CHAPTER I

INTRODUCTION

“Stress is basically a disconnection from the earth, a forgetting of the breath. Stress is an ignorant state. It believes that everything is an emergency. Nothing is that important. Just lie down.”

-Natalie Goldberg

“Adopting the right attitude can convert a negative stress into a positive one.”

-Hans Selye

The human civilization, at various stages of its life development, has always endeavored to grapple with the myriad challenges of disability. Disability surely, is a disadvantage for the individuals who endure it and also a challenge for the larger society in any part of the world, which has so far not been able to offer an ideal platform in many parts of the globe to the persons with disabilities. It is because of various imperfections prevailing in the society, handicaps in individuals become disability on their way to progress and prevents them to lead life like any other normal human being.

Then came a phase when they were given charity, care and protection in various parts of the globe. Later came the age of initiating them into the world of education and vocational training. With further advancement of the societies, path breaking developments in modern medicine as well as technology and also because of sustained movements by groups of persons with disability all over the world, the idea of securing social justice, equal rights and opportunities for them has come to occupy the central stage in many modern nations (Singh and Manoj, 2005).
In spite of all these opportunities, like ordinary children, handicapped children have certain basic needs which are essential for the good physical and mental health. The basic physical, mental and emotional needs are kept constant in mind by child’s caregiver; of all kinds that childhood itself is only a temporary phase in any human lifetime. It’s an active preparation for adult life (Arvindrai, 1995).

The Census 2001 states that there are 2.19 crore persons with disabilities in India, constituting 2.13% of the total population. However, this data is keenly disputed, with alternative estimates invariably much higher than the official ones. Compared to Indian statistics, the population of the persons living with disability in India’s neighbours is substantially higher: 5% in China, 5% in Nepal and 4.9% in Pakistan. In the most developed countries this number raises to 18% (Australia), 14.2% (United Kingdom) and 9% (the United States). One WHO report states that 10% of the entire world’s population live with disability (650 million) and that there are more people living with disability in India than in any other country. The tragedy is that the Census Commission failed to make any attempt to collect statistics on disability until 2001. The assumption is simple: no census, no statistics and no problem. And now with a 2.13% estimate in the 2001 census, the contentious status of figures for disability raises a fundamental obstacle to framing and implementing effective policies throughout India. Of all people living with disability, 35.9% belong to the 0 to 19 years age group, which in absolute terms amounts to 7 million young people. Across the subcontinent 90% of India’s 36 million children with physical and mental disabilities age between 4 to 16 years are out of school.

(http://www.clraindia.org/include/DPbriefno5.pdf).
As parents of typically developing children face many challenges in raising their sons and daughters in today’s complex society, parents of children with disabilities have additional and often longer-term responsibilities necessitated by their children’s special needs. These responsibilities may start very early and continue into their children’s adulthood. Thus parent’s involvement is important for the parents of children with disabilities to give them ongoing support and help them to meet their expanded roles and heightened expectations (Dardig, 2008).

Parents of exceptional children have intense role, including the following:

TEACHER – As teacher parents should give necessary support and materials, providing important supplementary teaching for their children at home, this will help them to learn academic, social, communicative and daily living skills.

BEHAVIOUR MANAGER –Parents must actively and systematically structure the home environment to reduce inappropriate behaviour and teach more adaptive skills.

COUNSELLOR – Student with disabilities face teasing or may not be able to engage in typical activities with their same age peers. In these cases, parents need to be able to counsel their children, help them to cope, encourage friendships and find appropriate activities in which they can participate.

ADVOCATE – Parents may have to become active advocates for appropriate programmes and services, both in school and out, for their child during their school years and beyond.

ACCESSOR OF COMMUNITY RESOURCE – Parents of children with disabilities must often navigate a maze of agencies and programmes to locate and obtain community
services such as medical treatment, recreational opportunities and vocational training for their child.

FUTURE PLANNER – When the child enters adulthood, parents of children with disabilities often have lifelong responsibilities to ensure the domestic, social, vocational and financial security of their children and must plan accordingly (Heward, Dardig and Rossett, 1979).

The above mentioned role of the parents with disabled child makes them stressed. Accepting a child with mental handicap becomes difficult to parents and the whole family particularly when competence and achievement are very much valued in modern world. Thus when it suddenly becomes necessary for parents to love someone who has a very limited capacity the parents are put in conflicting situation and results in a great deal of stress.

Olshansky (1962) has speculated that almost all parents who have a mentally retarded child suffer from chronic sorrow throughout their lives. The extent of this sorrow may differ from one parent to another but most will have manifestation of sorrow in varying degrees.

The birth and continuing care of mentally retarded children are often stressful experiences for family members as these children’s difficulties inevitably touch the lives of those around them (Crnic, Friedrich, Greenberg, 1983 and Featherstone, 1980).

Crnic and Greenberg (1985) found that the cumulative impact of daily parenting hassles and difficulties in dealing with children represents significant stressors that may subsequently affect parents and family functioning.
Many parents reported that the uncertainty of their mentally retarded child’s future caused the family deep concern and stress. The retarded child is a chronic stress to the family. This chronic stress gets “recycled” at each juncture of the life span when a developmental step would normally occur in the affected person. For example, when a retarded child reaches the age of high school graduation and cannot be graduated and launched as normal children are the family is newly reminded of the hopelessness of the child’s situation (Wikler, 1981).

Parenting is the process of promoting and supporting the physical, emotional, social and intellectual development of a child from infancy to adulthood. Parenting refers to the activity of raising a child rather than the biological relationship (Davies, 2000). There is no single or definitive model of parenting. What may be right for one family or one child may not be suitable for another. With authoritative and permissive (indulgent) parenting on opposite sides of the spectrum, most conventional and modern models of parenting fall somewhere in between. Parenting strategies as well as behaviours/ideals of what parents expect whether communicated verbally and/or non-verbally also play a significant role in a child’s development. (Barboza, Schiamberg, Oehmke, Korzeniewski, Post and Heraux, (2008).

Parenthood brings immense amounts of joy, pride, personal growth and other good things to those with children, it can also bring a lot of challenges and researchers are finding that these challenges can take a toll. Simon and Evenson (2005) found that higher levels of depression among parents who do not have children than adults.

According to Huxley (2010) “Nothing describes parenting better than stress”. Stress is defined as any physical or emotional demand that one feels unable to handle.
These demands encompass all of the little hassles one experiences every day, from the moment one tries to get children up for school to the moment finally get them to bed at night. Even though these daily hassles are often considered trivial, over a period of time, these hassles add up, building in pressure, until they are ready to burst out with anger and frustration.

Taking care of a normal child is an easy task for the parents when compared to that of a child with disability. Raising a child with disability can cause more daily stress and long-range health problems than parenting a child without disabilities. Parents of disabled children work fewer hours, feel more stress. The majority of parents who care for children with disabilities report, feeling stressed coping with the responsibilities and say as a result, their employment is affected. Parents of children with disabilities have a greater number of stressors and a higher number of days during which they have at least one stressor. They also report to experience a greater number of physical health problems. Parents with disabled children say that they experience stress ‘sometimes or always’ while trying to balance the responsibility of caring for their children and other obligations. Parents with children with mild to moderate disabilities report their child's condition is the ‘main source of stress’ (Scott, 2011).

MENTAL RETARDATION

Mental retardation is a particular state of functioning that begins in childhood and characterized by limitation in both intelligence and adaptive skills. It reflects the ‘fit’ between the capabilities of individuals and the structure and expectations of their environment.
DEFINITION OF MENTAL RETARDATION

American Association of Mental Retardation (2002) defined Mental retardation as a disability characterized by significant limitations both in intellectual functioning and in adaptive behaviour as expressed in conceptual, social and practical adaptive skills. This disability originates before the age 18. It is estimated that 6.2 to 7.5 million people have mental retardation. Mental retardation is 10 times more common than cerebral palsy and 28 times more prevalent than neural tube defects such as spina bifida. It affects 25 times as many people as blindness (Batshaw, 1997).

Mental retardation varies in severity. There are four different degrees of mental retardation: Mild, Moderate, Severe and Profound. These categories are based on the functioning level of the individual.

MILD MENTAL RETARDATION

Approximately 85% of the mentally retarded population is in the mildly retarded category. Their IQ score ranges from 50 to 75 and they can often acquire academic skills up to the sixth grade level. They can become fairly self-sufficient and in some cases live independently, with community and social support.

MODERATE MENTAL RETARDATION

About 10% of the mentally retarded population is considered moderately retarded. Moderately retarded individuals have IQ scores ranging from 35 to 55. They can carry out work and self-care tasks with moderate supervision. They typically acquire communication skills in childhood and are able to live and function successfully within the community in a supervised environment such as a group or home.
SEVERE MENTAL RETARDATION

About 3 to 4% of the mentally retarded population is severely retarded. Severely retarded individuals have IQ scores of 20 to 40. They may master very basic self-care skills and some communication skills. Many severely retarded individuals are able to live in a group or home.

PROFOUND MENTAL RETARDATION

Only 1 to 2% of the mentally retarded population is classified as profoundly retarded. Profoundly retarded individuals have IQ scores under 20 to 25. They may be able to develop basic self-care and communication skills with appropriate support and training. Their retardation is often caused by an accompanying neurological disorder. The profoundly retarded need a high level of structure and supervision (The Gale Group Inc, 2006) (http://www.answers.com/topic/mental-retardation).

