Chapter -2

REVIEW OF LITERATURE

The review deals with empirical studies of depression showing its relationship with personal and social determinants, gender, unemployment, caste(categories), and impact of cognitive behaviour therapy. The purpose of the review is to give the state of art knowledge on the topic. The review is divided in the sections to follow.

2.1 PERSONAL AND SOCIAL DETERMINANTS

Depression has disturbed human race since time immemorial. Almost everyone experiences depression at one or another time in their lives. But when one crosses threshold, he enters into clinical category. Clinical depression is diagnosed when one crosses normal level of sadness. In this condition, his mood is prominently sad which indicates psychiatric and psychotherapeutic treatment. Depressive disorders are also called mood disorders or affective disorders. Depressive disorders represent two types of extreme manifestations, low mood as depression, and elevated mood as mania. Helping people to come out from this condition is through psychopharmacology, and also through psychotherapy.

The parental relationships seem also to have a great impact in the course of affective disorders. A variety of authors have emphasized the importance of the quality of early experiences with parents in the development of adult depression. Beck was the first, who explicitly attributed the development of negative cognition and negative schemata of self, to critical, disapproving parents (Beck, 1967).

As mood disorders are the single largest risk factor for suicide, it is also of note that, in most western countries, the rate of suicide, especially in young adults,
increased considerably from the 1970s to 1990s, although the suicide rate is now declining in many countries. This reflects better recognition and treatment of depression for overall socio-economic welfare. The lack of a confiding and intimate relationship leaves individuals vulnerable to depression (Brown & Prudo, 1981; Costello, 1982). Difficulties in social functioning are concomitant to depressive disorders (Hirschfield et al., 1983). Depression has been studied extensively. It has drawn attention of several reviewers.

According to the helplessness model of depression, vulnerability to depression derives from a habitual style of explaining the causes of life events, known as attributional style (Peterson & Seligman, 1984).

The descriptive studies have suggested that marital conflict correlates highly with concomitant depression (Crowther, 1985). Moreover, marital therapy has been found to be effective in reducing the symptoms of depression alone, as well as in combination with pharmacotherapy. Further, previous research found dysfunctional patterns of communication in couples with a depressed spouse (Kahn, Coyne & Margolin, 1985). Several studies have now established the critical importance of untoward experience during childhood viz., loss of mother between the age of 11 and 17, which increases the risk to develop depressive illness (Harris, Brown & Bifulco, 1987).

Despite methodological concerns about the reliability of life-time major depression, studies across countries have reasonably consistently documented an increasing rate of major depression with an earlier age of onset (Cross National Collaborative Group, 1992).

In a review of a large body of research, Tracy et al. (1992) found that individuals suffering from depression think more negatively than healthy individuals.
Specifically, depressed patients have a tendency to make internal, stable, and global causal attributions for negative events and, to a lesser extent, the attribution of positive outcomes to external, specific, and unstable causes. In other words, depressed patients have a low self-esteem (Pardoen et al., 1993). Thus, when thinking about patient’s past, current and future circumstances depressed patients emphasize the negative aspects and this process is likely to contribute to the perpetuation of their depressed mood.

Brown, Harris and Hepworth (1995) illustrated that ‘humiliation’ in the form of separation and putting down entrapment through imprisonment and punishment, loss due to death, separation and danger involving threat of a future loss are severe life events associated with depression and they are contributing factor. Researchers have found that if events involving humiliation are combined with those of entrapment, risk was increased three-fold. They further documented that low risk of depression is associated with only loss. But when a severe event, for example, death of loved one is involved along with loss, depression may take place. The experience of humiliation associated with the loss, increases the risk of depression.

Impairment in social relationships, dysfunctional cognition, gender, economic status, and temperament has been suggested as involved in the emergence of mood disorders (Depue & Monroe, 1996). The concept of social support has been widely used to predict general health and more specifically psychiatric symptoms (Kendler, 1997). The relationship between marital disturbance and affective disorders has received increased attention over the past decades. The characteristic features of the most of the studies have produced broadly consistent findings that the role of life events is contributing factor in depression (Jenaway & Paykel, 1997).
A key clinical feature of the illness course in depression is the association of life events most strongly with first episodes of depression. Accordingly, the effect of life events and the brain changes that occur with repeated or chronic illness is of great relevance to prevention and reduction of the risk of future episodes (Kendler et al., 2000).

The growing literature on the role of the serotonin transporter gene in depression is of particular interest, as evidence has emerged for an important interplay with life event viz., childhood maltreatment predicted depression (Caspi et al., 2003).

Despite this well-established reality and the current increase in depression treatment investigations, the evidence for particular treatment approach connecting antidepressant medicine or cognitive behavioral therapy, recommend only modest optimistic effects achieved with a substantial investment of resources. The exact advantages over placebo for either treatment alone have been modest in many studies and nonexistent in several studies (Tads, 2004).

A literature search of epidemiological studies of adolescent psychological health indicates that in depression, substance abuse complicates the scenario to distort cognition leading to attempt to suicide. Hence, these conditions are most prevalent causes of death in adolescents (Brookman, 2006).

