Introduction
Depression is a part and parcel of human existence ever since the dawn of human consciousness. It has accompanied him throughout his history and the world's literature has chronicled it with the intensity and care that so ancient and so widespread a condition warrants. Reports of depression have been found in most ancient literary texts. Thousands of years ago, the Book of Job recorded psychopathological depression and in a more contemporary vein, the poetry of Gerard Manley Hopkins gives an immediacy and poignant horror to the anguish of depression (cf. Mendels, 1970).

Descriptions of affective disorders are found among the early writings of the Egyptians, Greek, Hebrews, and Chinese; similar descriptions are found in the literary works of Shakespeare, Dostowsky, Poe and Hemingway. The list of historical figures who suffered from recurrent depression is a long and celebrated one, including Moses, Rousseau, Dostowsky, Churchil, Lincoln, Tchaikovsky, & Freud (cf. Coleman, 1976).

In the contemporary society, mental illness, which now affects between 10 to 25 percent of the Indian population, could be a case of depression, a psychotic illness, substance abuse or a personality breakdown. Depression which constitutes almost 70 percent of all mental
illness, has taken alarming proportions, nudging the medical world awake (Mendonca, Prasad, & Ragunatha, 1993).

According to Dr. D. Mohan, Head of the Department of Psychiatry, All India Institute of Medical Sciences, New Delhi: Depression, the disease has been present for ages. The only reason why it is more visible now, is because the social structure is changing and the nuclear family can not give the support that the joint family could.

Today, the social support network is much smaller. With competition becoming the main driving force in today's world, everyone is busy trying to be one-up over the other and striving to keep an image afloat. This can wreck havoc in personal lives, especially now, in an age of eroded trust. With coping skills at a premium, stress, anxiety and depression could be natural outcomes. If not solved in time the acuteness may be exacerbated. One can talk a person out of general depression by patient listening, understanding and advice, but depression, the disease, is not so easy to get rid of (cf. Sunday Magazine: The Indian Express, April 18, 1993).

There is sufficient evidence of a growing interest in this topic outside psychiatry. Apart from the enormous disability and economic cost of depression, its well established treatability makes it a priority topic for attention in any public health strategy programme that aims to deliver efficiency (financial) as well as efficacy (clinical, social and economic functioning).

The depressive script as derived from empirical studies of depression related behaviour (Gotlib & Robinson, 1982) and the
description of a major depressive episode (with psychomotor retardation) in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, American Psychiatric Association, 1980) clearly suggests that the persons in the depressed condition express pessimism (e.g., "Right now I am so far behind, I "ll never catch up"), apathy (e.g., "I have given up"), helplessness (e.g., "It does not seem to matter what I do, I just fall farther behind"), and sadness (e.g., "Being with other people makes me feel more alone") regarding their academic and relationship problems. They also limit eye contact and speak slowly in a low, monotonous tone, with an increased latency response. Deficits in energy (e.g., "I am really not up to it") and interest in social activities (e.g., I have not felt like going out with friends or anyone") are also acknowledged.

Diagnostic schemes, such as the revised third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R, American Psychiatric Association, 1987) identify cardinal symptoms that include distinct patterns of daily behaviour (e.g. social isolation) and a list of psychological states (depressed mood, low energy, poor concentration, loss of interest in normal activities, feelings of fatigue, psychomotor agitation, and a sense of worthlessness) presumed to permeate much of a person's working hours. Although there is an increasing recognition that pessimism may be expressed differently in childhood and adolescence than in adulthood (Carlson & Gaber, 1986; Rutter, 1986), these features of daily behaviour and psychological experience are included in most classifications of depression (McConville & Bruce, 1985). More recently, Larson, Raffaelli, Richards, Ham, & Jewell (1990) found that depressed youth reported more negative effect and social emotions, lower psychological investment, lower energy, and greater variability in affect.
These differences were weaker for 5th and 6th grades, suggesting that self-reported feeling states are a poor indicator of depression prior to adolescence.

These core symptoms represent a distillation of the observations on depression made by clinicians from the beginning of recorded history. Kraepelin's description of what he called "melancholia simplex" neatly summarizes the nine diagnostic criteria of DSM-III-R in a precise, descriptive paragraph.