TYPES OF MENTAL RETARDATION

The different Types of mental retardations are:

Down's syndrome (Mongolism)

Phenylketonuria (PKU)

Cretinism (Thyroid Deficiency)

Cranial Anomalies

Microcephaly

Macrocephaly

Hydrocephalus
DOWN'S SYNDROME (MONGOLISM)

The term mongolism has been used in referring to this syndrome because persons so afflicted frequently have almond-shaped slanting eyes. A number of physical features are often found among children with Down's syndrome, but very few of these children have all of the characteristics commonly thought of as typifying this group. In addition to slanting eyes, the skin of the eyelids tends to be abnormally thick, the face and nose are often flat and broad, as is the back of the head and the tongue, which seems too large for the mouth, may show deep fissures. The iris of the eye is frequently speckled. The neck is often short and broad, as are the hands, which tend to have creases across the palms. The fingers are stubby and the little finger is often more noticeably curved than the other fingers.

Mongoloids are particularly susceptible to circulatory, gastrointestinal and respiratory disorders. However, antibiotics, better medical care and a more healthful and stimulating environment are increasing the life expectancy of many of the victims of this disorder.

Research has shown that possible chromosomal anomalies lead to this disorder. Subsequent studies have shown that 95% of people with Down's syndrome have 47 chromosomes instead of the normal component of 46 resulting from a trisomy of chromosome 21.

PHENYLKETONURIA (PKU)

Phenylketonuria is a rare metabolic disorder. In PKU the baby appears normal at birth but lacks an enzyme needed to break down phenylalanine, an amino acid found in protein foods. When this condition is undetected, the phenylalanine builds up in the blood and leads to brain damage. The disorder usually becomes apparent between 6 and
12 months after birth, although such symptoms as vomiting, a peculiar odour, infantile eczema (a skin disorder in infants) and seizures (fits) may become apparent during the early weeks of life. Often the first symptoms noticed are signs of mental retardation, which may be moderate to severe, depending on the degree to which the disease has progressed. Motor in coordination and other neurological manifestations relating to the severity of brain damage are also common, and often the eyes, skin and hair of untreated PKU patients are very pale.

PKU is thought to result from metabolic alterations involving recessive genes and 1 person in 70 is thought to be a carrier. Methods for the early detection of PKU have been developed and dietary related treatment procedures are utilized. With early detection and treatment – preferably before an infant is 6 months old– the deterioration process can be arrested so that levels of intellectual functioning may range from borderline to normal functioning. However, a few children suffer mental retardation despite restricted phenylalanine intake and other treatment measures. For a baby to inherit PKU, both parents must carry the recessive gene. Thus when one child in a family has PKU, it is important that other children in such families be screened as well.

CRETINISM (THYROID DEFICIENCY)

Cretinism provides a dramatic illustration of mental retardation resulting from endocrine imbalance. In this condition, the thyroid either has failed to develop properly or has undergone degeneration or injury. In either case, the infant suffers from a deficiency in thyroid secretion. Brain damage resulting from this insufficiency is most marked during the prenatal and early postnatal periods of rapid growth.
Although most cases of cretinism result from lack of iodine in the diet, thyroid deficiency may also occur as the result of birth injuries (involving bleeding into the thyroid) or in connection with infectious diseases such as measles, whooping cough, or diphtheria. The resulting clinical picture will depend on the age at which the thyroid deficiency occurs, as well as on the degree and duration of the deficiency.

Typical descriptions of cretins involve cases in which there has been a severe thyroid deficiency from an early age, often even before birth. Such a cretin has a dwarflike, thick-set body and short, stubby extremities. Their height is usually just a little over 3 feet, the shortness accentuated by slightly bent legs and a curvature of the spine. They walk with a shuffling gait that is easily recognizable. Their head is large, with abundant black, wiry hair, eyelids are thick, giving them a sleepy appearance, skin is dry and thickened and cold on the touch. Other pronounced physical symptoms include a broad, flat nose, large and flappy ears, a protruding abdomen and failure to mature sexually. The cretins reveal a bland personality and their thought processes tend to be sluggish. Most cretins fall within the moderate and severe categories of mental retardation, depending on the extent of brain damage. In cases with less pronounced physical signs of cretinism, the degree of mental retardation is usually less severe.

CRANIAL ANOMALIES

Mental retardation is associated with a number of conditions in which there are relatively gross alterations in head size and shape and where the causal factors have not been definitely established.

In MACROCEPHALY ("large headedness"), for example there is an increase in the size and weight of the brain, an enlargement of the skull and visual impairment,
convulsions and other neurological symptoms resulting from the supporting structure for brain tissue. Other cranial anomalies include Microcephaly and Hydrocephalus.

The term MICROCEPHALY means "small headedness". It refers to a type of mental retardation resulting from impaired development of the brain and a consequent failure of the cranium to attain normal size. The most obvious characteristics of microcephalic is small head, the circumference rarely exceeds 17 inches. Microcephalics differ considerably from each other in appearance, although there is a tendency for the skull to be cone shaped, with a receding chin and forehead. Microcephalics fall within the moderate, severe and profound categories of mental retardation, but the majority shows little language development and is extremely limited in mental capacity.

Microcephaly may result from a wide range of factors that impair brain development, including intrauterine infections and pelvic irradiation of the mother during the early months of pregnancy. A number of cases of microcephaly that occurred in Hiroshima and Nagasaki apparently resulted from atomic bomb explosions during World War II. The role of genetic factors is not clear yet. The treatment is ineffective once faulty development has occurred and at present, preventive measures focus on the avoidance of infection and radiation during pregnancy.

HYDROCEPHALUS

Hydrocephalus is a relatively rare condition in which the accumulation of an abnormal amount of cerebrospinal fluid within the cranium causes damage to the brain tissues and enlargement of the cranium.

In congenital cases of hydrocephalus, the head is either already enlarged at birth or begins to enlarge soon thereafter, presumably as a result of a disturbance in the formation,
absorption or circulation of the cerebrospinal fluid. The disorder can also develop in infancy or early childhood following the development of a brain tumour, subdural haematoma (clot in the brain covering), meningitis (infection of brain covering) or other such conditions. Here the condition appears to result from a blockage of the cerebrospinal pathways and an accumulation of fluid in certain brain areas.

The clinical picture of hydrocephalus depends on the extent of neural damage, which, in turn, depends on the age at onset and the duration and severity of disorder. In chronic cases the chief symptom is the gradual enlargement of the upper part of the head out of all proportion to the face and the rest of the body. While the expansion of the skull helps minimize destructive pressure on the brain, serious brain damage occurs nonetheless, leading to intellectual impairment and such other effects as convulsions and impairment or loss of sight and hearing. The degree of intellectual impairment varies, being severe or profound in advanced cases (http://www.dialforhealth.net/healthchannel/mental/types.asp 2000).

CAUSES OF MENTAL RETARDATION

Risk factors are related to the causes. Causes of mental retardation can be roughly broken down into several categories. They are:

INFECTIONS (PRESENT AT BIRTH OR OCCURRING AFTER BIRTH)

Congenital CMV, Congenital rubella, Congenital toxoplasmosis, Encephalitis, HIV Infection, Listeriosis and Meningitis.
CHROMOSOMAL ABNORMALITY

Chromosome Deletions (cri du chat syndrome), Chromosomal Translocations, Defects in the Chromosome or Chromosomal Inheritance (Fragile X Syndrome, Angelman Syndrome, Prader-Willi Syndrome), Errors of Chromosome Numbers (Down syndrome).

GENETIC ABNORMALITIES AND INHERITED METABOLIC DISORDERS


METABOLIC

Congenital Hypothyroid Hypoglycemia (poorly regulated diabetes), Reye Syndrome, Hyperbilirubinemia (very high bilirubin levels in babies).

NUTRITIONAL

Malnutrition

TOXIC

Intrauterine exposure to Alcohol, Cocaine, Amphetamines and other drugs, Lead Poisoning, Methylmercury Poisoning.

TRAUMA (BEFORE AND AFTER BIRTH)

Intracranial Haemorrhage before or after birth, Lack of oxygen to the brain before, during or after birth, Severe head injury (Kaneshiro, 2009).
TREATMENT AND MANAGEMENT OF MENTAL RETARDATION

A child with MR/ID is best cared for by a multidisciplinary team consisting of the Primary Care Doctor, Social Workers, Speech, Occupational and Physical Therapists, Neurologists or Developmental Paediatricians, Psychologists, Nutritionists, Educators and others. Together with the family, these people develop a comprehensive, individualized programme for the child, which is begun as soon as the diagnosis of MR/ID is suspected. The parents and siblings of the child also need emotional support and sometimes counselling. The whole family should be an integral part of the programme.

The full array of a child's strengths and weaknesses must be considered in determining what kind of support is needed. Factors such as physical disabilities, personality problems, mental illness and interpersonal skills are all taken into consideration. Affected children with coexisting mental health disorders such as depression may be given appropriate drugs in dosages similar to those given to children without MR/ID. However, giving a child drugs without also instituting behavioural therapy and environmental changes is usually not helpful.

All children with MR/ID benefit from special education. The federal Individuals with Disabilities Education Act (IDEA) requires public schools to provide free and appropriate education to children and adolescents with MR/ID or other developmental disorders. Education must be provided in the least restrictive, most inclusive setting possible – where the children have every opportunity to interact with non-disabled peers and have equal access to community resources.

A child with MR/ID usually does best living at home. However, some families cannot provide care at home, especially for children with severe, complex disabilities. This decision is difficult and requires extensive discussion between the family and their entire
support team. Having a child with severe disabilities at home requires dedicated care that some parents may not be able to provide. The family may need psychological support. A social worker can organize services to assist the family. Help can be provided by day care centers, housekeepers, child caregivers and respite care facilities. Most adults with MR/ID live in community-based residences that provide services appropriate to the person's needs, as well as work and recreational opportunities. Health Promotion for Educators is also important (http://francisjurado.wordpress.com/).

