is a healthy striving to experience a sense of self as competent and capable of mastering tasks, and the other a seeking to experience self as capable of gaining positive recognition from others. In a radical departure from conventional psychological research methods, Maslow emphasized the importance of focusing on positive qualities, and was the first to study person’s self-actualized persons on the basis of their contributions to society, such as Albert Einstein, Eleanor Roosevelt, William James, Jane Adams, Abraham Lincoln, among others.

1.5.3.4 Carl Jung (1875 – 1961)

Carl Jung believed the primary goal, universally, of every human being was to come to a full realization of an ego self, a concept he termed self-realization that is clearly similar to Maslow’s self-actualization. The self-realized person is actually not selfish, and rather oriented to seeking to find meaning in contribution. To Jung, the self represents an inner transcending power of all opposites, an inner stretching of self to realize an essential balance of energies within, one that is neither and both: male and female; conscious and
unconscious; good and shadow; individual and connected to the universe; and so on. Jung viewed the ability to balance opposites as critical to ego-strength, as they produce necessary friction, and thus movement toward growth and change. Without opposition, there is no energy to act, and risk of stagnation.

1.5.4 How to Strengthen Your Ego-Strength

The following are offered as beginning guidelines processes which we have incorporated in our basic Meta-States training, Accessing Personal Genius. If you have experienced that training, then you know these processes and can keep refreshing the meta-stating patterns until you not only strengthen your ego-strength, but actually super-charge it. This will empower you to face life on life’s terms and to develop a sense of self-efficacy in the face of changing times. It will enrich your powers of optimism, resilience, and creativity.

1.5.4.1 Acceptance

First and foremost, we strengthen our ego-strength by meta-stating ourselves with acceptance. Access the state of acceptance and apply that feeling to your “self.” Think of something small and simple that you simply accept. You could get yourself worked up about it, even furious and frustrated, but you have learned to just go along and accept it. It could be something like the rain, the traffic, changing the baby’s diaper, taking out the garbage, etc. Think small and simple.

What is that like when you are accepting something? Feel that and reflexively turn that feeling back onto yourself—your sense of self, life, the cards that life has dealt you, when and where you were born, your aptitudes and lack of aptitudes, etc. As you do this, you’ll experience a quiet and tender feeling, one that may not necessarily feel very positive. It’s just a feeling of welcoming something into your life but not with any particular thrill or liking. To do that is to experience appreciation. Yet acceptance also is not resignation or condoning. Acceptance is just welcoming something into your world without any negative fanfare.
In this, acceptance can be a truly magical state. In it, we simply acknowledge the world for what it is regardless of our likes or dislikes. We simply acknowledge the constraints that exist and that we have to deal with.

1.5.4.2 Adjusting Expectancies

Second, look at your self-expectancies and expectancies of others, the world, work, etc. and adjust them so that you have a fairly accurate map about what is, how things work, and what you can legitimately expect. What have you mapped about yourself, people, relationships, fairness, life, etc.? Every unrealistic expectation sets us up for a cognitive and semantic jar and for a possible disappointment. If it is unrealistic, then we are trying to navigate and work in a world that is ultimately an illusion of the mind. A more effective approach is to set out to create a good and useful map that will enable us to go and experience what we desire.

This explains how learning and developing greater understandings about things increases ego-strength. Knowing what is, how things work, the rules and principles of people, relationships, careers, etc. gives us the ability to adjust our thinking-and-emoting to such and this increases our ego-strength. It takes the surprise and shock out of being caught up short. It raises our level of frustration tolerance.

1.5.4.3 Stepping into Our Power Zone

Weak and strong ego-strength is related to our sense of personal power or the lack thereof. We increase ego-strength when we accept our personal powers or responses of thinking, emoting, speaking, and behaving, meta-state them with a frame of ownership and then by welcoming and practicing the use of our powers, step more and more into our power zone. This increases our self-efficacy, activity, proactivity, etc. The more resourcefulness we have, the more willing and able we are to face reality and to master our world.
1.5.4.4 Meta-Stating Flexibility

A fourth process for strengthening ego-strength involves replacing rigidity and closeness of mind with flexibility, willingness to accept change, and openness to the flux and flow of life. In weak ego-strength we strongly feel a sense of insecurity. Then we don’t want things to change we want things to stay the same. As we develop more personal security, we are more open to change and to adapting and to using our resources. Openness to change, which supports personal flexibility, enables us to face the world and our future with an optimistic attitude. Then, if things change, we feel fine because our security lies in ourselves and in our strength of ego to figure things out.

