CHAPTER II

REVIEW OF LITERATURE

A great deal of research has focused on determining significant risk and protective factors that predict suicide ideation. However, the suicide process, especially suicide ideation, is complex (Wu & Bond, 2006). A majority of people who experience suicide ideation do so as the result of a combination of risk factors and precipitating life events (Gould & Kramer, 2001). There are numerous risk and protective factors believed to be associated with suicide ideation, attempts, and completion: depression, ethnicity, family socioeconomic status, prior suicidal behavior, anxiety, hopelessness, substance use, family and relationships issues, aggressive/impulsive behaviors, physical and sexual abuse, stressful life events, impaired coping abilities, exposure to suicide, low self-esteem, homosexual or bisexual orientation, poor communication with family members, family discord, financial problems, personality, aggression, poor academic achievement and performance, and poor peer relationships. Cukrowicz, Wingate, Driscoll, & Joiner, 2004; Dogra et al., 2008; Furr, knowing that these predictive factors are associated with suicide ideation allows clinicians in both mental and physical health settings to identify people who are at a greater risk for suicide ideation, and thus, efforts can be made to prevent the suicide process from beginning or progressing beyond suicide ideation.
One strong predictor of suicide ideation in adults is depression. Depression in adults is frequently reported by those who have engaged in suicide attempts (Bae, Ye, Chen, Rivers & Singh, 2005). In addition, research has found that affective disorders, specifically a depressive episode, are common psychiatric diagnoses among people who have completed the act of suicide addition, various studies have reported a significant relationship between depression and suicide ideation among college students, where high levels of depression are associated with high levels of suicide ideation. Furthermore, numerous studies have conducted multiple regression analysis that revealed depression is a strong predictor of suicide ideation. (Gibb, Andover, & Beach, 2006; It is evident that past research has shown high levels of depression to be associated with increased suicide ideation, suggesting that depression is a significant predictor of suicide ideation (Furr et al., 2001; Hirsch, Conner, & Duberstein, 2007; Kumar & Pradhan, 2003; Lipschitz, 1995; 2008; Stephenson et al., 2006; Thompson, Thus, depression is a risk factor predictive of suicide ideation.

Hopelessness is another risk factor that predicts suicide ideation in adults. Hopelessness is the experience of despair or extreme pessimism about the future (Beck, 1979). According to Scheneidman (1996), hopelessness- helplessness is the most common emotion experienced among suicidal people. Numerous studies have found a link between feelings of hopelessness and suicide ideation, attempts, and completions.
For years research has supported the notion the hopelessness is a significant predictor of suicide ideation among college students.

Religiosity is also a predictor of suicide ideation often acting as a protective factor against it. Research related to the protective effects of religion against suicide ideation is extensive. In general, research supports that suicide risk is lower in people who are religious compared to those who are nonreligious (Maris, 1982). Various studies have shown that people who report being more religious also report lower levels of suicide ideation, and people who report being less religious also report greater suicide ideation. Different aspects of religion are though to protect against suicide ideation: the integrative benefits of religion, such as social support; the culture of hope represented by religion; and/o the moral constraints of religious beliefs that coincide will religious affiliation and practicing religion, given that many religions maintain belief prohibiting suicidal behavior (Dervic et al., 2004).

Research involves taking the advantages of the knowledge, which has been accumulated in the past as a result of constant human endeavors. It can never be undertaken in isolation of the work that has already been done on the problems related to a study proposed by a researcher. Review of related literature is an important prerequisite to actual planning and then execution of any research work. It helps in acquiring information about the studies done in the field, it facilitates in avoiding unnecessary
duplication and renders it possible to make a comparative study.

The problem of the present study was conceived by the researcher after reviewing thorough literature related to mental disorders. The researcher perceived that the two most common mental disorders were depression and anxiety among people falling in each age group may to be childhood, teenage (adolescence), adulthood or aged ones. The prevalence of depression was twice in women than the men due to various gender-related factors in their cognitive styles, life-styles, biological factors, psychological factors and economic stresses.

**Studies Related to Depression**

Various studies are conducted so far related to depression and anxiety and its causing factors. Some of the reviews of related studies are described here in the following chapter.

The Center for Mental Health Research (CMHR), The Australian National University (2001) described various factors which play a role in the onset of depression on the basis of exhaustive survey and counseling session. These factors were grouped in four categories:

- Biochemistry (mainly two chemicals in brain-Serotonin and norepinephrine were thought to be responsible for causing depression, anxiety, irritability and fatigue.)
- Genetics

- Personality - People with low self-esteem, who are easily overwhelmed by stress, or people who are pessimistic appear to be vulnerable to depression.

- Environmental Factors Continuous exposure to violence, neglect abuse, poverty may make people susceptible to depression.

CMHR also described, "how depression is treated". After a proper diagnosis through an interview and a physical examination, best treatment is determined psychotherapy and medications are prescribed together for quick and favourable results.