TRAINING

It includes school training and vocational trainings. Important protective factors include good physical health, a normal rate of growth, healthy parent-child attachment and a cohesive family unit within a supportive social network. Specialized educational and therapeutic services are central elements in the multidisciplinary care of children with mental retardation. During the adolescent years, issues related to sexuality, vocational training, and community living become more prominent. Speech therapy for improving speech and counselling the parents of the mentally challenged (http://www.krassindia.org/mr_tre.htm).

Many retarded children now have the opportunity to attend special preschool programmes and day schools. These programmes and schools teach children basic skills, such as bathing and feeding themselves. They also provide educational programmes, extracurricular activities and social events developed especially for retarded children.

Treatment may also include family therapy. The purpose of family therapy is to help family members understand the nature of mental retardation. It also helps them develop skills for dealing with the special needs of a retarded person. Parents may also
receive counselling to help them deal with feelings of anger or guilt (http://www.faqs.org/health/Sick-V3/Mental-Retardation-Treatment.html).

Every parent aspire to have a healthy and normal child. But when they have a disabled child all their expectations are vanished away. They try to make their child normal at any cost. They take them to doctor when it does not work they believe in God and pray to God to make them normal. It will take long period to any parent for accepting their child’s disability. They exhibit various defense mechanisms like denial, rejection, bargaining, depression and finally acceptance. They accept their child because of child’s life long adjustment. In order to assist the parents in dealing with the situation counselling is essential, as a part of the whole management plan. Counselling helps them to bear the shock and frustration, giving information regarding the existing services available for their children, providing timely assistance during crisis periods and genetic counselling. Family counselling to the other members of the family helps the family to adjust with the child and in managing their problems.

Training parents through workshops is also an extention of counselling incorporated into the training programme. The aims and objectives of training programme are:

- To train and educate parents to train their children at home
- To enable the parents to participate and enjoy the pleasure of training
- To make the parent feel that he/she is an active partner in the training programme
• To enable to follow sequentially, the child’s development, through various phases at the same time becoming aware of the obstacles and impediments to progress, the causes for these and how to overcome them

• To be able to perceive even the smallest improvement or development of behaviour

• To know the limitations, potentialities of the child through experiences

Thus training programmes, workshops and counselling helps the parents to understand and accept their children’s problems. It also helps to evaluate and develop plans which are appropriate to the capacity of the mentally retarded (Lokanadha, Sujathamalini and Kusuma, 2004).

STRESS

“Stress is not what happens to us. It’s our response TO what happens. And RESPONSE is something we choose”.

Maureen Killoran

Stress as a physical, mental or emotional response to events that causes bodily or mental tension. Stress is any outside force or event that has an effect on a person’s body or mind. Most of the people experience stress at one time or another. Without stress, there would be no life. However, excessive or prolonged stress can be harmful. Stress is unique and personal. A situation may be stressful for someone but the same situation may be challenging for others. People feel little stress when they have the time, experience and resources to manage a situation. They feel great stress when they think they can’t handle the demands put upon them. Stress is therefore a negative experience. And it is not an inevitable consequence of an event. It depends a lot on people’s perceptions of a situation
and their real ability to cope with it (http://ocsupportgroup.ning.com/forum/topics/understanding-and-managing-2).

The stress response is the body's way of protecting an individual. When working properly, it helps the person to stay focused, energetic and alert. In emergency situations, stress can save life – giving extra strength to defend oneself, for example or spurring him to slam on the brakes to avoid an accident. The stress response also helps one to rise to meet challenges. Stress is what keep one on his toes during a presentation at work, sharpens his concentration when he is attempting the game-winning free throw or drives to study for an exam rather than watching TV. But beyond a certain point, stress stops being helpful and starts causing major damage to health, mood, productivity, relationships and the quality of life (http://helpguide.org/mental/stress_signs.htm).

The diagnosis of mental retardation in a child can trigger a range of emotional response in parents and across family system. For some it will constitute a crisis that requires extraordinary psychological adjustment on a parents part and contains elements of harm, loss and weakness. For others the birth of a disabled child will be viewed as an unfortunate event. The initial parental response may be a form of emotional disintegration. A family with retarded child will experience many challenges such as “repeated physical and emotional crisis, interactive family issues, ruined schedule and additional expenses which can create financial burden for a family. It may be during these times of physical and emotional stress that parents will take out their frustration on each other, the other children, or even the child with disability or illness (Gohel, Mukherjee and Choudhary, 2011).
DEFINITION OF STRESS

The word stress is derived from the Latin word ‘stringi’, which means, ‘to be drawn tight’. The term ‘stress’ was coined by Selye (1936) and who defined as “the non-specific response of the body to any demand for change”.

According to Lazarus, (1993) “Stress is a feeling experienced when a person thinks that the demands exceed the personal and social resources the individual is able to mobilize”.

According to Hardy, “Stress is our bodies natural response to a situation that is perceived as hazardous or dangerous. It affects everyone and is a response by the nervous system. Like most mammals it is an evolutionary and survival response that has served to prevent and protect us from danger”.

Morrow, (2011) defined Stress is the body’s reaction to a change that requires a physical, mental or emotional adjustment or responses.

Stress is the way one responds to the circumstances that threaten us and tax our coping abilities. (Santrock, 2000).

Stress is the feeling one have when they evaluate or appraise a situation as something that overloads or strains their psychological resources (Plotnik, 1993).

Internal responses caused by the application of a stressor (Carson, Butcher and Mineka, 1998) Stress is an event that produces tension or worry – failing a final exam. It is a persons physical or psychological response to an event.

Stress is defined as the person’s perception of the event, a perceived difference between a demand placed upon a person and his or her ability to handle it or previous experience in coping with it (Mechanic, 1974; Wild and Haynes, 1976).
TYPES OF STRESS

The major types of stress can be broken down into four different categories: Eustress, Hyperstress, Hypostress and Distress.

EUSTRESS

Eustress is one of the helpful types of stress. It prepares the body to fight with or flee from an imposing danger. Eustress can also apply to creative endeavours. When a person needs to have some extra energy or creativity, eustress kicks into bring them the inspiration they need. An athlete will experience the strength that comes from eustress right before they play a big game or enter a big competition. Because of the eustress, they immediately receive the strength that they need to perform.

DISTRESS

It is the negative type of stress. In distress mind and body undergoes when the normal routine is constantly adjusted and altered. The mind is not comfortable with this routine and craves the familiarity of a common routine. There are two types of distress: acute stress and chronic stress.

ACUTE STRESS

Acute stress is the type of stress that comes immediately with the change of routine. It is an intense type of stress, but it passes quickly. It is the body’s way of getting a person to stand up and take inventory of what is going on, to make sure that everything is ok.
CHRONIC STRESS

Chronic stress will occur if there is a constant change of routine for week after week. It affects the body for a long period of time. It is experienced by someone who constantly faces moves or job changes.

HYPERSTRESS

Hyperstress is the type of negative stress that comes when a person is forced to undertake more than he or she can take. A stressful job that overworks an individual will cause that individual to face hyperstress. One who experiences hyperstress will often respond to even little stressors with huge emotional outbreak.

HYPOSTRESS

Hypostress stands in direct opposite to hyperstress. It is basically insufficient amount of stress. That is because this type of stress is experienced by a person who is constantly bored. Someone in an unchallenging job such as a factory worker performing the same task over and over will often experience hypostress (Baer, 2010).

SYMPTOMS OF STRESS

Depending on the stressors and the types of changes or events that one is dealing with, stress can manifest itself physically, emotionally and/or mentally.

PHYSICAL

It occurs when the body as a whole starts to suffer as a result of a stressful situation. Symptoms can manifest in a variety of ways and vary in their seriousness. The most common physical symptom is headache, because stress causes people to
unconsciously tense their neck, forehead and shoulder muscles. However long-term stress can lead to digestive problems including ulcers, insomnia, fatigue, high blood pressure, nervousness and excessive sweating, heart disease, strokes and even hair loss.

EMOTIONAL

These responses are due to stress affecting the mind and include anxiety, anger, depression, irritability, frustration, over-reaction to everyday problems, memory loss and a lack of concentration for any task. Anxiety is normally shown as a response to loss, failure, danger or a fear of the unknown. Anger is a common response to frustration or social stress and can become a danger to other individuals if not kept in check. Depression is frequently seen as an emotional response to upsetting situations such as the death of a loved one, illness and failure.

PSYCHOLOGICAL

Long-term stress can cause psychological problems in some individuals. Symptoms include withdrawal from society, phobias, compulsive behaviours, eating disorders and night terrors. A stressed person is unlikely to experience all of these symptoms and that even one can be a sign of stress.

EMOTIONAL/COGNITIVE SYMPTOMS

Emotional and cognitive symptoms of stress include feeling irritable, frustrated at waiting, restless, unable to concentrate, confused, memory problems, negative thoughts, negative self-talk, mood swings, overeating, lethargic, hopelessness, indecisiveness, emotional outbursts, feeling upset and lack of sense of humour (http://changingminds.org/explanations/stress/stress_symptoms.htm (2002-2011)).
BEHAVIOURAL SYMPTOMS

Behavioural symptoms basically results from emotional symptoms. When a person is under constant stress he may tend to isolate himself from others. Some of the visible symptoms include nail biting, pacing, teeth grinding or jaw clenching. One tends to overreact to minor problems and pick fights with others. As there is a perennial feeling of being overwhelmed one may start neglecting responsibilities (Baer, 2010).