1.5.4.5 Optimistic Explanatory Style

A fifth thing that increases the strength of our ego to face reality is the ability and attitude of interpreting things in such a way that we put a positive spin on things. We call this attitude, optimism. It stands in contrast to pessimism.

Martin Selgiman identified both the pessimistic and optimistic explanatory styles in his research with laboratory animals and then with humans. The pessimistic style consists of three P’s: personal, pervasive, and permanent. We take a “bad” thing, an unpleasant or unfortunate event and make it about ourselves (personal), about everything in our lives (pervasive) and about forever (permanent) and that’s a formula for pessimism and clinical depression.

Conversely, when we index the specifics of an event, we contain the “evil” or “badness” because then it is about the event and not us (non-personal), it is here in this situation and context (non-pervasive), and it is today (non-permanent). This frames the negative event so that it doesn’t contaminate us with the “evil” and infiltrate our mind so that’s all we can see and feel. It enables us to then think about other things, what we truly are and what we care about, what we can do and how we can take positive action to make a difference. This begins to create the attitude of optimism as it operates from a position of strength, confidence, possibilities, and taking pleasure in what is going right.
It is in this way that we develop sufficient ego-strength to face reality and to not be overwhelmed by frustration, disappointment, hurt, etc. We do what we can with what we have and we enjoy the process every day.

1.5.4.6 Consciously raising our Frustration and Stress Tolerance Level

If you look around the human situation at all the things that can and does trigger “stress” in people or that frustrates them and make a list—you will eventually make a list of everything. And the very things that frustrate the hell out of some people thrill and excite others. What one experiences as a stressor, another enjoys as excitement. In this, both stress and frustration are in the eye of the beholder.

The strength of yourself develops by framing things in such a way that we endow it with empowering meanings. Positive framing and reframing then allows us to take a new view of things which then effects how we actually feel about things. In this way, framing and reframing things can enhance our ego-strength to face, cope with, and even master the challenges of life. We often do this by developing the kinds of frames of mind that allow us to develop the insights, distinctions, and skills so that what would frustrate others gives us opportunities for development.

A study of Type D personality traits can hurt heart health (Harvard Mental Health Letter 2005) that the BOSTON — Chronic anger and hostility, or any severe stress, can impair cardiovascular health. None of us totally escapes feeling burdened, stressed, sour, or angry, but new evidence may now help us find the people at most risk, reports the November issue of the

People with a set of traits known as the Type D (“distressed”) personality suffer from a high degree of emotional distress, but they consciously suppress their feelings. Early studies show that once Type D’s develop coronary artery disease, they are at greater risk of dying, and they often have a poorer quality of life.

How might Type D personality traits contribute to poor heart health? The Harvard Mental Health Letter offers some possibilities:
Stress hormones may be so poorly regulated in Type D’s that the heart beats faster, blood pressure rises, blood vessels clench, and extra blood sugar is released. Type D’s may have more active immune systems, and therefore more inflammation, which results in damage to blood vessels and the rupture of atherosclerotic plaques. Platelets may get stickier, and so be more likely to form clots in coronary arteries. Type D’s could have higher concentrations of tumor necrosis factor, a chemical that promotes all these processes.

Studies are needed to determine what effects psychological treatments have on the risks of heart disease. “Whatever its effects on heart disease, psychiatric treatment for Type D patients certainly can relieve anxiety and depression, reduce stress, improve self-esteem, promote better self-care, and ultimately enhance their quality of life,” says Dr. Michael Craig Miller, Editor in Chief of the Harvard Mental Health Letter.