Chopra et al. (2006) reported that 27 out of 34 patients evaluated had not received any treatment at all though there were many episodes, and 15% of patients had rapid cycling episodes of manic accounted for 72% of episodes. A mania predominant course was observed in this study cohort.
2.2. GENDER

Besides these two specific conditions, the reasons for depression in gender difference are unclear, and are as likely to be social as biological. There has been some evidence that within the marriage, the traditional female role is limiting, restricting, which may lead to depression (Gove & Tudor, 1973). For example, the role of child caretaker has consistently been shown to be associated with both high level of stress and a higher incidence of depression for women (Thoits, 1986). Further, since women who are employed outside the home also tend to be responsible for household chores.

The most interesting statistical differences dealing with depression's prevalence rate occur between men and women. Women are twice more likely than men to suffer from depression (Wetzel, 1984). Women have a 20 to 26 per cent lifetime risk of developing depression, compared to an 8 percent to 12 percent lifetime risk for men (Wetzel, 1984). Six percent of women who suffer from depression require hospitalization, while half as many men i.e., 3 percent - require hospitalization (Wetzel, 1984). Studies have shown that people who are married are less likely to develop depression than single people (Dean et al., 1986). Having an opposite sex as intimate friend may substitute for a spouse compared with single person.

Age of onset is another difference between the sexes. Men develop depression at about 50 years of age while the average age of onset for women is 35 years of age (Comer, 1992). The notion that differentiation in occupational roles could partially explain the prevalence of depression in women is supported (Rosenfield, 1992).
There are several explanations for the discrepancy of rates of depression in men and women. The first explanation is that women are more likely than men to seek treatment (Schwartz & Schwartz, 1993). Perhaps, the difference in rates of depression lies in the fact that woman is physiologically different than men. However, this hypothesis is tentative (Schwartz & Schwartz, 1993). Women may experience two important periods, known to be associated with higher rates of depression, the first is pregency and second is post-partum period. The prevalence of major or minor depression among pregnant women ranges from 7 percent to 26 percent (Hobfoll et al., 1995). Higher rates of depression, anxiety and somatic symptoms are related to a range of risk factors such as gender-based roles, stressors and negative life experiences and events.

Bebbington (1996) and Nazroo, Edwards and Brown (1997) found that the well recognized greater risk of a depressive onset among women may relate to their greater sensitivity to severe events involving their role as mothers. They have also studied couples experiencing a severe event in common, but women were twice as likely to develop a depressive episode following events involving procreation children and housing. They have reported that for other severe events, risk was much the same among women. The studies do support the increasingly held opinion that the large gender difference i.e., between men and women, in the experience of neurotic depression is likely to have an essentially psychosocial explanation especially applicable to women. Evidence of sex difference in responses to depression comes from a large number of studies. Women are consistently reported to have greater prevalence of depressive disorders than men (Kroenke, 1998).
Gender specific risk factors for common mental disorders that disproportionately affect women include gender-based violence, socioeconomic disadvantage, low income and income inequality, low or subordinate social status and rank, and unremitting responsibility for the care of others (Patel et al., 1999; Kumar et al., 2005). They found that there is a positive relationship between the frequency and severity of such social factors and the frequency and severity of mental health problems in women. Severe life events that cause a sense of loss, inferiority, humiliation or entrapment can predict depression.

Depression during pregnancy is a strong predictor of postpartum depression. The prevalence of postpartum depression ranges from 10 percent to 15 percent in the first year after childbirth (Afifi, 2007).

Numerous studies have been conducted to estimate mental health in Iran. Using face-to-face interviews conducted by psychiatrists, 9.7% of the 17 to 24-year-olds were diagnosed as having a mental disorder. The number of cases of mental disorder is expected to increase with growing age, and women were twice more likely to be diagnosed with a mental disorder than men (Fakhari et al., 2007). Clinical depression has an undoubtedly difficult impact on the development trajectories of youth and adolescents.

2.3 UNEMPLOYMENT

Having employment is psychologically significant for maintaining socioeconomic relationships. Sometimes people are not able to wait in employment due to many reasons viz., work stress, mental health difficulty, employee-employer relationships, substance abuse, employment dissatisfaction etc. Competition in work place puts burden on individuals, and this generate work stress. Intense competition
produces unfavourable ongoing effects (Gelder, Gath & Mayou, 1983). When this stress crosses threshold, employee suffers from distress and institution suffers from low or poor productivity. Long-term stress at workplace or stressors from family, lead a person to mental health problems. Inequality and discrimination of any category disturbs working relationship between employee and employer. During this situation, generally employee suffers.

Many social psychologists have opined that, in fact, all that has happened is that old-fashioned racism which is considered as blatant feelings of superiority has been replaced by more subtle forms, which they term modern racism (McConahay, 1986; Swim et al., 1995).

A growing body of evidence suggests with the aim of, when employed individuals feel that they have been treated unfairly by employers or management and they have no legitimate means for correcting this circumstances, they may engage in employee theft or sabotage. During this way, they use more covert techniques for “evening the score” with their employers (Greenberg, 1997). If they are caught, they are punished and may lose employment, and they may become depressed.