EXTERNAL CAUSES OF STRESS

Life Changes, Work Relationship Difficulties, Financial Problems, Being too Busy, Children and Family (Smith, Segal and Segal, 2010). External Sources of stress are classified into physical, social, institutional, major life events and daily hassles.

- Physical stressors are noise, crowding, cold, heat, humidity, bright and low light, heights and confined places such as airplanes, elevators, lack of windows etc.

- Social stressors are relationship problem with family or friends, work relationship with boss or co-worker or customers, crowds, parties, strangers, rude, aggressive, critical or competitive people, unreliable, moody, indecisive or boring people.

- Institutional stressors in schools, work place, hospitals and government offices are rules and regulations, restriction, bureaucracy, “red tape”, deadlines, schedules, meetings, formalities, office politics.

- Major life events like getting married, having a child, moving to a new house or city, death of a close relative, promotion, loss of job. Changes in life circumstances may be positive or negative. Stressful impact lasts twelve to twenty-four months, but diminishes over time.
• Daily hassles such as rush-hour traffic, fear of crime, misplacing things, standing in line, being put on hold, mechanical breakdowns, home maintenance, finding a place to park, rising prices. Small, repeated, daily situations can be irritating, annoying and frustrating (Posen, 2006).

INTERNAL CAUSES OF STRESS

Inability to accept uncertainty, Pessimism, Negative Self-talk, Unrealistic Expectations, Perfectionism, Lack of Assertiveness (Smith, Segal and Segal, 2010). Internal Stressors are classified into Life style choices, Negative self talks, Interpretation of events, Mind traps, Belief systems, Stress-prone personality types.

• Life style choices are health habits: caffeine, insufficient sleep, poor nutrition, tobacco, drugs. Overloaded schedules, insufficient leisure or poor work-life balance, long work hours, shift-work, commuting, travel, financial overextension, social isolation or over-involvement.

• Negative self talk such as critical, judgemental, insulting or blaming thoughts, put-downs, bossiness. Destructive emotions like guilt, worry, regret, resentment, self-pity and jealousy. Negative filters such as pessimism, cynicism, defeatism, skepticism and suspicion. Undermining or self defeating comparisons, ruminating, wallowing, overanalyzing and second-guessing.

• Interpretation of events such as perceiving something as a danger of a threat, feeling a lack of control, judging something to be a problem, jumping to conclusions about other people’s motive and feeling not good about oneself.
• Mind traps like unrealistic expectation, over-identification with roles, job, title, possession, etc. Taking things personally, taking on other people’s problem as one’s own, exaggerating or generalizing the things, rigidity and “all or nothing thinking”.

• Belief systems like outdated, inaccurate, self-limiting, negative and rigid beliefs.

• Stress-prone personality types such as workaholics, overachievers, ‘Type A’ personalities, perfectionists, pleasers, caretakers and victims (Posen, 2006).

EFFECTS OF STRESS

Stress affects physical and emotional health. They are Heart Disease, Blood Pressure and Stroke, Metabolic Syndrome, Weight Gain, Stress and Immunity, Psychosomatic Illness. In times of stress, signals travel from the brain, through spinal cord to various other organs in the body where specific hormones are produced. Adrenaline and Cortisol are then released. Adrenaline stimulates the autonomic nervous system. Cortisol (Stress Hormone) is active in Carbohydrate and Protein metabolism. These flow into the nervous and circulatory system that affect numerous body organs, including heart to bring about changes that will help to fight and flight from danger, increase in blood pressure release of fats into the blood stream for use of as energy. Overtime release of fat can thicken the arteries, which can lead to coronary disease or heart attack and stroke. Chronic stress numbs the immune system’s responses to infections and in some cases even vitiates the body response to immunization. Distress can lead to headache, Diarrhea, constipation and stomach upset, insomnia, chest pain, thus leading to psychosomatic disorder (Baer, 2010). In Psychosomatic Disorder, emotions can lead to bodily symptoms or bodily and mental symptoms that arise from mental conflict or inner stress. Emotions such as anger, rage, grief, anxiety from unfulfilled deadlines or fear of
failure can manifest themselves in the form of a psychosomatic illness. For example, suppression of anger has been linked to breast cancer.

MENTAL AND EMOTIONAL EFFECTS OF STRESS


PSYCHOLOGICAL EFFECTS OF STRESS


It is because of faulty perception and refusal to accept that life situations cannot always be favourable. One cannot concentrate because entire thinking process is taken over by the problem that is worrying a person. Ability to take right decision will be hampered, cannot discriminate between good and bad. Psychological effects of stress eventually inhibit the cognitive ability and ability to rationalize. Psychological effects of stress vary from person to person. It depends upon the frame of mind, if one considers adverse life situations as challenge, look for positive aspects and use them to advance further in life (Baer, 2010).

COGNITIVE EFFECTS OF STRESS

PHYSIOLOGICAL EFFECTS OF STRESS

The brain releases endorphins to relieve Pain, Heart Rate Increases, Blood Pressure Rises, Digestion Slows Down, Salivation and Mucous Secretion Decreases - the result is a "cotton mouth" feeling. Pupils dilate to have a more sensitive vision, All the senses - sight, hearing, smell and taste - become more acute, ready to identify any threats, Sweating increases to flush waste and to cool down the body, Blood clotting increases, Sugars and fats are released into the blood stream to supply fuel, Adrenaline and other hormones are released into the bloodstream to provide energy, Muscle tension increases, Bronchi dilates, Breathing gets shallow and faster to supply more oxygen to the muscles and body tissue (http://www.stress-relief-tools.com/physiological-effects-of-stress.html 2010).

THEORIES OF STRESS

The different theories of stress are life-events theory, hardiness theory and social support theory. They involve mixed interplay of the different components of stress.

THE LIFE EVENTS THEORY OF STRESS

The life events theory of stress underscores that reaction to stress depend upon the duration of exposure to stressors and the degree or strength of these stressors. This theory is supported by Holmes and Rahe (1967), Lazarus (1966) and DeLongis, Coyne, Dakof and Lazarus (1982). Proponents of the life events theory measure stress as the accumulation of major and minor life events, minus major and minor uplifts. For example, a person may have experienced the death of a loved one, but won eight figures in a lottery the next day or that another failed a test in one subject, yet received a perfect mark in another. If a person experiences more stressors than uplifts, he or she is said to be stressed.
THE HARDINESS THEORY OF STRESS

The hardiness theory of stress underscores that individuals react to stress differently. Kobasa (1985) believes that hardiness, that is, perceiving stressful life events as challenges than threats, serve as buffer to stress. For example, one person may perceive of being fired from job as a major stressful problem, while another may see it as an opportunity to get a vacation and find better pastures. This theory, therefore, adds a third element in the stimulus-response interaction – the perceptive buffer – besides stressors and stress reactivity.

THE SOCIAL SUPPORT THEORY OF STRESS

The social support theory of stress underscores that besides the perceptive buffer, stressed individuals can turn to available social support systems and resources to reduce the impact of stressors and avoid being stressed. Overholser, Norman and Miller (1990) believe that stress occurs only when social support systems and resources are not enough to dissolve the threat of stressors. For example, only those students who are not ready in their class experience stress over a pop quiz or that scholars are stressed more over an average grade than non-scholars. (Razel Grace San Ramon 2010) (http://healthmad.com/mental-health/stress-theories/#ixzz1eyD2O4sT).

STRESS RESPONSE THEORIES

Stress may be defined as a nonspecific response to perceived environmental threats (called stressors). But a particular environmental change (a demand or an event) may be perceived by one person as stressful and by another as benign. An examination is, for example, likely to be less stressful for a student who has mastered all homework assignments than it is for a student who waits to cram the night before the test.
The generalized feeling of fear and apprehension associated with a stressor is called anxiety. Anxiety is typically accompanied by activation of the sympathetic nervous system and increased physiological arousal, which causes rapid breathing, increased heart rate, sweating and dilation of the pupils.

Cannon (1935) was primarily interested in the mobilization of the body in preparation for flight or fight. Cannon hypothesized that intense or chronic stress overwhelms the body’s homeostasis and prolonged arousal of the sympathetic nervous system eventually damages the body (Oltmanns and Emery, 2001). Although such responses may have promoted survival when they evolved in human history, they are not productive given the longer periods of stress exposure common in modern life. Such enterprises as keeping a job, going to school and playing on the soccer team require more complex responses.

The General Adaptation Syndrome proposed by Selye (1974) is credited with identifying the body's reaction to stress with a syndrome he called the general adaptation syndrome, which has three phases, as evidenced by the level of stress hormones (Figure 1).

![Figure 1. The General Adaptation Syndrome](image-url)
• **alarm**: The body first organizes physiological responses (similar to fight-or-flight responses) to threat

• **resistance**: Stress-activated responses continue, stabilizing the body’s adaptations to stress

• **exhaustion**: The body has depleted its reserves and can no longer maintain responses to the stressors

During the alarm phase, when the body is first aroused, the hypothalamus sends signals to the pituitary gland. This endocrine gland in turn secretes Adrenocorticotropic Hormone (ACTH), which travels via the bloodstream to the cortex (outer layer) of the adrenal glands, where corticosteroids are released. The hypothalamus also activates the adrenal medulla, the central part of the adrenal gland, which causes adrenaline (epinephrine) to be released and the activation of the sympathetic nervous system. After maintaining high levels of the hormones for a long time, the body loses its ability to do so and exhausts its resources. Selye (1974) is credited with identifying the fact that the incidence of certain types of diseases (stress-related diseases, such as some types of coronary disorders) increases during this stage of exhausted body resources and that a second stressor introduced during the resistance phase or the exhaustion phase further increases the incidence.