Winter Depressions 58-70" N is a cross-disciplinary, collaborative research project approved by The Norwegian Data Inspectorate and The Ethical Committee for Medical Research in health Region V (Northern Norway). The project was taken by Department of Psychology, University of Thomso, N-9037 Tromso, Norway in December 1999. The data collected by Norway Natural Research Laboratory was utilized to study association between natural daylight variations and seasonal affective disorder, depression, subjective well-being/quality of life, eating disturbances, sexual interest, sleep disturbances, personality traits, cognitive performances. The most suggestive therapy was light treatment to over come winter depression.
Tipper Gore (2002) provided on the line support depressed He worked a lot to Eliminate outdated Attitudes on Mental He showed pathways to help people in depression such as

- Worst things to say to some one who is depressed
- Better things to say to some one who is depressed (if you mean them)
- What does depression feel like?
- When you get depressed during holidays.
- You cannot fight depression by yourself
- Share with you partner, family, friends or counsellor/doctor.
- Help yourself get through depression on a day-to-day basis by changing your attitude, life style.

Students of Department of Psychology, University of Florida (2002) worked on "How to Deal with Depression". They found that to large degree, the manifestation of depression depends on the person's coping style, personality, and previous level of functioning. By adopting survey methods and organizing counseling session, they could find out some symptoms of depression falling in the following areas
Emotion

- Blunted emotional presentation or frequent crying spell
- Difficulty in finding pleasure in life activities such as
- Decreased sexual desire
- Profound feelings of guilt or shame
- Feelings of hopelessness and helplessness
- Could or distant feelings towards family or friends.

Behaviour

- Decreased interest in participating in activities previously enjoyed.
- Diminished interest in maintaining one's hygiene and appearance.
- Neglecting responsibilities
- Reduced coping ability and impaired communication with others (e.g. irritating, sarcastic).

Physical Complaints

- Loss of energy
- Headache, backache, general muscle ache without a specific cause.
• Compulsive eating or loss of appetite.

• Gastrointestinal problems (e.g. stomach pain, nausea, change in bowel habits.

• Insomnia or excessive sleeping.

The person suffering with such symptoms was found to be severely depressed and needed consultation with the professional counselor to understand the various causes of depression.

Treatment options were provided, Careful attention to determining source of inner conflict, strained emotions and behavioural changes is critical for addressing the development of depression and highlighting treatment options.

Key suggestions for offsetting depression were provided.

American Psychiatric association (2003) as a cosponsor of the National Public Education Campaign on Clinical Depression, in co-operation with the National Mental health Association, National Alliance for the Mentally III, National Depressive and Manic Depressive Association and the Depression/Awareness, Recognition and Treatment (D/ART) Program, National Institute of Mental Health, produced a series of pamphlets and circulated among the people for educational purposes i.e. to reduce the stigma surrounding mental illness by promoting

According to Dr. John Mann, Professor, Department of Psychiatry, Columbia University (2004), "Depression in children and adults is the major illness that underlines suicide, and we believe that the SSRT (Selective Serotonin Reuptake Inhibitors) class represents the medication with the great efficacy against this very serious condition."

Fifteen Clinical trials used varying methods and had disparate outcomes that SSRTs are effective in treating depression in children and adults.

But Dr. Richard Harrington, the Professor, Department of Psychiatry, University of Manchester, England, said he is still not sure the drugs are effective to control depression. May be they work, but if so, they do not work well."

Critics pointed out that British people did not undertake a sophisticated and difficult "meta-analysis" in which data from many studies are pooled for examinations.

Nancy Schimelpfening, a clinical nutritionist (2004) saw the problem of depression in a entirely different point of view. She felt that treating depression were as simple as taking a vitamin. There are a variety
of vitamin and mineral deficiencies that can lead to depression especially Vitamin B3, Vitamin B6, and Vitamin C.

She also declared that "Better Nutrition Needed, Not Drugs" to control mental illness. Elena Skorodumova, (2004) of Turkmenistan declares that "Depression is the number one disease of the present time."

Keneshbek Usenov, director of the Bishkek Psychotherapeutic Center said that "The World Health organization compares depression to a global epidemic". The 51st session of the WHO announced that depression is now the most frequent reason for absence from work and the second most frequent disease that leads to losing the ability to work. If no measures are taken, by 2020 depression could paralyse the economic life in both developed and developing countries. Specialists forecast that in some 15 years depression could have behind infectious and cardiovascular diseases.

Some of the American Psychologists suggested a Scale of Stress that evaluates the possibility of nervous disorder or depression. The scale includes quarrels, divorces, separation from relatives and friends, addition to the family, a change of job, death of some one in the family (a parent of spouse), personal traumas, and many others each given scores at 7 point scale. Higher the score the person is at a high risk of experiencing depression or mental disorder.
Saphie Lauren (2004) organized a conference on "coping with depression in the family" under the organization "Families for Depression Awareness". The conference was a great success. In this conference, family profiles were taken as a case one by one, and expects opinion were presented as how to cope up with depression.

The organization "Families for Depression Awareness" helps people in caregiver roles with depressive disorders understand the conditions, reduce stigma, and share issues. The organization has provided on line support, on which you can:

- Read and send family profiles to the families you know who are suffering from depression.
- Learn about depression support system books and medical help (the literature and contact members of psychologists and psychiatrists along with nutritionist and provided on line).
- Find out how you can help a depressed person in providing support, seeking treatment or manage treatment.
- Recognize your emotions as a caregiver and family members.
- Become a member of this organization to support the families in depression and helping those families learn about depressive disorders, reduce associated stigma and prevent suicides.
Help the organization is spreading the world that family and friends are more essential in managing their depressive conditions.