The burden of unemployment can also affect outcomes for children. The stress and depressive symptoms associated with job loss can have negative effect on parenting practices such as increasing punitive and arbitrary punishment (McLoyd, 1998). As a result, children report more distress and depressive symptoms.

Sen (2000) stated that “Unemployment can play havoc with the lives of the jobless, and cause intense suffering and mental agony. Empirical studies of unemployment brought out how serious this effect can be. Indeed, high unemployment is often associated even with elevated rates of suicide, which is an
indicator of the perception of unbearability that the victims experience. The effect of prolonged joblessness can be especially damaging for the morale (p.20).”

From the above views of Sen (2000), it is understood that when there is high rate of unemployment, people generally fail to meet the demands of social expectations. Hence cognition of unemployed people becomes negative and jobless persons become dependent on others. This adversely affects their behavior and they become vulnerable to criminal acts, which is also damaging to society and self. Unemployment takes away self-dignity of affected people and their relationship to others is disturbed. It can be implied that when their social environment causes them miserable living, naturally they rebel against society. This may cause family disturbance and ultimately social order is disturbed.

These programs include resilience-building mental health promotion programs for unemployed people, and these programmes have been found to be cost effective (Vinocur et al., 1991; Vuori et al., 2002).

Being married is a protective factor during period of unemployment and underemployment (Dooley & Prause, 2004; McKee-Ryan et al., 2005).

Like unemployment, underemployment (e.g., people working part-time because they cannot find full-time employment) is unequally distributed across the U.S. population, with women, younger workers and African Americans reporting higher rates of involuntary part-time employment and low pay, as well as higher proportions of “discouraged” workers who give up searching for a job (McKee-Ryan et al., 2005).

The negative effects of unemployment can be lessened. Individuals who face unemployment with greater financial resources, as well as who report lower levels
of subjective financial strain, report better mental health and more life satisfaction than those who experience unemployment with fewer economic resources and a greater sense of financial stress (McKee-Ryan et al., 2005).

Research on the effects of job dissatisfaction suggests that when people view their jobs as meaningless, their bosses as uncaring, their companies exploit them, and people develop negative attitudes toward their work (Baron et al., 2006).

Gelder et al. (2009) noted as: Persons at the greatest risk of suicide are usually middle-aged/older, non-married men with poor social and economic position, and a family history of mental disorders and suicidal behaviour. Usually they are living alone, and often unemployed or with insecure employment. They also typically have marked recent life stress and a weak social network. Most suffer from depression, feel hopeless and many have a comorbid substance abuse or personality disorder. They have also noted that major depression has the highest risk of suicide of all mental disorders.

A comparison of suicide rates between Sweden and Spain from 1980 to 2005 revealed that while the severe bank crisis in Sweden in the early 1990s that produced a rapid rise in unemployment, did not increase suicide rates, the reverse was observed in Spain following multiple banking crises in the 1970s and 1980s (Stickler et al., 2009).

Active labor market programs can counteract the detrimental mental health effects of unemployment to a certain extent (Stickler et al., 2009). In India also, during droughts, government introduces relief work programs in drought hit areas so as to lessen the burden of unemployment on families. It is well known fact that family support programs are extremely helpful during periods of economic crises. It
was found that European Union (EU) countries and U. S. spent $100 per person on support programs. It reduced the effect of unemployment on the suicide rate by 0.2 percentage points (Stuckler et al., 2009). These concepts can be relevant for all countries.

According to American Psychological Association (APA, 2009), there is a relationship between depression and unemployment. The APA reported as follows: The current state of the economy continues to be an enormous stressor for Americans, with 78 percent reporting money as a significant source of stress (APA, 2009). Unemployed workers are twice more likely, as compared to their employed counterparts, to experience psychological problems such as depression, anxiety, psychosomatic symptoms, low subjective well-being and poor self-esteem (Paul & Moser, 2009).

Gelder et al. (2009) reported classic and influential work of George Brown on working-class women, who have three or more children, lack of paid employment, and lack of confident, were at risk for the development of an episode of depression.

High unemployment and growing income inequalities are also key factors in declining social climate (International Labour Office, 2010). The United Nations (2010) claimed that growing social inequalities fuelled by extended global unemployment will increase social unrest and tension and a growing sense of unfairness. Increasing inequality in advanced economies is fundamentally linked to growing rates of physical, emotional, social and political disorder (Wilkinson & Pickett, 2010). Social support can also mitigate the negative impacts of unemployment and underemployment (Belle & Bullock, 2011).
World Health Organization (2011) has shown concern that depression is associated with unemployment. Hence, WHO has advised to find out measures to prevent psychopathology during periods of economic crisis including unemployment. As the association of unemployment with psychopathology, especially depression and suicide, has drawn attention worldwide, it calls for research programs to help people regain employment.

