CHAPTER V

DISCUSSION, CONCLUSION
AND
RECOMMENDATIONS
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Every one has some ups and downs, and occasional sadness is a normal emotion. But depression is more than feeling blue, sad, or down in the dumps once in a while. Depression is a strong mood involving sadness, discouragement, despair, or hopelessness that lasts for weeks, months, or even longer, and interferes with a person’s ability to participate in their normal activities.

Depression is one of the major mental health disorders affecting a large number of population especially younger generations across the world. Currently in the United States one in every three persons is the victim of depression owing to various socio-economic, familial, psychological and environmental factors (Nelson, 1982; Andrews and Brown, 1988; Kobak et al., 1991). In India, it has affected a large number of population mainly because of unemployment, poverty, adjustment problems, loss of close family members, disturbed family relationships, stress in daily life and chronic health problems.

Depression is a common feature in case of all mental as well as physical health problems. It is very difficult to find a person who did not undergo depression once or twice in lifetime on account of different reasons. When this mental health problem affects a person for a longer time it requires medication. During this period they exhibit different problems and sometimes it becomes very difficult for the family members to deal with the patients. The family members become totally confused about the mode of treatment if patient do not respond to some medication whether psychological or psychiatry. It happens mostly because of lack of knowledge about this mental health problem among the general population and lack of early intervention facilities in Indian society. In India normally family members do not feel like
to consult a mental health professional in case of any mental health problem suffered by any family members owing to social stigma. Family members consult a mental health professional as and when it becomes very difficult to manage the patient at home.

Given this background the necessity was felt to understand the mental health profile of the depressive patient in Kolkata and the types of problems encountered by the family members so that need-based measures can be suggested to deal with the problem professionally. Simultaneously literature review also indicates that no such study was carried out in India to explore the issues, which are addressed in this study.

The broad objective of the study was to ascertain the personality disposition, self-esteem, emotional control and suicidal tendencies of depressive patients. In addition, the present study also made an attempt to understand the problems encountered by the family members in dealing with depressive patients and solutions thereof. A group of 118 depressive patients, irrespective of categories were selected following incidental sampling method from different govt. and private health centers. For comparison of the data of depressive patients with regard to the variables mentioned above, a group of 118 normal population was selected purposively and they were matched in terms of age and gender. Data were collected by Bengali Version of Multi-dimensional Personality Inventory by Km. Manju Agarwal, Self-esteem Inventory by M.S.Prasad and G.P.Thakur, Emotional Control Inventory by Samuel E. Krug, Suicidal Tendencies Inventory by Samuel E. Krug after local adaptation. In addition, one semi-structured questionnaires was used to gather information about socio-economic and familial background of the depressive patients. In addition, the said schedule also gathered information about the onset of the disease and the problems encountered by the family members in dealing with the patients and their suggestions thereof to deal with depressive patients more effectively. Ethical issues like informed consent, voluntary participation, confidentiality of information and
convenience of data collection were taken care of while collecting data from the subjects and their family members.

**Profile Of The Depressive Patients:**

Findings revealed that the depressive patients came from all age groups. However, it mostly affected the people over 20 years of age. Out of a total of 118 depressive patients 63 (53.4%) were male while the rest 55 (46.6%) were female which is contrary to the previous study findings (Coryell et al., 1991; Blazer et al., 1994). It could be because of gender discrimination in India. In India male people always receive better attention and care in case of health, education and food intake especially in the middle and lower socio-economic classes. In case of depression, male patients were reported more perhaps because of their economic contribution in the family and/or sole earning member in the family.

Educational background of the depressive patients indicates that it mostly affects people with below graduation. Hence, it may be stated that people who could not complete graduation were unable to get better source of earning and thereby indirectly it became a cause of depression. However, people with better educational background i.e., Graduate and Post Graduate are also the victim of depression although their number is less compared to people with less education. So far as professional background is concerned, male members with both service and business background are the victims of depression. Male members who are in service are more prone to depression could be because of work pressure, lack of future growth, unsatisfactory salary and poor interpersonal relationship. Too much competition and loss in business could be the factors for the people who suffer from depression. Interestingly the women who are not employed i.e., the housewives become more depressed as compared to women who are employed.