Evidence demonstrates that prolonged stress also affects the ability of the immune system to function adequately and can affect the release of other neurotransmitters such as serotonin. Stress may also affect the release of endorphins, chemicals similar in structure to morphine and other opiate drugs used in the modulation of pain (Wiley, 2000-2011).
STRESS MANAGEMENT

There are many different ways to manage stress. Basically, it's best to eliminate as many stressors as can and finding practical and emotional ways to handle the stressors that are left. The following are among the simplest and most effective stress management techniques:

Feeling Better
Taking Care of oneself
Maintaining a Right Attitude
Creating a Right Atmosphere
Resources for Busy People
Healthy Habits
Interactive Resources

FEELING BETTER

If one wants to lower his stress level in a matter of minutes, these techniques are all relatively fast-acting. Using them as needed to feel better quickly, practising them regularly over time, one can gain even greater benefits, Breathing Exercises, Meditation, Reframing With a Sense of Humour, Music, Progressive Muscle Relaxation (PMR), Yoga, Exercise Guided Imagery / Visualizations, Journaling, Cognitive Restructuring, Finding Perspective.
TAKING CARE OF ONESELF

When stressed, one doesn’t always take care of the body, which can lead to even more stress. Some important ways to take care of oneself and keep stress levels lower are Healthy Eating, Better Sleep, Exercise, Hobbies, Good Nutrition and Healthy Sex Life.

MAINTAINING A RIGHT ATTITUDE

Much of individual’s experience of stress has to do with one’s attitude and the way they perceive life’s events. Some resources which helps in maintaining a stress-relieving attitude are Optimism, Being in Control, Overcoming Perfectionism, Using The Law of Attraction, How To Be Happier, Maintaining a Sense of Humour, Mindfulness and Stress Relief, Letting Go of Stressful Thoughts, Letting Go of Anger and Tips on Having Fun.

CREATING A RIGHT ATMOSPHERE

The physical and emotional surroundings can have impact on stress levels in subtle but significant ways. These are the several ways that can change atmosphere and lower the stress such as Soothing Environment, Music, De-Cluttering, Aromatherapy, Positive Energy and Create a Home Spa.

RESOURCES FOR BUSY PEOPLE

Many stressed people are busy people--people who may have more stressors in their lives (because they have more activity in their lives), and less time to devote to stress management. Different ways to eliminate stress are Ongoing Stress Reduction Resources, Time Management, Finding Time, Prioritizing and Best Stress Relievers for Busy People.
HEALTHY HABITS

The following are some healthy habits along with resources to make it easier to make them a lasting part of one's life: Morning Habits, Habits for Better Sleep, Choosing the Right Habits, Sticking With New Habits and E Courses.

INTERACTIVE RESOURCES

Interactive resources can help one to relieve stress and put what one has learnt into practice; polls to tell what others are experiencing and thinking about stress and more ways to really get involved with stress management. Stress Polls: A Fun Way To Check Public Opinion, The Stress Management Blog: Reading About Stress and Sharing the Comments, Free Quizzes, Assessments and Personality Tests, Getting The Free Weekly Newsletter and E Courses and Ongoing Resources for Stress Management (Scott, 2011).

ACUPUNCTURE

Acupuncture helps in tranquillization and psychic elation and allows one to relax. It does not depend on drugs, it is safe, simple, economical and yet an effective therapy with hardly side effects. Its clinical success has demonstrated that it has a definite role to play in coping with stress.

MEDITATION

"Meditation is of far greater importance than medication for whatever afflicts mankind today" (Bhamgara, 1977). Meditation is a practical, systematic method which allows one to understand himself/herself at different levels of being, to understand the environment completely, to eliminate and prevent inner conflicts, to obtain a tranquil and peaceful mind. It is defined as a continuous stream of effortless concentration, on a single
point, over an extended period of time. Dua (1998) compared the effectiveness of various meditation procedures and concluded that the practice of meditation reduces many problem behaviours, increased emotional and physical health and psychological well-being, reduces the frequency of thoughts, reduced substance abuse and generally improved the quality of life. He further pointed out that it is also effective in reducing, managing and controlling stress.

**BIOFEEDBACK**

Biofeedback method is being used for training patients in the act of relaxation and thereby treating various psychosomatic disorders like hypertension, headaches, migraine headache, backache, depression etc. The purpose of biofeedback is to heighten awareness of body functions as well as to see the body and mind as one unit (Pestonjee, 1999).

**RECREATION**

Recreation provides an opportunity to let oneself go, become inhibited, thus, reducing tension and stress. There are various forms of recreation like music and entertainment, painting, fishing, hunting, gardening, dancing etc. These recreational pursuits are important to the prevention of the damaging effects of the stress (Husain, 1998).

**DEPRESSION**

"The world leans on us. When we sag, the whole world seems to droop"

-Hoofer

Depression is a common disorder. Most people at some point of their life, experience at least some degree of low mood or depression. It is a normal response to painful circumstances, such as financial losses, the breakup of relationship or losing a
job. It may continue for a prolonged period of weeks or months. At this stage a psychiatrist might diagnose a depressive disorder (Giles, 2005). The forecast is that by 2020, depression would be the single leading cause of death (Murray and Lopez, 1996). Approximately 10 to 25 percent of women and 5 to 12 percent of men experience a period of major depression in their life time. The average age for the development of depression is 40, with an estimated 50 percent of all patients experiencing major depression between the ages of 20 to 50 (Giles, 2005).

DEFINITION OF DEPRESSION

According to World Health Organization (WHO), (2008) “Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy and poor concentration. These problems can become chronic or recurrent and lead to substantial impairments in an individual’s ability to take care of his or her everyday responsibilities. At its worst, depression can lead to suicide, a tragic fatality associated with the loss of about 8,50,000 lives every year” (http://www.who.int/mental_health/management/depression/definition/en/).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2000) defines Mood disorder as “Abnormal mood characterized by depression, mania or both symptoms in alternating fashion. Depression is indicated by sadness, gloominess, and dejection, mania is indicated by excitement, irritability and expansiveness”.

Beck (1967) believes depressed people draw illogical conclusion about themselves, they blame themselves for normal problems and consider every minor failure a catastrophe.
Depressive disorder is a mood disorder in which the individual suffers depression without ever experiencing mania. The severity varies, some individual experience a major depressive disorder others dysthmic disorder (Santrock, 2000).

Depression is a pervasive feeling of sadness that may begin after some loss or stressful events, but that continues long afterwards. Inappropriate thought patterns that generalize every event as calamity are characteristic (Sarason and Sarason, 2005).

**DEPRESSION**

Depression is primarily a disorder of emotion or mood, there are three types of symptoms: cognitive, motivational and somatic (physical).

Cognitive symptoms are a central part of depression. Depressed people have difficulty in concentrating and making decisions. They usually have low self esteem, believing that they are inferior, inadequate and incompetent. When a setback occurs in their lives depressed people tend to blame themselves, when failure has not yet occurred, they expect that it will be caused by their own inadequacies. Depressed people almost always view the future with great pessimism and hopelessness (Clark, Beck and Alford 1999).

Motivational symptoms in depression involve an inability to get started and to perform behaviours that might produce pleasure or accomplishment. A depressed student may be unable to get out of the bed in the morning, let alone go to class or study. Everything seems too much of an effort. In extreme depressive reactions, the person may have to be prodded out of bed, clothed and fed. In some cases of severe depression, the person’s movements slow down and she or he walks or talks slowly and with excruciating effort.
Somatic (bodily) symptoms often include loss of appetite and weight loss in moderate and severe depression, whereas in mild depression, weight gain sometimes occurs as a person eats compulsively. Sleep disturbance and weight loss lead to fatigue and weakness, which tend to add to the depressive feelings. Depressed people also may lose sexual desire and responsiveness (Passer and Smith, 2007).

In clinical depression, the frequency, intensity and duration of depressive symptoms are out of proportion to the person’s life situation. Some people may respond to a minor setback or loss with major depression. Other people exhibit dysthymia. The negative mood state is the core feature of depression. When depressed people are asked how they feel, they most commonly report sadness, misery and loneliness. Whereas people with anxiety disorder retain their capacity to experience pleasure, depressed people lose it (Mineka, Watson and Clark, 1998). A depressed person may have recurring thoughts of death, especially thoughts of suicide, with or without a specific plan (Schimelpfening, 2009).

TYPES OF DEPRESSION

There are several forms of depressive disorders. The most common are major depressive disorder and dysthymic disorder.

MAJOR DEPRESSIVE DISORDER

It is also called major depression, one who has major depressive disorder without ever experiencing a manic or hypomanic episode. It is marked either depressed mood or a loss of interest or pleasure in almost all activities, as well as at least four additional symptoms from the following group; marked weight loss or gain when not dieting;
constant sleeping problems; agitated or greatly slowed down behaviour; fatigue; inability to think clearly; feeling of worthlessness and frequent thoughts about death or suicide. These symptoms must last at least 2 weeks and represent a change from the person’s usual functioning. An episode of major depression may occur only once in a person’s lifetime, but more often, it recurs throughout a person’s life (Sarason and Sarason, 2005).