WHO Report (2011) recommended the following measures:

- Control of alcohol prices and availability, in view of the association of increases in unemployment with a rise in deaths from alcohol use in many EU countries (Stuckler, 2009) and increases in alcohol-related deaths following the crises of 1991 and 1998 in Russia (Zaridze et al., 2009).
- Early recognition of mental health problems, suicide ideas and heavy drinking.
- Development of community-based mental health services, since this has been associated with reduction of suicide rate (Pirkola et al., 2009).
- Promoting problem-solving skills that may protect against depression and suicidal behavior (WHO Report, 2009).
- Debt relief programs.
- Countering stigma (general population complains have shown modest effects and targeted approaches are indicated).
- Demonstrating that investing in mental health has economic benefits.
- Continuing mental health reforms (especially deinstitutionalization and delivery of mental health services in primary health care), but linking funding to accreditation system and assessment of provider performance.
The Society for the Psychological Study of Social Issues has stated that the stress of unemployment can lead to declines in individual and family well-being (Belle & Bullock, 2011). Depression in children and adolescents is linked to multiple negative outcomes, including academic problems, substance abuse, high-risk of sexual behaviour, physical health problems, impaired social relationships and increased risk of suicide (Birmaher et al., 1996; Stolberg, Clark & Bongar, 2002; Le, Munoz, Ippen & Stoddard, 2003; Chen & Paterson, 2006; Verona & Javdani, 2011).

According to Kasrils (2011), further, the unemployment is considered as a ‘virus’- where more than 40% are without work, income and dignity – which destroys human solidarity. It is one of main factors behind crime, gangsterism, drug abuse and violence against women and children unemployment is not a natural disaster but an outcome of the failure to redistribute wealth in the most unequal societies in the world and the workings of globalised capitalism based on the drive for profits and lowering of costs under conditions of extreme competition. It is spreading alarmingly all over the globe like HIV.

Data from Greece are in line with the above findings. It has been shown that suicide rates were reversely associated with the number of primary health care, mental health service providers and the number of mental health infrastructure in Greece (Giotakos et al., 2012).

Considering the gravity of the problem of depression, on October 10, the World Mental Health Day, WHO (2012) had specifically mentioned that depression is a global crisis to create worldwide awareness about this illness.

2.4 CASTE

According to Sadock and Sadock (2000), race/ethnicity has “no effect” in occurrence of Bipolar I & MDD.
Presently, overt discrimination on the basis of gender, race, and religious affiliation is illegal in most of the countries. However, this does not mean that stereotype-based discrimination has been eliminated. Although overt and blatant discrimination may be substantially reduced, other more subtle forces continue to operate in ways that perpetuate discrimination in even well-meaning people (Crosby, 2004).

The World Health Organization (1992) adopted international classification of diseases, 10th revision (ICD-10) in which ‘loss of confidence or self-esteem’ has been included as a symptom of depression hence it is of importance to note that Schedule Cast and Schedule Tribe peoples are socially discriminated against by the mainstream society, as a result the ‘self-esteem’ in downtrodden remains low, which may contribute to depression in Scheduled Caste and Scheduled Tribe communities (Gelder et al., 2009).

Gelder et al. (2009) that leading anthropologists viz., Margaret Mead, Ruth Benedict and Irving Hallowell have developed broader ties with psychology by their leading research interests in cognition, lifecycle development, self-concepts and self-images as well as experiences of childhood, child rearing, adolescence, midlife, and ageing. These concepts apply to the exploited also as to how their cognitions have developed and how they view themselves and how these concepts play role in expression of their depressive condition.

However, higher SES is at greater risk for Bipolar I; and lower SES is at greater risk for MDD (p.1304).

The above researches have global suggestion that means these findings may have implications for Scheduled Caste and Scheduled Tribe communities in India.
2.5 EFFECTIVENESS OF CBT IN TREATMENT OF DEPRESSION

Before cognitive therapy emerged, in the 1950s, Albert Ellis observed that whenever we become upset, it is not the events taking place in our lives that upset us, it is the beliefs that we hold cause us to become depressed, anxious, enraged etc. The idea that our beliefs upset us was the first expressed by Epictetus around 2000 years ago, which says, men are disturbed not by events, but by the views which they take of them.

Than in 1960s Aaron Beck proved that cognition as a mental process plays significant role in maintaining depressive illness. Especially, he empirically proved that negative cognition does not permit patients to get rid of depression hence through cognitive therapy, he focused to lead patients to develop positive thinking to lift depression.

Cognitive therapy for depressive disorder is a complex procedure combining behavioural and cognitive techniques, with emphasis on procedures for changing ways of thinking. It was one of the first effective forms of psychotherapies developed by Beck (1960). Cognitive behaviour therapy (CBT) has become effective mainstream psychosocial treatment for many emotional and behavioural problems.

One of the earliest cognitive restructuring approaches was rational emotive therapy (Ellis, 1962). Cognitive Behaviour Therapy is one of the psychotherapeutic methods. The broad spectrum of psychotherapy is defined as the treatment by psychological means, of problems of an emotional nature in which a trained person deliberately establishes a professional relationship with the patient, with the objective of removing, modifying, or retarding existing symptoms, of mediating disturbed
pattern of behaviour, and of promoting positive personality growth and development (Wolberg, 1966).

The same efficacy is shared by therapist who uses Beck’s cognitive therapy (Beck, 1976; Beck et al., 1979). Behaviour therapy approaches were first developed in the 1950s when experimentally based principles of behaviour were applied to the modification of maladaptive human behaviour (Wolpe, 1958; Eysenck, 1966).