So far as marital status is concerned, people of all categories become the victim of depression as 38.1% married, 23.7% single, 16.9 divorcee/separated and 21.2% widowed were found to be depressive. About two-fifth i.e., 40.7%
of the patients have been suffering from depression for the last one year while the rest three-fifth (59.3%) have been suffering from the same mental health problem for more than last one year. Marital problems have also positive correlation with depression. Studies of marital couples in which one is clinically depressed have shown relatively negative interaction patterns marked by hostility, tension, difficulty resolving conflict, and reports of marital difficulties associated with depression (Gotlib and Whiffen, 1989; Gotlib and Hammen, 1992).

In Kolkata more than half of the depressive patients suffer from dysthymic depression (59.3%) could be because of stress in daily social life and poor interpersonal relationships. It is unfortunate about one-fifth of the depressive patients did not receive any medication for a long time on account of lack of knowledge of the family members about the disease, lack of available information about the mental health services and ignorance of the family members because of poor economic condition. However, the patients who received some sorts of medication, 26.3% reported that they have fully benefited by the same while 34.7% stated that they have been benefited partially and the rest 30.5% stated that they are not at all benefited.

Family Profile Of The Depressive Patients:

Both psychodynamic and social learning theory models of human development emphasis the importance of experiences in early childhood in the family environment. When those experiences are dysfunctional or when the child lacks critical experiences such as a close bond with a stable caretaker, he or she may develop in maladaptive ways. Both of these models hypotheses that depression might be a form of psychopathology resulting from certain unique family experiences.

In the present study, family environment is found to have some positive link with depression since more than 70.0% patients come from disturbed family environment. A number of previous studies have also confirmed the
hypothesis of disrupted family environments and relatively dysfunctional relationships between parents and children (Kaslow et al., 1994; Hammen and Rudolph, 1996). The quality of parent-child relationships is frequently impaired for depressed children. Both clinical and community samples of depressed youngsters report relatively negative interactions with their parents (Garrison et al., 1990; Cole and McPherson, 1993).

No such link of family history of depression have been found out as only 21.2% of the depressive patients came from a family with a family history of depression. However, a number of earlier studies indicated that the children of depressive patients appear to be an increased risk for developing depression as well as other disorders (Weissman et al., 1987; Gotlib and Lee, 1990). So far as family type and size is concerned, an overwhelming number of depressive patients came from nuclear family (87.3%) with small family size.

In this regard, it is relevant to mention the notion of Bowlby (1978; 1981) with regard to depression. John Bowlby has articulated a model of the importance of early attachment bonds between the infant and caretaker, which has implications not only for depression, but also for key elements of individual personality and adaptive functioning. Specifically, Bowlby argued that infants have an innate and fundamental tendency to form attachments bonds to a primary caretaker, in the service of protection and survival. Further, the development of a stable and secure attachment bond is essential for healthy development. An infant with a mother who is consistently responsive, accessible and supportive will acquire a 'working model' i.e., cognitive representations of the self that is positive. The child will be able to use the relationship as a 'secure base' from which to explore the environment and acquire essential skills, and will form representations (beliefs and expectations) of other people as trustworthy and dependable. If, however, the attachment bond is insecure due to actual disruption or loss, or to maternal rejection, unresponsiveness, or inconsistency, the person becomes vulnerable to depression. The individual acquires negative cognitions about the self and others.
Simultaneously, poor social network is found to have positive correlation with depression. Findings of a previous study stated that depressed children report less social support, perhaps because of low social network, potentially exacerbating the ill effects of stressful family life (Daniels and Moos, 1990). A large-scale sample of medical and psychiatric patients decreased over a 2-year period as a function of availability of perceived support, and that if support was available, patients were less likely to develop a new episode (Sherbourne et al., 1995). Several studies reported that when a major life event occurs, persons who lack a supportive intimate relationship with another person are significantly more likely to develop depression (Brown and Harris, 1978; Costello, 1982).