Elena Skorodurnova, TCA contributor, Turkmenistan (2004), said we have forgotten our nature. We do not live like people lived thousands and millions of years ago—before money, television, cars, and other comports of civilization. We have forgotten how to sleep, breathe and move. But our body and mind remember every thing and give us reminders in the language of disease and disorders. But we are deaf. Our genetic program however allows the necessity of natural violence. We must lead an active life style, but we are lazy, we chronically overeat, and forget about the elementary rules of a healthy lifestyle. I understand that recommendation like "do something for yourself' alone would not help, but I believe that mankind has a realistic chance to change the situation for the better."

University of Bristol, Department of Psychology (2003) studied on "Pathways to Violence in Children of Depressed Mothers".

They conducted a longitudinal study, studied 122 families living in two communities in South London to see what affect the aging mother's depression has on the development of their children's violent behaviour. The participants were representative of urban populations in contemporary Britain. The mothers were interviewed at the age of 45 years, 55 years and 65 years for their temperament, attitude and
behaviour in the family. Their children were also questioned about violent symptoms. The study revealed that the children who had depressed mothers were more violent and maladjusted. The violence and maladjustment was more common in boys than girls and mostly involved fighting which often led to injury. The results of this and studies reveal that the mother's mental state is an easily identifiable risk factor for her child's intellectual and social development. What is not clear is the mechanism but it is possible that attention and emotional problems shown by the children of depressed mothers had biological origins, possibly related to hormonal mechanisms at work. (The findings are published in "Developmental Psychology" vol. 39 No. 6 and full text of this study is available from American Psychological Association in Washington, DC).

William M. Reynolds (2000) University of British Columbia, Vancouver, BC, Canada described Depression as an internalizing disorder. He also explained tripartite model as Bio psychosocial to mains and interactions which influence the mental disorders. Various self-report measures for assessing the depression among adults, aged and children were described. A range of therapeutic approaches was explained which included nature-therapy, psychotherapy and medication.

Lynn P. Rehm (Department of Psychology, University of Houston) described the traditional view of depression and conceptualized it as an internal emotional disorder which may have interpersonal symptom logy,
such as withdrawal from others and possibly interpersonal conflicts. There is a call from various theorists and researcher to include interpersonal factors in the list of etiological, initiating, maintaining and treatment factors in depression.

Sherryl H. Goodman and Ian H. Gottib (2002), APA: explored the mechanism and moderators for depression and other disorders in children of depressed parents. Among the most common of mental disorders, depression is a highly heritable and recurrent disorder that may be especially prevalent among aging women with adolescent or grown up children. These factors converge to suggest that if children are exposed to depression they are at great risk for developing the mental disorder. In their article, "Children of Depressed Parents; Mechanism of Risk and Implication for Treatment" they have described the mechanism that helps in transmitting risk for developing depression and also at moderators that may help alleviate possible risk. By taking a development approach, the children are examined at various age levels for understanding the risk of developing depression and for providing suggestive measures to treat depression.

Robert J. Reese (Abilene Christian University) and Collie W. Conoley D Daniel F. Brossart (Texas A&M University) found that telephone counseling was beneficial and satisfactory, marked by specific improvement on the issue that lead to counseling and global improvement
in emotional state of the 186 respondents, 68 percent reported feeling very or completely satisfied with the telephone counseling and 53 percent said they felt somewhat better as a result of counseling. In the case of severe depressed people telephone counseling did not appear to work as well as face to face counseling.

In contrast to face to face counseling, telephone counseling was found convenient and less expensive by the clients and the therapists also. For people who do not have therapists also. For people who do not have access to affordable mental health care, telephone counselling may be a viable option. It was also pointed out by the researchers that without an office, clothes and physical appearance to potentially distract them, client being counseled via phone may be comfortable and inclined to focus better on what the therapist says.

D. Smith (2002, American Journal of Psychiatry) shows that Placebo medication can induce changes in brain functioning for individuals with major depression.

Andrew F. Leuchter (Psychiatrist) & Elise A. Witte (Psychologist) their colleagues used quantitative electroencephalography to measure differences in brain function between a group of 25 participants with depression who received antidepressants and another group of 26 who received a place be. Over nine weeks, the researcher found that 52 percent of antidepressant group and 38 percent of the placebo group
responded to treatment. However, "the two groups" brain responses were very different. Medication responders showed brain function changes within 48 hours of starting treatment with suppressed activity in the brain's prefrontal cortex, while the placebo responders changes began to occur after one to two weeks but with increased activity in the area.

The researchers say that findings raise doubts about medication and placebo to be compared and for this, further studies are needed to conduct long term follow up of clients and examine other conditions. They further add that "These findings show us that there are different pathways to improvement for people suffering from depression. Medications are effective, but there may be other ways to help people get better without any side effect."

National Institute of Mental Health (NIMH) 6001, Executive Boulevard, MSC 9663, Bethesda, MD 20892-9663 in NIH publications (September 2002) gives description about major depression, its symptoms, possible causes, diagnosis of depression and all possible treatments. These publications provide helps and hope for the depressed people, family and friends.