As a result, cognitive therapy techniques were developed and eventually integrated with behavioural approaches to form cognitive – behaviour treatment for a variety of psychological disorders, mainly depression. In the 1970s cognitive processes were also recognized as an important domain of psychological distress (Bandura, 1969).

Cognitive therapy was developed as a departure from traditional therapeutic approaches to mental illness. While working with patients, Aaron Beck, a pioneer in cognitive therapy, observed that negative moods and behaviors were usually the result of distorted thoughts and beliefs not of unconscious forces as proposed in Freudian theory. Cognitive Behaviour Therapy of treatment involves strategies from cognitive therapy (CT) and behavioural activation (Beck, Rush, Shaw & Wmery, 1979; Lewinsohn, Biglan & Zeiss, 1976). The concept of ‘wait & Watch’ is not useful in the treatment of depressive patients.

In Cognitive Behaviour Therapy, the treatment involves strategies from cognitive therapy to behaviour therapy activation (Beck, Rush, Shaw & Mery, 1979; Lewinsohn, Biglan & Zeiss, 1976). Smith and Glass (1977) reviewed and analyzed 375 different studies of psychotherapy and concluded that average people receiving psychotherapy were better off than the people who had similar problems but got no therapy. This proves the notion that therapy is better than no therapy. CBT also
derives from the ideas of Meichenbaum (1977) and the treatment studies of Beck, (1976). Beck has devised a comprehensive system of treatment (Beck et al., 1979) which combines behavioural task with questioning and argument designed to alter cognitions directly.

Clinical significant psychometric measures suggested that 82% adolescent in IPT and 59% of these in cognitive behaviour therapy (CBT) are efficacious treatments for depressed Puerto Rican adolescent patients (Demission et al., 1979). Effective treatments directed to change behaviour also produce changes in cognition. In other words, people think differently when they behave differently.

Kuruvilla, (1980) asserted that CBT has had its impact on the Indian scene also. There are few psychiatrists and many psychologists practicing it, but publications in this field in Indian Journal of Psychiatry have been few. He reported 17 patients with major depressive disorder showed that CBT can be practiced in Indian setting also. Of the 14 patients who completed the course, 11 showed marked improvements and three had partial improvement in depressive symptoms.

Aaron Beck’s approach is designed primarily for the treatment of depression. Its effects with moderately depressed patients are about the same as those of antidepressant drugs (Rush et al., 1977; Blackburn 1981). Despite the large number of studies that have been reported using cognitive therapy, only a handful studies used adequate control groups. Cognitive therapy tended to be effective in reducing depressive symptoms. It is one the most promising psychotherapeutic interventions available currently for depression in the field of psychiatry.

Psychotherapy combined with drug treatment accelerates prognosis in most depressive disorders. In fact, several approaches now emphasize cognitive processes so heavily that they are often grouped under the heading of ‘Cognitive Therapy’; but
when their behavioural emphasis is strong, they are often grouped under the heading of ‘Cognitive Behaviour Therapy’. Many other studies have shown cognitive therapy to be more effective than antidepressant medication (Blackburn, Bishop, Glen, Whaley & Christie, 1981; Evans, et al., 1992; Kovacs, Rush, Beck & Hollon, 1981; Rush, Beck, Kovacs & Hollon, 1977; Rush, Beck, Kovacs, Wiesenberger & Hollon, 1982). Commonly used psychotherapies for depression include CBT and interpersonal therapy. CBT has been globally applied since Aaron Beck (1985) introduced and proved its effectiveness on treating depression. Since then numerous manuals are available for formulating different goals like reduction of acute symptoms or prevention of relapse. Much attention has been given to studying the effectiveness of Beck’s cognitive therapeutic approaches to depression, as can be seen by several meta-analyses that evaluate it. In meta-analyses examining 58 investigations, Robinson, Berman and Niemeyer (1990) found that depressed clients benefited considerably from psychotherapy, with gains comparable to pharmacotherapy.

Other studies have shown cognitive therapy to be as effective as antidepressant medication (Hollon et al., 1992) or combined cognitive along with drug treatment (Beck, Hollon, Young, Bedrosian & Budenz, 1985; Blackburn et al., 1981; Covi & Lipman, 1987; Evans et al., 1992; Hollon et al., 1992).

Yet other studies suggest that cognitive therapy adds to the efficacy of standard antidepressant drug treatment (Dunn, 1979; Teasdale, Fennell, Hibbert & Amies, 1984; Bowers, Bishop & Dow, 1989; Miller, Norman, Keitner, 1990).

Cognitive therapy changes the negative ideas, unrealistic expectations, and overtly critical self-evaluations that create depression and sustain it. Cognitive
therapy helps the depressed persons recognize which life problems are critical, and which are minor. It also helps patients to develop positive life goals, and do a more positive self-assessment. Cognitive behaviour therapy is a problem solving therapy which changes the areas of the person’s life that are creating significant level of depression. This requires to developing better coping skills, and interpersonal positive relations. All depressed patients, whatever mode of treatment they may receive, need appropriate clinical management. Such management should provide education, encouragement, help to execute life skills, home-work assignments etc. These measures also require pessimistic patients to comply with specific work to be done outside therapeutic settings, so as to help them to cultivate optimistic thinking.