A study of Distressed"-personality heart-disease patients at increased risk of future events, Tilburg, the Netherlands - Heart-disease patients with a general propensity to psychological distress are at a significantly higher risk of adverse cardiovascular events, according to the results of a new analysis. In identifying individuals with the type-D personality construct, physicians might be able to better identify high-risk patients at risk for future events, say researchers.

"This is the type of patient that tells you everything is okay, that there are no problems, but you can sense that something is going on, something is not quite right," explained lead investigator Dr Johan Denollet (Tilburg University, the Netherlands)

A study of Type D personality and depression for C.H.D., Diabetes, Kidney, Blood pressure patients.Zala,K,J,2010), that the result is there is significance difference in male and female for all dieses.(Including area and Social economics status variables)

A study of Type D personality and depression between psychosomatic male and female S, Herachi, 2009), that the result is there is significance difference between male and female on Type D personality and depression.

A study of Type D personality and depression between psychosomatic and Normal people.S, R, Thomas, 2009), that the result is there is significance difference between psychosomatic and Normal people on Type D personality and depression.
A study of Ego strength and depression between psychosomatic and Normal people (L, V, Waugh, 2010), that the result is there is significance difference between psychosomatic and Normal people on Ego strength and depression.

1.6 IMPORTANCE OF STUDY

This section brings out the various organizations in which the study was undertaken and under which guidance the study was authorized. Saurashtra University, Dept of Psychology, Rajkot authenticated the research work and under the guidance of Dr. T.L. Zalawadia, The clinical practice and Data collection for psychosomatic patients under the guidance was undertaken with the help of Dr. Mukesh Patel, Dr. Samani, and other Doctors. American Psychiatric association, with their website www.apa.org, www.en.wikipedia.org, www.google.com contributed in the collection of the literature from their websites. Population of general category from the Saurashtra, Surendranagar, Kutch etc. region and also population of various organizations working in this region have been considered for the study. The group was randomly selected by administering the testing inventories. The library of Saurashtra University, The library of Gujarat University, the Library of Surendranagar, Rajkot, M.B.College (Gondal), have largely benefited in collection of the historical evidences of Psychology. Government Hospital of Rajkot, Government Hospital of Surendranagar, Government Hospital of Kutch etc. its associates have largely contributed in the collection of the data for the research work.

Now after having known the organizations in which the study was conducted, it is essential to understand as to how the study was conducted an overview of the same is brought under: This study has been intended to bring out the clinical importance of the differences between psychosomatic and normal people on Type d personality, Depression and Ego strength. this study is very useful from different field like as: Health psychology, medical or clinical psychology and also community psychology. Last but not least this study high lights in the area of mental health. By achieving mental health of the patients, we produce the sane society for future mankind.
1.7 ORGANIZATION OF STUDY MATERIALS

So the entire study is divided into five chapters and brief description of each chapter is brought down here under:

Chapter 1: Introduction

The first chapter is of the introductory nature dealing with the need of this type of research work and its relevance in the present day context tracing to the historical background of psychosomatic Dieses, the classification for I.C.D.and related Health problem, what is Type d personality, what is depression and Ego strength etc.

Chapter 2: Review of Literature

In this chapter various literatures on the psychosomatic dieses, Type D personality, depression and ego strength have been seen and discussed also. First of we seen the Review of Literature for Type d personality than we seen the Review of Literature for Depression and in the last we seen the Review of Literature for Ego strength.

Chapter 3: Research design of the study, Procedures and Method of analysis

The third chapter deals with the research design. It also states how the sample was selected from the population, which sampling method was used and its detailed narration has been discussed. Collection of data, research tools, measurement of independent variables discussed in detail.

Chapter 4: Analysis of the Result, Interpretation and Discussions

This chapter deals with the analysis of the chapter in terms of statistics and the interpretation from the inferences obtained through the statistics. Further, case histories, suggestions for improvement and recommendations are discussed in detail.

Chapter 5: Research Report

This chapter deals with the summary of the research, conclusions based on statistical technique, conclusions regarding all the variables, Recommendations, suggestions for further research are discussed.