Even current studies as clinical trials on Depression and other mood disorder are published by NIH. Various researches were conducted and summaries were presented in conferences and workshop help by NIH. Some of the topics discussed are as follows:
• "Challenges in Preventing Relapse in Major Depression" (May 2001)

• Depression can Differ in Men and Women (March, 2001)

• Maternal Depression Round table : Prevention and Treatment of Depression in Adults, Aging or Aged (January, 2001)

• Genetica and Mental Disorder (September 1977)

Time to time various articles were released by NIH to treat Depression:

• Gene More Than Doubles Risk of Depression following Life Stresses (July, 2003)

• Medication and Psychotherapy Treat Depression in Low-Income Minority women (July 2003).

• New study of Treatment for Minor Depression (March 2003) Depression, Bone Mass, and Osteoporosis in Aging Women (July, 2001)

• Educating Older Americans and Health Professional about the Risks of Depression (August 1999).

These seminars & workshops, articles and newspaper releases provide information for health professionals and consumers, and links to
consumer health information, from the NIH and outside organizations (also in Spanish and other Languages), dictionaries, lists of hospitals and physicians. These publications have provided clear guidelines of treatment and symptoms to diagnose the severity of depression.

Lynanne (MC Guire. Ph.D. of John Hopking School of Medicine and Co-authors Janice K. Kiecolt-Glaser, Ph.D, and Ronald Glaser, Ph.D. of Ohio State University College of Medicine found that even chronic, sub-clinic mild depression may suppress an older person's immune system. Those with chronic milk depression had poorer lymphocyte cell responses to 2 mitogens at the follow up 18 months later. And the older a person was the poorer the immune response was to mitogens - a model for how the body responds to outside agents, like viruses and bacteria.

Persistent Mild Depression in Older Adults May Lower Immunity and Ability to Fight Off Disease, According to new study reported on this month's Journal of Abnormal Psychology, Published by the American Psychological Association (APA) is an 18 months prospective study of 78 older adults (Average age of 72.5 year old) that compared those who suffer from chronic depression (22) and those who don't (56) on their ability to generate enough white blood cells to fight off an infection agent.
There was no significant difference found for risk of depression between those who were married, those with more education or those at a higher income level. All the depressed Participants reported clinically relevant depressive symptoms at the beginning of the study and 18 months later, said McGuire, but fewer than half of these participants met formal diagnostic criteria for depression. "In this study, it seems that is the length of time of the depression. Not the severity that is affecting a Person's immunity "depressive symptoms can exacerbate and accelerate the immunological declines that typically accompany aging, change in the immune response, including dysregulation of the Proinflammatory cytokintes and endocrine function has been associated with depression as well as aging especially in adults over 60" said McGuie. Others factors in addition to aging can have a role in lowering older adults Immunity. Lack of Social Support has been reported in the research as a risk factor for depression.

McGuire and colleagues postulate the age-related change in cell-mediated immunity causes by mild depression is linked to the increased risk and severity of infection and cancer found in older adults.

Ramos, MI, Allen LH Haan MN, Green R. Miller JW Plasma concentrations are associated with depressive symptoms in elderly Latina women despite folic acid fortification (Am J. Clin Nuter 2004 Oct : 80 (4) : 1024-8) A relation between low float status and depression has been
recognized since the 1960s. Since 1998, flour in the Unit’ States been fortified with folic acid, and the Prevalence of float deficiency decreased dramatically.

They investigated whether, in this era of folic acid fortification, folate status is a determinant of depressive symptoms in a cohort of elderly Latinos (aged >/=60y) Participating in the Sacramento Area Latino Study on Aging (SALSA).

**Design**: In a cross sectional logistic regression analysis of data form SALSA (n=627M, 883F) odds ratio (ORs) were ascertained for depressive symptoms {Center for epidemiologic studies Depression Scale (CES-D) score >/=16}. Depressive symptoms were assessed by using the CES-D.

**Results**: The prevalence of folate deficiency (Plasma folate </=6.8 nmol/L) in the SALA Population was <1% for men, no significant association between folate fertile and high CES-D score in women in the lowest tertile of folate was 2.04 (5% cel : 1.38, 3.02) which was significantly different from that in women in the highest tertile of folate (p<0.001).

**Conclusion**: These data indicate that, despite folic acid fortification, Low foliate status is associated with depressive symptoms in elderly Latino women (but not elderly Latino men).
Studies Related to Age and Depression

It has long been observed that women are about twice as likely to become clinically depressed, as are men. These differences occur in most countries around the world, with the few exceptions coming from developing and rural countries such as tribes in Nigeria and Iran. In the U.S., this sex difference starts in adolescence and continues until about age 65, when it seems to appear (Carison et al, 1998). A number of studies have been carried out in western countries to find out sex differences in depression. According to Weissman and Klerman (1977), in all age groups, rate of depression are higher for women than for men.