**Mental Dispositions:**

In the present research four metal variables of depressive patients have been studied. These are: personality dispositions, self-esteem, emotional control and suicidal tendencies.

The term ‘personality’ refers to the total functions of an individual who interacts with his environment. So far as personality disposition is concerned, findings revealed that depressive patients and normal population differed significantly in case of all the personality variables, i.e. introversion/extroversion, self-concept, independence/dependence, temperament, adjustment and anxiety.

Introversion/extroversion has been considered as one of the important potential personality variable. Introversion – the preference for solitary activities and discomfort in social situations – is consistently associated with depression both during the episode and in remission (Hirschfeld et al., 1983; Barnett and Gotlib, 1988). Introverted behaviours and cognitions imply that a person have difficulties in their interpersonal relationships, perhaps experience less enjoyment of social situations and relationships and have less
self-confidence in social occasions. Findings of the present study revealed that depressive patients and normal population differed significantly in case of introversion/extroversion variable which means that depressive patients are more introvert in nature and they act according to their own expectation and thinking.

The self has been considered as a central construct of the personality; the core of one's being or ego, and the end result of one's experience, the potential or the nucleus of personality. This thinking conscious entity is a complex of various vital psychological processes. It possesses a cognitive structure of adjustment and interactions. With regard to this personality variable depressive patient and normal population differed significantly which indicates that self-identification of depressive patients with a cluster of values or traits and consistency of functional existence is lower as compared to normal population.

Dependence/independence is another important variable of personality, which has close association with intelligence or uniqueness of the personality. Significant difference between depressive patients and normal population means that intellectual functioning of depressive patients is impaired as compared to normal population.

Clinical lore and empirical observations have noted that an important predictor of depression is dependency - emotional reliance on others, the belief that the affection, acceptance, and support of other people is essential to personal worth. There are two versions of this approach - one emphasizing trait dependency as a vulnerability factor, and the other emphasizing a diathesis-stress model that depression occurs when a match between interpersonal stressors and underlying dependency motives and cognitions occurs.

The trait approach has been support by studies showing that depressed people are relatively more dependent even when the person is not
symptomatic (Hirschfeld et al., 1986). Higher levels of dependency traits during the depressive episode may predict less likelihood of or slower recovery (Klein et al., 1988).

Temperament refers to reaction of the person toward emotional situation. By knowing temperament of the person one can estimate personality of the person because this is related to the consistency or mental imbalance and considered as one of the important factors of personality. Depressive patients and normal population differed significantly in temperament variable, which means that depressive patients are less consistent than those of their normal counterparts.

Adjustment is an index of integration between needs and press, which has a close relation to personality. It has been considered as a trait of personality. Significant difference between depressive patients and normal population in adjustment variable of personality means depressive patients are less capable to shape and reshape his/her personality to adjust with the changing situation in daily life.

Anxiety is generally defined as the feeling of apprehension caused by anticipation of danger, which may be internal or external. It is considered as an important personality variable. The current complexity of civilization, the rapidity of change, and the loss of certain traditional religious and familial values are creating more conflicts and anxiety in an individual's life. Present findings revealed significant difference between depressive patients and normal population in respect of anxiety variable, which indicates that depressive patients are more anxious than the non-depressed persons.

The male and female depressive patients irrespective of age or chronicity of the disease differ significantly only in case of temperament and adjustment variable. They did not differ significantly in case of rest of the personality variables, viz., extroversion/introversion, self-concept, independence/dependence and anxiety. However, mean scores indicate that
male depressive patients possessed high self-concept, they were more adjusted, more independent as well as more anxious than their counterparts while female depressive patients were more introvert and short tempered as compared to male counterparts.

Personality dispositions of depressive patients with respect to extroversion/introversion, self-concept, independence/dependence, temperament, adjustment and anxiety across chronicity of the disease differ significantly. Hence, it may be inferred that that the depressive patients who suffer from depression for more than one year are more introvert, more dependent on others, well tempered, poorly adjusted and have low anxiety along with low self-concept.