**DYSTHYMIC DISORDER**

Dysthymia is defined as a condition characterized by mild and chronic depressive symptoms. It is common in the general population and probably affects 5 to 6% of all persons (Sadock and Sadock, 2003). Diagnostic criteria for dysthymic disorder are depressed mood most of the day, more days than not, for at least 2 years. Two or more of the following symptoms while depressed: poor appetite or over eating, insomnia or sleeping too much, low energy, low self-esteem, poor concentration or difficulty in making decisions and feeling of hopelessness. These symptoms will be present for more than 2 months in a 2 year period. During the first 2 years of the disturbances, there has never been a major depressive episode. If one of these episodes occurred in the past, there has been a complete remission or disappearance of symptoms. The disturbance is not a part of a chronic psychotic disorder or result of some chemical substance or a general medical condition. The symptoms cause clinically significant distress or impairment in important areas of functioning (DSM-IV-TR).

If a person with dysthymic disorder develops symptoms of major depression as well, he or she is said to have ‘double depression’, because the criteria for both diagnoses are met. Almost half of the people who had dysthymic disorder also had at least one episode of major depression (Weissman et al., 1996).
PSYCHOTIC DEPRESSION

About 15% of the people with major depression have some psychotic symptoms, usually delusions. The delusions typically include guilt, punishment and poverty. Sometimes, but more rarely the delusions do not have depressive themes.

POSTPARTUM DEPRESSION

It is diagnosed if a new mother develops a major depressive episode within one month after delivery. It is estimated that 10 to 15% of women experience postpartum depression after giving birth.

SEASONAL AFFECTIVE DISORDER (SAD)

It is characterized by the onset of a depressive illness during the winter months, when there is less natural sunlight. The depression generally lifts during spring and summer. Symptoms of SAD include mood changes, loss of energy, weight gain and an increase in hours of sleep. The disorder is most likely to begin in early adulthood, although substantial numbers of children and adolescents seem to be affected. SAD may be effectively treated with light therapy, but nearly half of those with SAD do not respond to light therapy alone. Antidepressant medication and psychotherapy can reduce SAD symptoms, either alone or in combination with light therapy (Sarason and Sarason, 2005).

Bipolar disorder, also called manic-depressive illness, is not as common as major depression or dysthymia. Bipolar disorder is characterized by cycling mood changes—from extreme highs (e.g., mania) to extreme lows (e.g., depression) (http://www.nimh.nih.gov/health/publications/depression/complete-index.shtml, 2011).
Bipolar I disorder a mood disorder in which the individual experiences at least one episode of mania and in most patients, one or more major depressive episodes. Bipolar II disorder a type of bipolar disorder in which the person has experienced at least one major depressive episode and one hypomanic episode but has never had a manic episode or cyclothymia (Sarason and Sarason, 2005).

COMMON CAUSES OF DEPRESSION

GENETICS

Research indicates that depression is, at least in part, inherited. Thus far, however, no studies have isolated the specific genes responsible for depression. Both genetic and neurochemical factors have been linked to depression (Donaldson, 1998). Genetic factors surface in both twin and adoption studies (McGuffin, Owen and Gottesman, 2005). Identical twins have a concordance rate of about 67% for experiencing clinical depression, compared with a rate of only 15% for fraternal twins (Gershon, Berrettini and Golden, 1989). Among adopted people who develop depression, biological relatives are about 8 times more likely than adopted relatives to also suffer from depression (Wender et al, 1986).

BRAIN CHEMISTRY IMBALANCE

Depression is believed to be caused by an imbalance in the neurotransmitters which are involved in mood regulation. Neurotransmitters are chemical substances which help different areas of the brain that communicate with each other. When certain neurotransmitters are in short supply, this may lead to the symptoms, recognized as clinical depression.
FEMALE SEX HORMONES

It has been widely documented that women suffer from major depression about twice as often as men. Because the incidence of depressive disorders peaks during women's reproductive years, it is believed that hormonal risk factors may be to blame. Women are especially prone to depressive disorders during times when their hormones are in flux, such as around the time of their menstrual period, childbirth and perimenopause. In addition, a woman's depression risk declines after she goes through menopause.

CIRCADIAN RHYTHM DISTURBANCE

Seasonal Affective Disorder is believed to cause a disturbance in the normal circadian rhythm of the body. Light entering the eye influences this rhythm and during the shorter days of winter, when people may spend limited time outdoors, this rhythm may become disrupted.

POOR NUTRITION

A poor diet can contribute to depression in several ways. A variety of vitamin and mineral deficiencies are known to cause symptoms of depression. Researchers have also found that diets either low in omega-3 fatty acids or with an imbalanced ratio of omega-6 to omega-3 are associated with increased rates of depression. In addition, diets high in sugar have been associated with depression.

MEDICAL ILLNESSES

Illness is related to depression in two ways. The stress of having a chronic illness may trigger an episode of major depression. In addition, certain illnesses for example, Thyroid disorders, Addison's disease and Liver disease can cause depression symptoms.
DRUGS, BOTH LEGAL AND ILLEGAL

Several prescription drugs have been reported to cause symptoms of depression. In addition, a variety of drugs of abuse have been associated with depression symptoms.

STRESSFUL LIFE EVENTS

Stressful life events, which overwhelm a person's ability to cope, may be a cause of depression. The major changes in life circumstances that can have a stressful impact for months or years depending on the situation. At the top of the list is the death of a spouse, child or parent. But it also includes losing job, moving to a new city, separation or divorce and being a victim of crime or accident. Major life events can be stressful even when they are positive like marriage and pregnancy (Posen, 2006). Scientists have theorized that high levels of the hormone cortisol, which are secreted during periods of stress, may somehow induce depression by affecting the neurotransmitter serotonin.

GRIEF AND LOSS

Although grief is a normal response to death and loss, the extreme stress associated with grief can trigger an episode of major depression.

CONFLICT

Depression may result from personal conflicts or disputes with family members or friends (Schimelpfenig, 2009).

PREVENTION OF DEPRESSION

Although depression is a highly treatable condition, some forms of depression may not be preventable. That's because depression may be triggered by a chemical malfunctioning in the brain. However, the latest medical studies confirm that depression
may often be alleviated or sometimes prevented with good health habits. Proper diet, exercise, taking time out for fun and relaxation, not overworking and saving time to do things to enjoy may work together to prevent a depressed mood. (http://www.webmd.com/depression/guide/understanding-depression-prevention, 2011).

THEORIES OF DEPRESSION

The effects of depression on a person's everyday life can be debilitating and can grow increasingly worse with time. As of yet, the specific cause for this condition remains unknown. The physical and psychological components that accompany depression symptoms have formed the basis for a number of theories on its origin.

Depression is classified as an affective disorder that disrupts a person's emotional state. Feelings of sadness, loss of interest in daily activities, fatigue and muscle aches and pains are all possible symptoms of this disorder. A person's emotions, thoughts and behaviours are factors that play a part in how this condition is experienced. A theory of depression will incorporate one or more of these factors to explain how this condition develops within a person's life.

NEUROBIOLOGY THEORY

The neurobiological theory of depression identifies specific neural processes that contribute to the symptoms a person experiences. Chemicals in the brain called neurotransmitters are responsible for regulating the processes that take place in the body. Epinephrine, dopamine and norepinephrine are the chemicals involved in regulating emotions and thought processes. When any one of these chemicals is out of balance, depression symptoms can result. Treatment models based on this theory use antidepressant medications as a way to correct whatever chemical imbalances may be present in the brain.
COGNITIVE THEORY

A prominent, 20th century psychologist named Aaron T. Beck (1982) the founder of the cognitive-behavioural branch of psychotherapy. Beck's Cognitive theory of Depression--identifies the source of depression within the thought processes of the mind. Individuals who experience symptoms like sadness, loss of self-esteem and hopelessness are typically plagued with negative patterns of thinking. This theory views thought processes as the "conduits" of emotion. Treatment approaches focus on eliminating these negative thinking patterns and replacing them with positive, constructive patterns of thinking. Once negative thought processes are gone, their resulting emotional symptoms are eliminated.

EVOLUTIONARY THEORY

Evolutionary psychology is concerned with how human behaviours relate to the survival of the species. A theory of depression, called Rank Theory, views depression disorders as a survival tactic that promotes the survival of the weaker members of a society. Individuals who accept their lower ranked status in society exhibit depression symptoms as a defensive mechanism and as a way of coping with their status. As depression symptoms can be readily visible in the form of sadness and fatigue. These symptoms reduce the likelihood of competition or conflict with others, while at the same time work toward maintaining the social equilibrium of the species.

MALAISE THEORY

The Malaise Theory of depression views the disorder as caused by a hyperactive immune system response that attacks specific chemical processes within the body. This theory defines depression as a sickness behaviour caused by higher than normal

45
levels of cytokines in the system. Cytokines are a class of immune active agents. These agents are believed to be responsible for the fatigue and muscle aches that accompany some forms of depression. Symptoms become further aggravated by negative thought processes and emotions. Malaise theory views antidepressants as a type of analgesic or pain-killer that reduces the number of cytokines in the system, which is why symptom relief occurs. (http://www.ehow.com/about_5403605_theory-depression.html#ixzz1cRYnXJFH).

TREATMENT FOR DEPRESSION

MEDICATIONS

The first-line treatments for depression are antidepressant drugs that are a class of medications used in cases of severe depression to improve the patients mood. It was found that patients suffering from tuberculosis who were given the drug Iproniazid suddenly became happier and more optimistic. When the same drug was tested on people suffering from depression, a similar results occurred and drugs became an accepted form of treatment for depression (Shuchter, Downs and Zisook, 1996). Tricyclic drugs increase the availability of norepinepherine at the synapses of neurons, whereas MAO inhibitors prevent the enzyme Monoamine Oxidase (MAO) from breaking down neurotransmitters. Newer antidepressant, Selective Serotonin Reuptake Inhibitors (SSRIs), target the neurotransmitter serotonin, permitting it to linger at the synapse. Lithium, a mineral salt is a drug used to treat bipolar disorder. Drugs such as Depakote and Tegretol are effective in reducing manic episodes (Dubovsky, 1999).