A comprehensive review of treated cases and community surveys, as well as demographic studies of suicides and suicide attempts, all point to the clear conclusion that women are more likely than men to become depressed. A review of rates of mental illness of all kinds over childhood and adolescents received that, while boys were more likely than girls to receive treatment for psychological difficulties prior to adolescence, this trend reversed in adolescence (Vove & Herb, 1974), in particular neurotic, transient, and reactive disorders among adolescents showed a preponderance of girls. Another study (Gregg, 1976) found that adolescent girls experienced more internal distress - including tensions, depression, and psychosomatic problems - than did boys. This difference in internal versus external modes of experiencing distress is supported by
the studies on defense mechanisms in adolescent boys and girls (Conger and Peterson, 1984). This investigation revealed that boys tended to externalize conflict through the use of projection and aggression as defensive reactions while girls relied defense that -internalize the conflict, primarily through directing while girls defense that internalize the conflict, primarily through directing aggression inwards - with these sex differences emerging in early adolescence and increasing over the adolescent year (Gramer, 1979).

Questions have been raised about whether these differences stem from some kind of artifact, such as young women in adolescence becoming more willing to report their feelings, but the data do not supports the idea (Nolen-Hocksema 1990; Young et al., 1990). What kind of theories have been proposed that can explain this interesting collection of observations?

One set of theories is biological - for example, suggestions have been made that hormonal factors account for the differences. Studies examining this hypothesis have not been very supportive, however. Other biological theories have proposed that among women and men sharing a common genetic diathesis, women are more likely to become has also addressed the possibility that women are simply more predisposed to depression because of some kind of mutant gene on the X chromosome (of which women have two and men only one). However, research does
not support any of these biological hypotheses, leading us to look at social and psychological factors.

Psychologists have proposed that by virtue of their roles in society, women are more prone to experiencing a sense of lack of control over negative life events. These feelings of hopelessness might stem from any or all of the following: discrimination in the workplace, the relative imbalance of power in many heterosexual relationships, high rates of sexual and physical abuse against women, and role overload. There is at least some evidence that each of these conditions is associated with higher-than-expected rates of depression. There appears to be a growing consensus among researchers that females are more likely to manifest depression and related difficulties than are males because of the stresses inherent in the female sex role (Chesler, 1972; Gove and Herb, 1974; Gove and Tudor, 1973). If so, it would make sense that sex differences in depression would first emerge by the end of the adolescence, because of the gender intensification (Hill & Lynch, 1985) - the narrowing and intensification of sex roles - that tends to occur during this stage.

Another hypothesis is that women have different responses to being in a depressed mood than do men, and it may be these different responses that lead to differences in the severity and duration of depression for women and men. In particular, it seems that women are more likely to "ruminate" when they become depressed. Rumination
includes responses such as trying to figure out why you are depression, crying to relieve tension, or talking to your friends about your depression. Men, by contrast, are more likely to engage in distracting activity when they get a depressed mood, and distraction seems to reduce depression (Nolen-Hocksema, 1990). Distraction might include going to a movie, playing a sport, or avoiding thinking about why you are depressed.

Finally, we must consider why the sex differences only start in adolescence. This is a time for rapid physiological, environmental, and psychological changes known to create turmoil for many adolescents, but why are adolescent females more likely to become depressed. There is evidence that the development of secondary sexual characteristics is harder psychologically for girls than for boys. Body dissatisfaction goes up for females at this time, and down for males; moreover, body dissatisfaction is more closely related to self-esteem for girls than for boys. In addition, this is a time for an increase in sex role socialization. Girls tend to have increased pressure to assume a feminine sex role, and if they accept this somewhat nonassertive, depending role they may be predisposed to anxiety and depression. But if they reject this role, they may in turn be rejected by the opposite sex. One piece of evidence consistent with this hypothesis is that adolescent girls do perceive competence as a liability and tend to conceal their intelligence. Indeed, one study showed a significant positive correlation between I.Q. and
depression in adolescent girls. For boys, by contrast, there was a small negative correlation between I.Q. and depression. Again, much research remains to be done to fully reveal how sex difference in depression emerge in adolescence, but these are intriguing ideas that will be pursued in the future (Nolen-Hoecksema, 1990).

The relationship between sex and depression has been investigated by many psychologists such as Paradiso, Sergio and Robinson, Bobert G (1998) examined gender differences in post stroke depression. They found that women were frequently diagnosed with major depression than men. Byrne D.G. (1981) examined sex difference in the reporting of symptoms of depression in the general population and they found rates of depression for women were higher as compared to men. Compas, Bruce E; Oppedisano, Genri, Connar, Jennifer K; Gerhardt, Cynthia A (1997) studied gender differences in depressive symptoms in adolescence and they found girls scoring higher on depression than boys. Diaz, Gnerrero, Rogelio (1984) investigated the relationship between emotional states and psychopathological behaviour by using male and female subjects. They found female generally suffered more depression. Grueen, Rand, J; Marya and Marrobel, Diana (1994) examined gender differences in the stress-depression relationship. They found that emotional response was significantly related to depressive symptoms in females as compared to males. Similar results are also found in researches done by many

On the contrary, Finch, A.J.; Saylor, Conway F and Edwards Gary L. (1985) investigated children's depression inventory: Sex and grade norms for normal children and they found that females' reported fewer depressive symptoms. On the other hand, there are many investigators who have not found the sex difference in depression. Brown, Diane R. Millburn, Norwesta. Gand, Gary, Lawrence E. (1992) examined symptoms of depression among older African Americans in males and females. However, no gender difference is found in depression. Bryson, Susan, E and Pilov, P; David J. (1984) studied sex difference in depression and the method of administering the beck depression inventory and results show no evidence was found that depression was more severe or common in females that males. Moran, Patricia B and Eckenrode, John (1991) support on adolescents emotional well being. They found that for females social stress was strongly correlated with
higher depression, while for males, social stress was correlated with lower depression dwelling older women.