"... the mood is dominated by a profound inward dejection, the patient is hopeless; he is indescribably unhappy, skeptical. Everything is disagreeable, he sees only the dark side of life; the world appears to him aimless, and he feels superfluous. Phobias may occur in simple melancholia, and the patient is tormented with guilt feelings. Energy is virtually absent, the patient has depressive concomitants such as decreased sexual interest, anorexia and weight loss, sleep disturbance with early morning awakening, and psychomotor retardation" (Kraepelin, 1921).

In the case of DSM-III-R, the presence of diminished mood or loss of interest or pleasure in all activities for at least two weeks together with a cluster of other symptoms from the somatic field and psychological domains, is necessary for a diagnosis of major depression to be made. Predictably, the longstanding diagnostic confusion in the realm of mood disorders renders problematic any comparison between older and newer studies of its epidemiology. If psychiatry is to be considered science, its classification systems must be prepared to change as new discoveries are
made. The fundamental challenge is to define exactly when depression crosses the line from being a normal experience into a pathological state.

WHY A STUDY OF DEPRESSION IN ADOLESCENCE?

Development is a complicated process in which many components influence each other. Psychologists, sociologists, physiologists, educators, psychiatrists, and others, have tried to tease out the elements that are most critical to healthy development (Quadrel, Fischhoff, & Davis, 1993; Zaslow & Takanishi, 1993).

In presenting this study of adolescent's depression, it seems prudent to start by a brief mention of reasons for selecting period of adolescence. Although, scholars have written about adolescents for centuries, and a developmental phase called adolescence was identified at the beginning of this century, research on adolescence has been meager (Peterson, 1988; p. 583). Despite, the paucity of research on this topic, most people believe they know what adolescence is like and are unreceptive to findings that challenge their beliefs (Brooks-Gunn & Peterson, 1984, cf. Peterson, 1988).

A number of authors (Peterson, 1988; Santrock, 1987; Steinberg, 1985; Conger & Peterson, 1984; Adelson, 1980) have made a comprehensive review to communicate the flavor of current research on adolescence. According to Peterson (1988), three major areas in which there has been a great deal of recent psychological research on adolescence include: (a) adjustment or turmoil, (b) puberty and its effects, and (c) adolescent - family relations. All three areas have long traditions of work, though, in each case the current work is of a different nature, in part because of technological advances. For example, research on the biological
changes of puberty was advanced by the development of radioimmunoassay as a technique for measuring hormones; psychological research on puberty was then stimulated by the exciting biological findings. Similarly, parents-adolescent interaction research has been aided by audio and video technology, especially when accompanied by computer monitoring and storage of information on-line.

Given the belief that adolescence is characterized by moodiness, it is odd that there is a little research on this topic. Larson, Csikszentmihalyi, & Graef (1980), using the method of random time sampling with automatic paging devices, found more mood variability among high school students than among adults.

Adolescence, especially during the early years, is a period of important developmental changes and a time of stress and conflict. The physiological changes often precipitate special problems and doubts about self-concept, sexual identity, and relationships with others (Musen, 1973). Research indicates that important changes in personality and cognition occur during adolescence, with early adolescence being the most crucial time. Kagan (1971) maintains that changes that occur during puberty "justify the positing of a psychological stage called early adolescence" (p. 998). Early adolescence encompasses the age range of 12 to 15 years (Loevinger, 1976; Gordon, 1971).

At this time, society makes numerous demands on the individual and it is expected that these demands will be met within a very short period of time: achieving independence from the family; establishing satisfying give and take relationships with peers of both sexes; undertaking new tasks and social roles, and deciding on and preparing for
a meaningful vocation (Kulas, 1986; Mussen, 1973). Further, adolescence is a time of transition with a focus on becoming independent from parents and forming supportive links with peers and other adults. Stress-related problems may become more common and an increase in depression, suicidal ideation, and suicide are seen. Yet few adolescents seek help from counseling or health care facilities in dealing with their mental health needs.