PSYCHOTHERAPY

Psychotherapy is a process in which a trained professional enters a relationship with a patient for the purpose of helping the patient with symptoms of mental illness,
behavioural problems or personal growth. The process involves the patient and therapist sitting in a room talking, which is why it is often called "talk therapy." Psychotherapy in conjunction with medication is considering being the most effective treatment for depression. Interpersonal Psychotherapy is a therapy based on psychodynamic ideas concerning the importance of relationships and on the protective role of social support when life stress occurs. IPR is often used to help prevent relapse after recovery from a depressive episode. Existential theorists view depression as a loss of self esteem. Humanistic theorists emphasize the differences between the person's ideal self and his or her perception of the actual self. If the differences is too great, depression is likely to result.

Behavioural treatments for depression an effective behavioural approach to treating depression is social skills training focused both on appropriate behaviour and on improved skills in understanding the cues other people give in social interactions.

Cognitive Behaviour Therapy, from the cognitive perspective utilizes both cognitive and behavioural elements and is often called Cognitive Behavioural Therapy (CBT). The therapist works with the client to change his or her dysfunctional thought patterns. Special emphasis is put on the identification of clients automatic thoughts and eventually, the modification of their early maladaptive schemas.

ELECTROCONVULSIVE THERAPY (ECT)

Electroconvulsive Therapy (ECT) first introduced during the 1930's, is a procedure in were an electric current of 70 to 150 volts is briefly administered to a patient's head causing a loss of consciousness and often seizures. Usually the patient is sedated and receives muscle relaxants prior to administration of the current, to reduce the intensity of muscle contractions produced during ECT. The typical patient receives about
10 such treatment in the course of a month, but some patients continue with maintenance treatments for months afterward (Nierenberg, 1998 and Fink, 1999).

Generally, a series of treatment is given over a period of weeks. Situations when ECT might be administered when medications have not been effective, when medications might endanger the patient or when a rapid response is needed.

**VAGUS NERVE STIMULATION (VNS)**

Vagus Nerve Stimulation or VNS involves the use of an implanted device to provide periodic stimulation to the vagus nerve. The device was originally developed as a treatment for epilepsy. It has since been approved in the U.S., Canada and the European Union for treatment-resistant depression in both unipolar depression and bipolar disorder (Schimelpfening, 2007).

**GENERAL WELL-BEING**

“Gratitude makes sense of our past, brings peace for today and creates a vision for tomorrow”

- Melody Beattie

General well-being refers to the state of being or doing well in life. Well being has many aspects. It is based on self-esteem how one feels about oneself and behaviour that is appropriate and healthy. The characteristics of an emotionally healthy person are:

- Understands and adapts to change
- Copes with stress
- Has a positive self-concept
• Has the ability to love and care for others

• Can act independently to meet his or her own needs

Before the 1970s, quality of life received little attention in the medical or public health literature, but since then the situation has been reversed. Despite its widespread use, the term "quality of life" has different meanings to different people. For some researchers and clinicians, quality of life means almost anything beyond information about death and death rates. For others quality of life is an umbrella concept that refers to all aspects of a person's life, including physical health, psychological well-being, social well-being, financial well-being, family relationships, friendships, work, leisure etc. In contrast, some approaches to quality of life emphasize the social and psychological aspects of life and contrast quality of life with quality of care.

DEFINITIONS OF GENERAL WELL BEING

The American Heritage Dictionary of the English Language (2000) defines Well-Being as “The state of being healthy, happy or prosperous; welfare”.

According to Collins English Dictionary (2003) Well-Being is defined as “the condition of being contented, healthy or successful”.

Researchers at the University of Toronto’s Quality of Life Research Unit define quality of life as “The degree to which a person enjoys the important possibilities of his or her life”

“The state or condition of being well, welfare, happiness, prosperity as, virtue is essential to the well-being of men or of society”.
People who are truly healthy enjoy a positive state of wellness or well-being. Maintaining wellness is a lifelong pursuit and hopefully a labour of love. People who attain optimal wellness are both physically and psychologically healthy. They engage in positive thinking, show emotional resilience and they are optimistic and self-confident (Lightsey, 1996).

A new integrative theoretical perspective on well-being may provide additional assistance in bridging the gap between our research based understanding of living well and ability to promote it (Lent, 2004).

The most acceptable definition of Health is given by the WHO (1978): “Health is the state of complete physical, mental, social and spiritual well-being and not merely an absence of disease or infirmity”.

MEANING OF GENERAL WELL-BEING

The term quality of life is used to evaluate the general well-being of individuals and societies. The term is used in a wide range of contexts, including the fields of international development, healthcare and political science. Quality of life should not be confused with the concept of standard of living, which is based primarily on income. Instead, standard indicators of the quality of life include not only wealth and employment, but also the built environment, physical and mental health, education, recreation and leisure time and social belonging (Gregory et al, 2009).

While Quality of Life (QOL) has long been an explicit or implicit policy goal, adequate definition and measurement have been elusive. Diverse "objective" and "subjective" indicators across a range of disciplines and scales and recent work on
Subjective Well-Being (SWB) surveys and the psychology of happiness have spurred renewed interest (Costanza et al, 2008). Frequently related concepts are freedom, human rights and happiness. However, since happiness is subjective and hard to measure, other measures are generally given priority. It has also been shown that happiness, as much as it can be measured, does not necessarily increase correspondingly with the comfort that results from increasing income. As a result, standard of living should not be taken to be a measure of happiness. (Layard, 2006 and Gregory et al, 2009).

Quality of life is an important concept in the field of international development, since it allows development to be analyzed on a measure broader than standard of living. Within development theory, however, there are varying ideas concerning what constitutes desirable change for a particular society and the different ways that quality of life is defined by institutions therefore shapes how these organizations work for its improvement. (Gregory et al, 2009).

Organizations such as the World Bank, for example, declare a goal of working for a world free of poverty, where poverty is defined as “a low quality of life”. Using this definition, the World Bank works towards improving quality of life through neoliberal means, with the stated goal of lowering poverty and helping people afford a better quality of life (The World Bank, 2009).

Because of the differences in the theory and practice of development, there are also a wide range of quantitative measures that are used to describe quality of life. The term quality of life is also used by politicians and economists to measure the liveability of a given city or nation.
Some crimes against property (e.g., graffiti and vandalism) and some "victimless crimes" have been referred to as "quality-of-life crimes." American Sociologist, Wilson encapsulated this argument as the Broken Window Theory, which asserts that relatively minor problems left unattended (such as public urination by homeless individuals, open alcohol containers and public alcohol consumption) send a subliminal message that disorder in general is being tolerated and as a result, more serious crimes will end up being committed (http://en.wikipedia.org/wiki/Quality_of_life).

THEORIES ON WELL-BEING

SET POINT THEORY

Set point theory predicts that well-being tends to fluctuate around a stable level—a level that generally remains uniform over time. After individuals experience positive events, their well-being might rise transiently but then will revert to this stable level or set point. Likewise, after individuals experience negative events, their well-being might decline momentarily, but will then regress to the previous level.

ADAPTATION LEVEL THEORY

Adaptation level theory may provide some insights into the source of this stability in well-being (Helson, 1948, 1964). According to this theory, over a period of time, individuals form expectations of the future, called frames of reference. Events that are more favourable than such expectations evoke positive emotions, whereas events that are less favourable than such expectations evoke negative emotions. These events, however, also shape the expectations or frames of reference. To illustrate, if individuals are assigned to a salubrious office—an office that exceeds their expectations—they will
initially enjoy positive emotions. Over time, however, their frame of references changes and they expect these surroundings. Hence, after several weeks or months, the office no longer elicits positive affective states (Moss, 2010).

SUBJECTIVE THEORIES OF WELL-BEING

It is difficult to figure out where an immaterial trait such as "goodness" could reside in the world. A counterproposal is to locate values inside people. Some philosophers say that if some state of affairs does not tend to arouse a desirable subjective state in self-aware beings, then it cannot be good.

Most philosophers think that goods have to create desirable mental states also say that goods are experiences of self-aware beings. These philosophers often distinguish the experience, which they call an intrinsic good, from the things that seem to cause the experience, which they call "inherent" goods. Failing to distinguish the two leads to a subject-object problem in which it is not clear who is evaluating what object.

Some theories describe no higher collective value than that of maximizing pleasure for individual(s). Some even define goodness and intrinsic value as the experience of pleasure and bad as the experience of pain. This view is called hedonism, a monistic theory of value. It has two main varieties: Simple and Epicurean.

Simple hedonism is the view that physical pleasure is the ultimate good. However, the ancient philosopher Epicurus used the word 'pleasure' in a more general sense that encompassed a range of states from bliss to contentment to relief. Contrary to popular caricature, they valued pleasures of the mind to bodily pleasures and advocated moderation as the surest path to happiness.
Bentham's (1988) book “The Principles of Morals and Legislation” prioritized goods by considering pleasure, pain and consequences. A similar system was later named Utilitarianism by Mill (1861). More broadly, utilitarian theories are examples of Consequentialism. All utilitarian theories are based upon the maxim of utility, which states that good is whatever provides the greatest happiness for the greatest number. It follows from this principle that what brings happiness to the greatest number of people is good.