**Studies Related to Life Style and Depression:**


Cross-sectional study of community dwelling women aged 70 year and over (n=278 mean age - 74.6 year). Lifestyle variables assessed included smoking, alcohol consumption, Physical activity, nutrition, and education. The mental health measures of interest were depression, anxiety, quality of life and cognitive function, as assessed by the Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), SF-36 and the Cambridge Cognitive Examination for Mental Disorder of the Elderly (CAMCOG), respectively,

Results: Physically active women and half as likely to be depressed (BDI score >or=10) and anxious (BAI score >or=8) when compared to their physically inactive counterparts (OR=0.5, 95% CI=0.3-0.8 for both, adjusted for marital status and smoking in the case of depression). Having ever smoked more than 20 cigarettes per day was associated with increased risk of depression (OR=2.08, 95% CI=1.4-5.5 adjusted for marital status and physical activity). Moderate alcohol use was associated
with increased likelihood of having a CAMOG score with in the highest 50 percentile (OR=2.0, 95% CI=1.1-3.5, adjusted for age and education), as was more than minimum statutory education (OR=2.0, 95% CI=1.14-3.5, adjusted for age and alcohol consumption.

Conclusion: The results of this study are consistent with the hypothesis that depression is directly associated with heavy smoking and inversely associated with Physical activity. They also support the idea that non-harmful alcohol consumption is associated with better cognitive performance. Randomized clinical trials should be now designed to clarify whether management of lifestyle factors reduces the incidence of mood disorder and cognitive impairment in later life.

Tzvia Blusmtein, Yael Benyamini, Zahava Funchs, Ziva Shapira
liya Noviloy Adrain Walter - Ginzburj, Baruch Modam the effective of Communal Lifestyle on Depression Symptoms in Late Life. This study compares depression levels life time Kibbutz members (n=525) and old age Kibbutz residents (n=366) with a comparable national sample (n=412) and assesses the relationship between de d individual differences related to life time in a Kibbutz (e.g. health) and those related to current living condition (e.g. social network). The analysis is based on data from the Cross sectional and Longitudinal Aging Study conducted is Israel between 1989 and 1992 and following up during 1993 and 1994.
Results: The findings indicate significantly lower depressive symptomatology away women, but not among men, residing in Kibbutz Communities. The women's Lower level of depressive symptoms appears to be a result of better physical and mental functioning among Kibbutz members and of such favorable life style characteristics as frequent contact with their children among old age, Kibbutz residents.

Discussion: Both lifetime and current living conditions contribute to better mental health of women in the Kibbutz at older ages. (Journal of Aging and Health, Vol. 15 No. 2, 151-174 (2004).

Marmot M., Director of the International Institute for Society and Health, University College London (September 2006), in his article "Aging in an Unequal World: Social Status and life Expectancy" described that The simplest measure of successful aging is staying alive. The difference, internationally, are dramatic. The world leaders for some time have been Japan with life expectancy (male female average) of 81.8 years. The UK runs significantly behind, with 78.5 - 3.3 years is a big difference. At the other end of the scale are Zimbabwe (37.3) and Botswana (35.5). Why should there be a 45 years difference in life expectancy among countries? Poverty? AIDS? Yes, of course. But let us start at the simplest level. As a first approximation, these international differences are, potentially, reversible. They are unlikely to arise because Africans are genetically predisposed to premature death, In the largely
African-origin population of Jamaica, for example, life expectancy is 70.8. It is probably not tropics that are doing it either: life expectancy in tropical Sri Lanka is 74.4.

One way of describing these international differences is to say that they are socially determined. They relate to the nature of the economy, the system of governance and social conditions, on top of the constraints and pressure of the natural environment.

Perhaps these comparisons seem too extreme. There are simply too many differences between sub-Saharan Africa and Japan to draw conclusions as to causes. I live and work in the London borough of Camden. In a travel time of under half an hour I can cycle from Kilburn, with male life expectancy of 70, to Hampstead, life expectancy for men of 80. If took my bicycle on the train to Glasgow I could cycle through parts of the city with the expectancy under 60. These differences of nearly 20 years within the UK are not due to AIDS and poverty, in the sub-Saharan African meaning of the world. The main 'cause of death' contributing to the life expectancy differences are heart disease, cancer, and accidental and violent deaths. At a more fundamental level, the causes are linked to social environment conditions. This is shown by the intimate link between degrees of social and economic deprivation and life expectancy.
There is more to life than breathing. The English Longitudinal Study of Ageing (ELSA) shows that there are substantial differences in physical and mental functioning according to socioeconomic level. The first data from this study show that people of higher social position have onset of disability and cognitive decline about 15 years later, on average, than people of lower position.