The literature reveals that depression in adolescents has long been conceptualized as a normal or transient phenomenon necessitating no therapeutic intervention (Lefkowitz & Burton, 1978; Werry & Quay, 1971; Lapouse, 1966). This had the effect of limiting research in this domain of childhood and adolescent psychopathology. In the early 80s, the results of clinical reports and epidemiological studies reflecting high rates of depression and suicide in the adolescent population, and the publication of the DSM-III in which it was recognized that adult criteria could be used to diagnose depressive disorders in children and adolescents, markedly influenced the emergence of research on adolescent depression. These changes in the applicability of the adult diagnostic criteria for depression in adolescents have led to greater acknowledgement of the existence of depression in adolescents as a recognizable disorder while recognizing that developmental factors could influence the phenomenology of that disorder at different ages.

Studies conducted with the general population in Canada and the United States reported the presence of depressed mood in 20 to 35% of male and 25 to 40% of female adolescents. Out of this sample, 4 to 12% of adolescents present with characteristics of clinical depression (Marton,
Rates are higher in clinical samples, up to 42% across studies (Peterson, 1993), making depressive disorders the most frequent diagnosis applied to young people seeking help in mental services (Kashani et al., 1981). Depressive symptoms increase from childhood to adolescence, and a marked increase appears between the ages of 13 and 15, reaching a peak around 17-18 years of age, and later stabilizing at the adult rate (Radloff, 1991; Rutter, 1986, 1991; Angold, 1988). Rates of depression for girls have been shown to be higher than for boys. This discrepancy seems to appear at 14-15 years of age and remains present throughout adulthood (Reynolds, 1985; Rutter, 1986; Teri; 1982). The devastating effect of depression during adolescence is also reflected in the fact that the incidence of a depressive episode during that stage of development is productive of recurrent depressive episodes later in adolescence or adult life (Harrington, Fudge, Rutter, Pickles, & Hill, 1990; Kovacs et al., 1984).

For example, Kandel & Davis (1986) found a consistency between 15 and 24 year old subjects in depressive symptoms. Depression during adolescence was also associated with lower psychosocial functioning in young adulthood.

Epidemiological studies of adolescents have found that 10 to 30% of teens may be depressed at a given time and that somatic complaints may also be a part of their presenting picture (Garrik, Ostrov, & Offer, 1988; Wells, Deykin, & Klerman, 1985; Kandel & Davis, 1982; Carlson & Cantwell, 1980).
SEX AND AGE DIFFERENCES IN DEPRESSION

Sex and age are routinely included as variables in almost all empirical research. A look at these variables in the developmental research of depression shows the following:

An increase in both depressive feelings and depressive disorders and a change in sex ratio for such disorders take place in adolescence (Brooks-Gunn, 1991; Rutter, 1986); while most research has reported no clear sex difference in depression in childhood, and some studies a male excess, it is clear that there is a change in the sex ratio around puberty: from adolescence on, the rates for females in depression exceed those for males. The mechanisms underlying these changes are of great interest in developmental research into depression. The importance of pubertal changes, the cumulation and timing of stressors, coping, parental and peer support, transition times and key turning points are among the issues studied.

First, why an increase? It seems unlikely that an increase in depression could be explained by differences in reporting or case definition. Hormonal changes, emotional and cognitive development are among the possible explanations given. In many studies age and pubertal development are confounded, but those workers who have separated these two suggest that an increase in depression is associated with puberty. Pubertal children of both sexes are depressed more often than prepubertal of the same age (Rutter, 1986). It has been suggested that the increase could be due to an increase in risk factors: adolescents experience more stressors or loss events than do younger children, and they may also
experience a decrease in protective factors by having less family support than younger children.

Why more girls? Several explanations have been put forward. Some studies have suggested that girls experience is more stress associated with physical maturation and growing up into a woman's role or in their social environment (Peterson, 1991). Others have suggested that girls might have less resilience or that the coping strategies of girls are less effective and more dysfunctional than those of boys.