Education and reassurance should be given to the patient’s spouse, other close family members, and other people involved in the care of patient (Gelder, Gath, Mayo & Cowmen, 1996).

Besides, the substantial empirical support for the treatment model, the cognitive model of depression has also received wide empirical support, demonstrating that depression is characterized by the distortions in information processing that Beck and his colleagues had first proposed (Dobson, 1989; Hollon, DeRubeis & Evans, 1996).

One of the largest studies undertaken is the study of depression by the National Institute of Mental Health for the treatment of depression under the project of Collaborative Research Program (TDCRP) (Elkin, 1994; Elkin, Gibbons, Shea & Shaw, 1996). The study tested the comparative effectiveness of Cognitive Behaviour Therapy (CBT), Interpersonal Psychotherapy, pharmacotherapy using imipramine, and a pill-placebo in clinical management approach. This study was carried out in
three different cities with a random placement of a total of 250 patients into each of the four treatment categories. Each treatment session was videotaped so that the process as well as the outcome of psychotherapy could be measured and documented. Although findings continue to be gathered in this study, some conclusions have been made. Cognitive Behaviour Therapy was not significantly inferior to pharmacotherapy or significantly superior to placebo treatment with minimal support. Also, cognitive therapy seemed to work better for those who were less depressed than for those who were more depressed (pharmacotherapy appeared to be particularly effective for the latter group viz., more depressed patients). They have further opined that the CBT in depressive patients has proven effective and is being widely applied and behavioral techniques that are used to increase patient activity can also be used for rehabilitation and relapse prevention. Therefore, a combination of adequate pharmacotherapy and psychotherapy is helpful to achieve complete remission of major depressive disorder.

Similarly, the procedure outlined by Beck has been found to be highly effective in treating depression (Brader et al., 1997). Perhaps even more important, the effects of cognitive therapy tended to be long-lasting than those produced by other forms of therapy for depression, for instance, antidepressant drugs, psychoanalysis, etc. (Brader et al., 1997).

The concept of empirically supported psychotherapies (EST) emphasizes the evidence of its efficacy (Chambless & Hollon, 1998). Gloauguen, Cottraux, Cucherat and Blackburn (1998) reviewed 72 studies of adults using randomized clinical trials. They concluded that cognitive therapy helped patient significantly better when compared to waiting list, antidepressants, and miscellaneous therapies. Cognitive therapy alone for depression did not produce significantly better results than
behaviour therapy. In a later follow-up there was some support for CBT as being somewhat better than pharmacotherapy in some groups, on certain measures. DeRubeis and Crits-Christoph (1998) point out that the positive effects of cognitive therapy continued beyond 1-year follow-up, whereas the effectiveness of medication sometimes stopped because when patients who had been feeling less depressed, they discontinued their medication.

Fewer studies have been conducted with adolescents, so conclusions need to be tentative. However, cognitive therapy was found to be superior to wait list, relaxation therapy, and supportive therapy at the conclusion of treatment and in 6 to 12 week follow-up in 13 studies (Reinecke, Ryn & DuBois, 1998).

DeRubeis and Crits-Christoph (1998) review meta-analyses and large scale studies on the effectiveness of cognitive therapy that meet stringent criteria for comparing treatments of depression. They found cognitive therapy to be effective, but not necessarily more often than psychopharmacology or psychodynamic or interpersonal approaches.

Studying major depression, Gortner, Gollan, Dobon and Jacobon (1998) found that those in the cognitive therapy treatment group took longer to relapse than those taking medication, but relapse did occur after 12 and 18 months follow-ups. In large-scale randomized controlled treatment trials have found that CBT and IPT are superior to pill or psychological placebo-controlled treatments or efficacious as antidepressants or other established treatments (Chambless & Hollon (1998).

Tang and DeRubeis (1999) found that gains in the treatment of cognitive therapy for depression were often the result of significant changes in thinking about problems related to depression that occurred in the previous session.
Rosello and Bernal (1999) evaluated the efficacy of cognitive behaviour therapy (CBT) and interpersonal therapy (IPT) with depressed adolescents in Rico. Result suggests that interpersonal therapy (IPT) and cognitive behaviour therapy (CBT) significantly reduce depressive symptoms when compared with the wait list (WL) condition.

Kuruvilla, (2000) has summarized the origin, theoretical foundations, and application of CBT in depression and anxiety disorders. The role of CBT and its efficacy in the treatment of psychotic conditions, dysthymia, obsessive compulsive disorder, personality disorders, hypochondriasis, post-traumatic stress disorder, alcoholism etc., are also described there.

In recent years, there has been great interest in the study of the effectiveness of cognitive therapy in depressed patients, particularly in contrast with behaviour, psychodynamic, and psychopharmacological treatments (Butler & Beck, 2000).

Depressed patients who did assigned psychotherapy home–work were found to improve much more than patients who did little or no homework (Burns & Spanhler, 2000). Interestingly and surprisingly, it has been found out that severity of depression did not seem to be a factor in whether or not patients did homework.