In seeking explanations for these dramatic social differences in length of life, an obvious place to start is with medical care. Obvious, but not necessarily correct, in the USA, up to 15 per cent of people have a no health insurance and hence limited access to medical care, at least under the age of 65. Hence much of the debate on 'disparities' in health centers on misdistribution of access to care. Yet the UK provides an instructive contrast. With an NHS we come a little closer to universal access to care, but differences in access may still exist.

In the Whitehall 11 Study of British Civil Servants, we examined the contribution to differences in access to care made by socioeconomic differences in cardiovascular disease rates. We found that the lower the people were in the occupational hierarchy, the more likely they were to have coronary heart disease. But the lower they were in the hierarchy, the more likely they were to have been investigated for coronary heart disease or to have had invasive treatment such as coronary artery surgery. The extra rate of treatment was in proportion to the extra rate of ease.
There was no evidence of under treatment for people in lower socioeconomic positions.

The likely explanation of socioeconomic differences in life expectancy is difference in the rate of occurrence of disease. There is, much concern with lifestyle. It is worryingly the case that most features of unhealthy lifestyle are found to be progressively more on as the social hierarchy is descended. Unhealthy diet, physical inactivity, obesity and smoking loom, large.

But why are there social differences in lifestyle? We need to focus on the social determinants of lifestyle, not simply treat health behaviors as something that can be turned on and off with the advice of a health educator or government pronouncement. As smoking rates for the population have declined, the concern is with smoking among disadvantaged groups such as those in deprived areas of single mothers in poverty.

There is a need to go further in searches for social determinants. One potential insight comes from the fact that health is not distributed such that there is bad health for those in poverty, however defined and good health for everyone else. But health follows that social gradient: the lower the socioeconomic position, the worse the health. What is it about position in the hierarchy that leads to length and quality of life? The evidence points to influences acting throughout life: from pregnancy and
degree of thinness of babies at birth, through the effects of early child development, environmental influences in early childhood and education, to the social circumstances in which people live and work in adulthood.

His own interests had centered on the psychological and social factors that influence our adult lives. He had argued (in my book Status Syndrome) that the opportunity to live a flourishing life - with control over your life and full of social engagement and participation - is vital for physical as well as mental health. These are important contributors to length and quality of life.

De Groot LC, Vrheijden MW, de Henauw S, Schroll M, van Staveren WA; SENECA Investigators in his article lifestyle, nutritional status, health and mortality in elderly people across Europe: a review of the longitudinal results of the SENECA study. This article provides an overview of the longitudinal Survey in Europe on Nutrition and the Elderly: a Concerted Action (SENECA) Study, which was designed to assess differences in dietary and lifestyle factors among elderly Europeans, and to identify the factors that contribute to healthy aging. Elderly people from Belgium, Denmark, France, Italy, Portugal, Spain, Switzerland, and The Netherlands participated in the SENECA study. Standardized measurements were conducted at baseline in 1988/1989 and were repeated in 1993 and 1999. Diet, physical activity and smoking, as well as maintenance of health and survival, were assessed. At baseline,
considerable differences in lifestyle factors existed among elderly people. Mealtime patterns as well as dietary intake varied across Europe, and geographical patterns were, apparent. Similar results were found for engagement in sport or professional activities. The smoking prevalence among women was generally low. Distinct geographical differences were also observed in percentages of death during the SENECA study and in overall survival time. A healthy lifestyle was related to stable self-perceived health, a delay in functional dependence, and mortality. Inactivity and smoking and to a lesser extent a low quality diet, increased mortality risk. A combined effect of multiple unhealthy lifestyle factors was also observed. The SENECA study showed that a healthy lifestyle at older ages is related to a delay in the deterioration of health status and a reduced mortality risk. Improving and maintaining a healthy lifestyle in elderly people across Europe is a great challenge for the Europe Community.

Health notes Newswire (June 14, 2001) - Men may have greater personal control over their physical and mental health as they age than previously thought, according to a landmark review published in the June edition of the American Journal of Psychiatry. Lifestyle choice Predict "Successful" Aging in Men and Women. The author tracked lifestyle factors that were out of the participants' control (i.e., social class of their parents, family togetherness, major depression, ancestral longevity,
childhood temperament, and physical health at age 50) as well as lifestyle factors that reflected some measure of personal control (i.e., alcohol abuse, smoking, marital stability, exercise overweight, coping mechanisms and education).

At 70 to 80 years of age, the participants' quality of life was evaluated. Well being in old age was defined along a continuum ranging from the happy - well to the sad - sick. Between the two poles were individuals with a mixed evaluation of their well being. The relative success' with which an individual aged was expressed as a composite of physical health, death and disability before age 80, social support, dental health, key activities of daily living, and life enjoyment.

The authors found they were able to accurately predict 'good' and 'bad' aging from age 70 by evaluating lifestyle factors age 50, and sometimes as far back as adolescence. Including 'warm' marriage, absence of major depressive disorder, and good physical health at age 60 are also associated with lower rate of health decline education appears to have been a more significant determinant of successful aging than other differences in socioeconomic status.