On the other hand, when one thinks about the greater prevalence rates of antisocial acts, alcohol problems and suicide among boys than girls (Aro, Marttunen, & Lonnqvist, 1992; Aro, 1988; Almqvist, 1986) one may seriously question the earlier explanations and ask whether there really is a difference in well-being between the sexes, and do boys just express their ill-health in other - and even more destructive - ways?

Some research support for each of the explanations presented can be found in the literature, but these questions have by no means been answered.

One may also ask whether the phenomenon of depression is similar or dissimilar among the sexes. In a prospective longitudinal study, Block and coworkers (Block, Block & Gjerde, 1991) reported that, for boys aged 7, to be aggressive, self-aggrandizing and undercontrolled predicted depressive tendencies at the age of 18, whereas for girls it was to be intropunitive, oversocialized, and overcontrolling. In the same study, preschool IQ correlated positively with dysthymia in girls and negatively in boys.
These examples demonstrate that even the most basic variables, sex and age - provide us with further questions and challenges for research.

CONCLUSION

Although the presence of depressive symptomatology in children and adolescents has been amply demonstrated, much less is known about the phenomenon in these age groups than in adults. Further, the inconsistency of findings of the empirical research is a cause for serious concern (Kazdin & Petti, 1982). In order to help clarify a variety of conceptual issues, there is a pressing need to learn more about normative patterns of depression among normal as well as clinical population (Achenbach, 1982), and to examine the possible contributions of developmental level, gender, and other relevant variables to variations in normative parameters (Worcel, Nolen, & Wilson, 1987; Smucker, Craighead, Craighead, & Green, 1986; Kazdin & Petti, 1982).

Although, there has been far fewer prevalence or incidence studies of depression in non-clinical populations, the growing literature on psychiatrically normal population in the last few years suggests that adolescents are substantially more depressed than children (Angold, 1988; Rutter, 1986), and that they may be more depressed than adults (Garrison, Shoenbach, & Kaplen, 1985; Shoenbach, Kaplan, Grimson, & Wagner, 1982).

More precisely speaking, in recent years, there has been an increased interest in the phenomenon of adolescent depression in terms of both theoretical and clinical perspectives. However, most of the investigators showing interest in the phenomenon of adolescent's
depression, have based their conceptualizations of adolescent depression on clinical samples. We, thus, do not know to what extent the multitude of findings that have emerged from the adult literature in the recent past and clinical samples of adolescents are generalizable to non-clinical samples of adolescents. The data of depressive symptomatology among clinical samples of adolescents, are limited in their generalizability to nonclinical population of adolescents.

From a preventive perspective, given the sharp rise in adolescent suicide (Frederick, 1985) and the finding that being depressed substantially increases the likelihood of having further episodes (Amenson & Lewinsohn, 1981), it is critically important that clinical investigators turn their attention to the study of depression in this age group. Further, this is particularly important because of the rising rates of adolescent suicide, substance abuse, school failure, and juvenile delinquency, all of which have been linked to adolescent delinquency, all of which have been linked to adolescent depression (Gibbs, 1981; Chiles, Miller, & Cox, 1980; Greuling & DeBlassie, 1980; Lesse, 1979; Offer, 1979; Finch & Poznanski, 1971; Chwast, 1967).

Keeping in view what has been said in the preceding paragraphs, the purpose of the present study was to explore the prevalence of depression and the relationships between prevalence of depression and various sociodemographic factors in the adolescent population of India and Iran by giving special weightage to gender (males vs. females) and age (mid-adolescence vs. late adolescence). The present cross cultural study of
Indian and Iranian adolescents has been conducted using an internationally accepted diagnostic instrument for assessing depressive symptoms.*

* Differences in definitions (e.g., symptom manifestation vs. clinical diagnosis operationalised in DSM-IV or ICD-9), methods of assessment (e.g., Self-report vs. ratings) and target populations (e.g., general population, medical patients, psychiatric patients, variation in the age of the population) may partly explain the divergent results, but there may also be real differences between countries. More precisely speaking, one has to remember that there are differences between the studies in the definition of the disorder, the age distribution of the sample and the period from which the prevalence is given. A substantial part of the differences between the rates may be due to these facts. All studies are community surveys of samples representing the adult population, and all have used clinically defined case finding methods.