Kuruvilla (2000) stated that like any psychological method of treatment, CBT also needs some modifications and adaptation to suit the culture in which it is practiced.

Beck (2001) reviewed 14 meta-analyses on cognitive therapy that included 325 studies and 9,138 individuals. The meta-analyses included several psychological disorders and had many findings, the most significant being that cognitive therapy provided help to those who received treatment as contrasted to those who received a
placebo or other control condition. Without doubt, the greatest amount of effort has been devoted to research on depression.

Asarnow (2001) meta-analysis has been shown to support the effectiveness of cognitive behavioral therapy (CBT) in treating childhood depression, with moderate level of depressive symptoms compared with wait list control conditions and other treatments. In the CBT model, depression results from faulty interpretations of the environment and negative interactions with it. Treatment involves challenging negative cognitions and increasing adaptive thinking and behavior. Cognitive behavioral skills include practicing positive attributions, accurate identification of feelings, monitoring and increasing self reward, problem solving, social skills, and relaxation procedures. Another study suggests that relapse can be reduced by training patients to be intentional rather than automatic in the way they process unwanted thoughts (Teasdale et al., 2001) rather than change their beliefs, they can label them as “events in the mind.”

Churchill et al. (2001) in a recent meta-analysis found that CBT and IPT equally effective in reducing depressive symptoms in heterogeneous groups of patients with depressive symptoms and syndromes, and both were superior to counselling, other therapies or control treatments in primary care.

In addition, there is evidence from a prevention of depression study to show that youth participating in CBT have been found to have significant reductions in their depressive symptoms when they entered the trial with a greater number of past psychiatric diagnoses, lower levels of depression and suicidal ideation (Barbe, 2004).

Fava et al. (2004) the result suggest that the sequential use of cognitive behaviour treatment after pharmacotherapy improves the long term outcome in
recurrent depression. A significant proportion of patients with recurrent depression might be able to withdraw from medication successfully and to stay well for at least 6 years with a focus on psychotherapy, which is aimed at restructuring patient’s personality.

At 18-month follow-up, relapse rates in the CBT plus antidepressant group were reduced by 45-50 per cent compared with the control group (Paykel, Scott, Cornwall et al., 2005).

According to Clarke (2005) cognitive behavioral therapy for depression is a currently focused, time-limited, collaborative approach. It emphasizes the significance of a careful consideration or functional psychoanalysis of cognitive and behavioral factors associated with primary symptoms. The CBT therapist commonly aims to accomplish one or more of the following: decrease depressingly distorted cognition, develop problem solving and coping skills and enhance youths’ and patients’ participation in healthy, enjoyable actions. CBT treatments frequently consist of necessary skill-building sessions and optional modular session for particular problems. Studies have integrated variants of CBT, with some placing a larger emphasis on cognitive reorganization and others taking a more behavioral and modular skills educational approach, such as the adolescent coping skill classes for depressive classes.

Another study found that individuals with mild or moderately severe depression did equally well with either 8 or 16 sessions, but those with severe depression showed better response with 16 sessions (DeRubeis et al., 2005). Three recent large efficacy trials by Scott, Colom and Vieta (2006) used CBT, family therapy, or group psycho-education, respectively. They found that depressive patients
have been benefitted more and these therapeutic modalities were effective in their relapse prevention.

Rohde (2006) found that CBT intervention was more effective for depressed Caucasian youth, than a life skills control condition, whereas non-white adolescents had similar recovery rates across conditions.

Stuart et al. (2006) describes the effectiveness of cognitive behaviour therapy for depression. Studies have shown that cognitive therapy is an effective treatment for depression and is comparable in effectiveness to antidepressants and interpersonal or psychodynamic therapy. The combination of cognitive therapy and antidepressants has been shown to effectively manage severe or chronic depression. Cognitive therapy also has proved beneficial in treating patients who have only a partial response to adequate antidepressant therapy.

Good evidence has shown that cognitive therapy reduces relapse rates in patients with depression, and some evidence has shown that cognitive therapy is effective for adolescents with depression (American Family Physician, 2006).

Five longer-term randomized controlled trials have now shown relapse and recurrence reduction with CBT (Paykel, 2007). In the cognitive interventions, client learns to recognize maladaptive, negative thoughts and to substitute (alternate, replacement) these for more realistic, constructive thoughts. In the behavioural interventions, clients are encouraged to engage in behaviours that elicit positive reinforcement, avoid negative reinforcement from the environment, and generally enhance and improve feelings of self–respect (Hopko, Lejuez, Ruggiero & Eifert, 2003; Cuijpers, Van Straten & Warmerdam, 2007).
Similar to manualize face to face CBT, the treatment comprises a balanced set of home-work assignments and scheduled therapeutic sessions in which assignments are explained and adapted to the needs of the clients. CBT has been shown to help patients with previously untreated depression but there is currently little evidence about what alternative treatments doctors should discuss with patients if they have not responded to antidepressants (Wiles, 2009).

David & Tolling, (2010) describes the more effectiveness of cognitive behaviour therapy than other therapy. Cognitive Behavioral therapy (CBT) is effective for a wide range of psychiatric disorders. However, it remains unclear whether CBT is superior to other forms of psychotherapy, and previous quantitative reviews on this topic are difficult to interpret.