Adding Life of Years; Not Just More Years to Life some things do not diminish with age, such as our ability to love and experience joy. In 1990, there were 4 million people age 85 and older in the United States. There will be ten times that many in 2040. The octogenarian of today,
thanks to changes in lifestyle and medical advances, is more active and less disabled than the octogenarian of 20 years ago. Nevertheless, aging is associated with inevitable decline. Senses slowly fail after the age of 20: vision in dim light declines steadily; by age 70, adults can perceive only 50% of the smells they could recognize at 40. The ability to move about declines until, by age 90, most people can no longer use public transportation. In addition, we become increasingly dependent on medications. However, the extent to which the decline of aging debilitates an individual varies considerably.

A previous study on aging recently concluded, "Old age is not foremost a negative and problem-ridden phase of life." The new findings concur and paint a hopeful picture for young adults who will live into old age. The protective factors that distinguish the happy-well from the sad-sick (i.e., weight exercise, abuse of cigarettes and alcohol) are largely within our power to control. With hard work and possibly therapy, strategies for coping with stress and difficulties in relationships with spouses can be improved. The authors conclude, "A successful old age, Horatio, may lie not so much in our stars and genes as in ourselves."

Jennifer Sisk, NIA (Vol. 6 No. 7, p. 34) Aging and Fitness - The Shape of Things to Come. Exercise can help prevent the physical and mental deterioration of aging. Older people who exercise may be swimming in the fountain of youth.
The research: Long-term National Institute of Aging studies have revealed that normal physiological aging varies among individuals, and chronological age does not always correlate with physiological age. Individual genes and lifestyle interact to affect the rate of aging, and while we cannot change our genes, certain lifestyle modifications - such as exercising and not smoking - can influence how we age. Regular physical activities that include strength training cardiovascular conditioning, flexibility and balance training can offset age-related changes. Researchers have concluded that while normal aging is variable, in general, the following physiological age-related changes occur:

- The heart muscle thickens and arteries stiffen, causing a decline in maximal pumping rate and the body's ability to use oxygen from the blood.
- Maximum breathing capacity decreases by approximately 40%.
- Brain function diminishes.
- Bone loss accelerates and often results in osteoporosis and/or osteopenia.
- Muscle mass, strength, and power decline significantly.
Research also supports the role of exercise in decreasing the risk of certain cancers. McTiernan et al., studied more than 70,000 women aged 50 to 79 to determine the relationship between physical activity and breast cancer risk. Women who walked briskly activity and breast cancer risk. Women who walked briskly for 1.25 to 2.5 hours weekly had an 18% decreased risk of breast cancer, and women who exercised for 10 hours or more weekly had slightly greater risk reduction. In a review of published data on exercise and cancer risk reduction, Lee7 concluded that 30 to 60 minutes daily of moderate-to vigorous-intensity exercise reduced the risk of colorectal cancer in men and women by up to 40% and the risk of breast cancer by 20% to 30%.

In 2001, the international Council on Active Aging (ICAA) in Vancouver, British Columbia, Canada, was launched with the goal of uniting professionals in the fitness, rehabilitation, wellness, long-term care, and assisted-living fields and providing information, education, and tools for serving our aging population. The ECAA emphasizes whole person wellness based on the six dimensions of wellness for older adults' emotional, intellectual, social physical, spiritual and vocational health.

Active Aging Week coincides with the World Health organization's international Day of the Older Adult (October 1), a day established to promote the importance of health and productivity for the world's increasing older adult population. Information on Active Aging Week can
be found online at www.icaa.c. its mission is to encourage fitness and a longer and more independent lifestyle for adults by expanding awareness and involvement in health and fitness activities to prevent illness, disability, and obesity.

"There is no pill that can be taken to get people moving," says Fisher. She relies on an upbeat attitude and strong but gentle approach to "get them out of the bingo hall and moving." While Fisher is familiar with the research that supports exercise for older adults, she sees the benefits every day. "Exercises keeps their bodies functioning and able to do the things the want to do," Fisher explains.

Any exercise program that is fun, effective, and safe appropriate for seniors, says Fisher. It is important to find whatever exercise works for them. Whether it is tai chi, golf, water aerobics, groups fitness classes, dancing, or chair exercise. Milner says "The moot helpful exercise are those that relate to activities to daily living," says Milner, "like leg strength for getting out of a chair or climbing stairs. " practical exercises such as leg presses, leg extensions, and leg curls can improve both stability and leg strength, and triceps exercises can help with getting up out of a chair, Milner adds.

"Seniors tend to isolate themselves. Their ability to communicate with the outside world diminishes," Fisher notes. New class members are usually quiet and withdrawn, but as they continue to exercise with other
seniors, they become more outgoing. "They feel better about themselves, begin to smile more, and make friends. Exercise helps them break out of their shells," Fisher says.

It allows the researcher to acquaint herself with current knowledge in the area where he proposes to research. Other purposes served area where he proposes to research. Other purposes served by the review of related literature include the following:

1. It enables the researcher to define the limits of his field.

2. By referring to it research can avoid unfruitful and useless problem areas. He can select these areas in which positive finding are likely to result.

3. Unintentional duplication of well established finely, could be avoided.

4. The researcher gains an understanding of the methodology of research that could be used for his study.