A benefit of tracing good to pleasure and pain is that both are easily understandable, both in oneself and to an extent in others. For the hedonist, the explanation for helping behaviour may come in the form of empathy—the ability of a being to "feel" another's pain. People tend to value the lives of gorillas more than those of mosquitoes because the gorilla lives and feels, making it easier to empathize with them. This idea is carried forward in the ethical relationship view and has given rise to the animal rights movement and parts of the peace movement. The impact of sympathy on human behaviour is compatible with Enlightenment views, including Hume’s (2000) stances that the idea of a self with unique identity is illusory, and that morality ultimately comes down to sympathy and fellow feeling for others, or the exercise of approval underlying moral judgments.

A view adopted by Griffin (1986) attempts to find a subjective alternative to hedonism as an intrinsic value. He argues that the satisfaction of one's informed desires constitutes well-being, whether or not these desires actually bring the agent happiness. Moreover, these preferences must be life-relevant, that is, contribute to the success of a person's life overall.
Desire satisfaction may occur without the agent's awareness of the satisfaction of the desire. For example, if a man wishes for his legal will to be enacted after his death and it is, then his desire has been satisfied despite the fact that he will never experience or know of it.

Baba proposed that it is not the satisfaction of desires that motivates the agent but rather "a desire to be free from the limitation of all desires. Those experiences and actions which increase the fetters of desire are bad, and those experiences and actions which tend to emancipate the mind from limiting desires are good." It is through good actions, then, that the agent becomes free from selfish desires and achieves a state of well-being: "The good is the main link between selfishness thriving and dying. Selfishness, which in the beginning is the father of evil tendencies, becomes through good deeds the hero of its own defeat. When the evil tendencies are completely replaced by good tendencies, selfishness is transformed into selflessness, i.e., individual selfishness loses itself in universal interest."

**OBJECTIVE THEORIES OF WELL-BEING**

The idea that the ultimate good exists and is not orderable but is globally measurable is reflected in various ways in economic (Classical Economics, Green Economics, Welfare Economics, Gross National Happiness) and scientific (Positive Psychology, the Science of Morality) well-being measuring theories, all of which focus on various ways of assessing progress towards that goal, a so-called Genuine Progress Indicator. Modern economics thus reflects very ancient philosophy, but a calculation or quantitative or other process based on cardinality and statistics replaces the simple ordering of values. For example, in both economics and in folk wisdom, the value of
something seems to rise so long as it is relatively scarce. However, if it becomes too scarce, it leads often to a conflict and can reduce collective value.

In the classical political economy of Smith (2002) and Ricardo (1817) and in its critique by Karl Marx, human labour is seen as the ultimate source of all new economic value. This is an objective theory of value, which attributes value to real production-costs and ultimately expenditures of human labour-time. It contrasts with marginal utility theory, which argues that the value of labour depends on subjective preferences by consumers.

The economic value of labour may be assessed technically in terms of its use-value or utility or commercially in terms of its exchange-value, price or production cost. But its value may also be socially assessed in terms of its contribution to the wealth and well-being of a society.

In non-market societies, labour may be valued primarily in terms of skill, time and output, as well as moral or social criteria and legal obligations. In market societies, labour is valued economically primarily through the labour market. The price of labour may then be set by supply and demand, by strike action or legislation or by legal or professional entry-requirements into occupations.

MID-RANGE THEORIES

Conceptual metaphor theories argue against both subjective and objective conceptions of value and meaning and focus on the relationships between body and other essential elements of human life. In effect, conceptual metaphor theories treat ethics as an ontology problem and the issue of how to work-out values as a negotiation of these metaphors, not the application of some abstraction or a strict standoff between parties
ENHANCEMENT OF GENERAL WELL BEING

Humans and non-human animals are fundamentally sufferers. They possess consciousness that gives them the capacity to suffer or to enjoy life, to be miserable or to be happy. Singer identifies the suffering/enjoying status of all animals with their quality of life. It follows from this precept, then, that those who suffer more than others have less quality-of-life, and those who do not possess an insufficiently developed consciousness fall below the plane of personhood. (Demarco, 2003).

A human being is a positive asset and a precious national resource which need to be cherished, nurtured and developed with tenderness and care, coupled with dynamism. Each individual’s growth presents a different range of problems and requirements at every stage from the womb to the tomb. The catalytic action of discovering the whole person for well being involves appreciating oneself, identifying the inner self, living in the present and a mature retrospection (Kuriapilly, 1996).

Among all the very many things created by God in the world, man is considered as the crown of His creation. In the human body, there is unlimited power and energy. The potentiality of the human mind is beyond our estimation. A strong and steady mind is the greatest asset of a human being and a flimsy mind, shaken by every passing fancy will retard fulfillment in every department of life. Thus a healthy mind leads to a better quality of life (Grimaldi, 2001).
The Doctrine of Karma is a direct outcome of the extension of the age-old and well-established principle “as you sow, so you reap” to the spiritual sphere. According to the karma doctrine the course of life of every living being here and hereafter is determined by his Karma or his deeds and a pious life leads to comforts, contentment and general well-being in the present life and rebirth in higher and better forms of existence (Kumar, 2008).

POSITIVE THERAPY

Relaxation technique is also known as relaxation training. It helps a person to relax and to reduce levels of anxiety, stress or anger. It is often employed as stress management programme to decrease muscle tension, lower the blood pressure and slow heart and breath rates, among other health benefits. A relaxation technique such as deep breathing, visualization, progressive muscle relaxation, meditation and yoga helps to activate this relaxation response. When practiced regularly, these activities lead to a reduction in a person's everyday stress levels and boost the feelings of joy and serenity. Relaxation response is a technique that draws upon the power of the human mind to overcome stress, pain and anxiety. Benson (1975), an internist, Harvard University, United states, developed this type of self healing has the ability of the mind to control the responses of the body. There are various types of relaxation response techniques employed with different conditions. (Baer, 2010). They are:

Biofeedback is a process of recording and amplifying physiological signals from the body, such as muscle activity, brain waves or temperature so that one can learn to increase or decrease them.
Progressive Relaxation is an exercise of tensing and relaxing the major muscle groups of the body until one is able to relax the groups when needed (Plotnik, 1993).

Guided Imagery in which people visualize images that are calming or beneficial in other ways. Relaxation can be promoted by visualizing peaceful scenes (by picking places where one feels safe calm and at ease).

Stress Inoculation is the use of positive coping statements to control fear and anxiety (Coon, 2000).

Transcendental Meditation (TM) which involves assuming a comfortable position, closing one’s eyes and repeating and concentrating on a sound to clear one’s head of all thoughts. Besides transcendental meditation there are various forms of Eastern Meditation (yoga) as well as Western Version. All the techniques generally produce similar results (Plotnik, 1993).

Above all there is Positive Therapy which is the package of combining Eastern Techniques based on Yoga and Western Techniques based on Cognitive Behaviour Therapies. The assumption of Positive Therapy is that the perception of a situation or a person as a problem is owing to one’s own perception, rather than the actual situation or the person. It improves both physical and mental health, helps in the management of negative emotions, adjustment, marital and family problems, stress disorder, depression and to have a pleasing personality with positive perception. This therapy is also a self help psychological approach. Positive Therapy includes four strategies namely Relaxation Therapy, Counselling, Exercises and Behavioural Assignments.
NEED FOR THE STUDY

Mental retardation is a particular state of functioning that begins in childhood and characterized by limitation in both intelligence and adaptive skills. Mental retardation reflects the “fit” between the capabilities of individuals and the structure and expectations of their environment. Mental retardation varies in severity. Parenting refers to the activity of raising a child rather than the biological relationship.

The mentally challenged show behavioural problems and deficits in their adaptive behaviour in various areas, such as communication skills, self-help skills, socialization, application of basic academic skills to daily life activities, social skills, vocational and social performance and responsibilities, which lead to lot of stress and depression in their parents. All these, in turn, will affect their well-being.

Raising a child who is mentally challenged requires emotional strength and flexibility. Parents of mentally challenged children commonly experience a gamut of emotions over the years. They often struggle with guilt. One or both parents may feel as though they somehow caused the child to be disabled. Some parents struggle with "why" and experience a spiritual crisis or blame the other parent. Occasionally, parent feels embarrassed or ashamed that their child is mentally disabled. Physical exhaustion can take a toll on the parents of a mentally challenged child. The degree of this is usually relative to the amount of care needed. Feeding, bathing, moving, clothing and diapering an infant is much easier physically than doing the same tasks for someone who weighs 80 pounds. They need to be watched to avoid inadvertent self-harm such as falling down stairs or walking into the street. These additional responsibilities can take a physical toll on a parent, leading to exhaustion. Raising a child with a mental challenge may be more
expensive than raising a typical child. These expenses can arise from medical equipment and supplies, medical care, care giving expenses, private education, tutoring, adaptive learning equipment or specialized transportation. The care of the child may last a lifetime instead of 18 years. All these issues can cause significant caregiver stress. Thus it is found in a study that parents have significantly higher levels of depression than adults who do not have children.

In order to overcome stress and depression and develop positive attitude towards their child and life Positive Therapy was administered to parents of mentally challenged, which in turn reduced their stress and depression to such an extent that they were able to accept their child as he or she is and also changed their approach towards life.

Earlier researches proved that Positive Therapy was successful in reducing stress and depression and help in the enhancement of general well-being. Positive Therapy (Hemalatha, 2004) is a package combining the Eastern techniques based on Yoga and Meditation with the Western techniques based on Cognitive Behaviour Therapy. It helps people to have a pleasing personality with positive perception. It helps to deal with problems more effectively and lead a successful life. Hence, the researcher conducted a study to help the parents of mentally challenged to manage their stress and depression and enhance the general well-being through Positive Therapy.