David & Tolling (2010) reported that the evaluators have found that CBT was superior to psychodynamic therapy; although not interpersonal or supportive therapies at post-treatment and at follow-up. Methodological strength of studies was not associated with larger or smaller differences between CBT and other therapies. Researchers' self-reported allegiance was positively correlated with the strength of CBT's superiority; however, when controlling for allegiance ratings, CBT was still associated with a significant advantage. The superiority of CBT over alternative therapies was evident only among patients with anxiety or depressive disorders. These results argue against previous claims of treatment equivalence and suggest that CBT should be considered a first-line psychosocial treatment of choice, at least for patients with anxiety and depressive disorders.

Cognitive Behavioral Therapy (CBT) is an effective treatment for depression. At the heart of CBT, it is an assumption that a person’s mood is directly related to his
or her patterns of thought. Negative, dysfunctional thinking affects a person's mood, sense of self, behavior, and even physical state. The goal of Cognitive Behavioral Therapy is to help a person learn to recognize negative patterns of thought, evaluate their validity, and replace them with healthier ways of thinking. At the same time, therapists who practice CBT aim to help their patients change patterns of behavior that come from dysfunctional thinking. Negative thoughts and behavior predispose an individual to depression and make it nearly impossible to escape its downward spiral. When patterns of thought and behavior are changed, according to CBT practitioners and researchers, mood is also changed (Goldberg, 2012).

However, there are studies that have expressed reservation about the effectiveness of CBT. Sadock & Sadock (2000) has reports reservations on efficacy of CBT. Most subjects in his studies were “dysphoric”, and thus the review (on CBT) could not aid in determining whether cognitive-behavioural strategies are efficacious in more severely ill adolescents with major depressive disorder or bipolar I disorder. The short-term benefits of cognitive-behavioural therapy do not necessarily translate into long-term successful outcome. In some (but not all) cases, psychosocial treatments may substantially improve long-term outcome in the most severely ill young person’s when combined with pharmacotherapy. Systematic data are lacking regarding the utilization of cognitive therapy for severe, psychotic, or melancholic depression, and for depressive episodes in bipolar I disorder. In view of the limited number of studies, cognitive therapy is not recommended as the initial treatment for depressed inpatients. Patients with long standing chronic conditions who have been treated by many professionals without lasting results may not do well in time-limited cognitive therapy. Sometimes an appropriate pharmacological agent
added to cognitive therapy will produce a synergistic effect. In any event, cognitive therapy is not a panacea even though its success rate is respectable.

According to Lynch et al. (2009) a review of literature suggests that CBT is ineffective in preventing relapse in bipolar disorder. The review also suggests that CBT has only a weak effect in treating depression. This inspired the researcher to test the effectiveness of CBT on Indian sample.

The huge research studies on depressive disorders and Cognitive Behaviour Therapy are difficult to summarize, however, salient features of the review of literature is briefed as follows.

Depression has not divorced human race. In a way, depression is with human being since time immemorial. It is evident from the review of literature that the depression has affected every culture, race, caste, class, society and nation. That is why effective socio-economic measures have been outlined by WHO (2011) so as to save human race against the catastrophic effects of depression.

Sadness and elevated mood are main features of depression. Depression has negative effects on personal, social, and occupational life of individuals, besides, it puts burden on national economy. It carries high risk in suicide. Woman has higher rate of prevalence of depression than in man. Women manifest depression in 30s, while men manifest depression in 50s. Contributing factors for depression in female are e.g., their traditional role with lower status; caring spouse, family, child and house, less economic power, violence, and their physiology. Host of theories viz., learning, child rearing, biological, sociological, life events, personality, gender, economical, cultural, and environmental are partially conclusive. Research gaps viz., sampling, sample-size, cross-cultural/national studies, are controversial matters in
research on depression also. Not a single double-blind study on CBT in treatment of depression has been found. Negative aspects viz., life events(e.g., death, divorce, separation, suicide), low self-esteem, strained relations at home & at work, unemployment, low income, marital disharmony, personality/temperamental problems, any sort of discrimination, lower caste/category/class/social status, violence, are some of the major contributing factors in depression. Some of the protective factors against depression have been found in the review, e.g., familial support, sustainable income, cordial married life, employment and distribution of wealth among under-privileged communities.

The foundation of Cognitive Behaviour Therapy is mainly on the premise of thinking and behavior. CBT emphasizes that in depression, negative thinking (distorted cognition) results in negative behavior (dysfunctional behavior) and vice-versa (Beck, 1976 & Meichenbaum, 1977). If cognition is changed, behavior changes; if behavior is changed, cognition changes.

There are mixed findings on the effectiveness of CBT in treatment of depression. Moreover, CBT is choice of psychotherapy in mild to moderate level of depression. But its efficacy in all types of depressive disorders is not well documented. Cross-cultural and cross-national effectiveness of CBT is not found in literature. There is high public demand for psychotherapies in western countries. Such demand in India will take time as ours is developing economy and superstition is rampant. Guidelines for psychotherapy are less well developed and less robustly based than for pharmacotherapy. Such a state of affair suggests further investigation on the subject.