So far as self-esteem is concerned, it has been observed that depressive patients and normal population of same age group differed significantly which means that the self-esteem of depressive patients is low as compared to normal population. Further, findings revealed that self-esteem of male and female depressive patients irrespective of age or chronicity of the disease differed significantly which indicates that male depressive patients possess high self-esteem than those of female depressive patients. It could be because of outdoor activities and/or more interaction of male depressive patients with the larger society as compared to female depressive patients. Self-esteem of depressive patients across chronicity of the disease also differed significantly. From the mean score it is evident that individuals who were suffering from depression for more than one year posses low self-esteem, which means that gradually the self-esteem of depressive patients goes down.

Depression is one of several disorders generically called affective disorders, which means depression badly affects the emotion of an individual. Findings of the present study revealed that emotional control of depressive patients and normal population of same age group differed significantly which indicates that the stress tolerance level of depressive patients is low as compared to normal population. Emotional control of male and female
depressive patients irrespective of age also differed significantly in the present study, which indicates that stress tolerance level of male depressive patient is higher as compared to their counterparts. In the present study, emotional control of depressive patients across chronicity of the disease also differed significantly, which means that with the passage of time the stress tolerance level of depressive patients goes down.

Some have called depression a disorder of thinking, as much as it is a disorder of mood. Depressed people typically have negative thoughts about themselves, their worlds, and the future. They experience themselves as incompetent, worthless, and are relentlessly critical of their own acts and characteristics, and often feel guilty as they dwell on their perceived shortcomings.

The cognitive features of depression have been given particular emphasis by some investigators, who note that thinking in such grim and self-critical ways actually makes people more depressed or prolongs their depression. The negativistic thinking is commonly irrational and distorted, and represents very different interpretations of the self and the world during the depressed state than an individual would typically display when they weren't depressed. This observation gave rise to Aaron Beck's cognitive model of depression (Beck, 1967). Findings of the present study reveal that suicidal thoughts of depressive patients and normal population of same age group differed significantly which indicates that depressive patients have lost hope in life and wish to end their lives.

One of the most noteworthy characteristics of depression is that it is far more common among women than men (Weissman and Olfson, 1995). This apart, there are also indications that women's course of depression is different from men's. For example, women may have earlier onsets than men do (Sorenson, Rutter and Aneshensel, 1991). However in the present study male and female depressive patients did not differ significantly with regard to suicidal tendencies variable. Suicidal tendencies of depressive patients across
chronicity of the disease differ significantly. Interestingly, the people who are suffering from depression for more than last one year possess more suicidal thoughts as compared to the depressive patients who are suffering from depression for the last one year.

In India general population and even the educated people neither have adequate knowledge about mental health problems nor they are aware of services available for the same. Findings of the present study corroborate the said above statement since only about one-fourth (23.7%) patient parties immediately consulted health service providers for advice and medication while the rest three-fourth did not pay attention to the problems of depressive patients and/or could not understand the problems. The issue requires attention of health policy makers for the needful steps.

Whenever there is a patient in the family with mental health problem, in reality all the family members become victim of anxiety, stress and depression, thinking about the remedy of the said mental patient in the family. It also affects the output of the entire individual in the family, as they remain busy with the patients. Hence it is loss of human resource. In order to understand the problems faced by the family members in dealing with a depressive patients, it has been observed that majority of the family members stated that withdrawal (63.6%) is the common problem of depressive patients, followed by lack of sense of responsibility (60.2%), lack of social support (57.6%), poor interpersonal relationship of the patient (57.6%), poor hygienic sense (46.6%), lack of interest in work (35.6%), irritating nature (29.7%), not attending office or work place (27.1%), suicidal attempts (23.7%), sleeping for a longer time (23.7%), crying (18.6%), and others like unable to remember, not responding to stimulus (18.9%) (Chapter IV, Table 24).

Out of a total of 118 depressive patients covered in the present study 23.7% attempted to commit suicide at least once. Further probing revealed that 8 attempted to commit suicide more than once. Greenberg (1982) reported that as many as half of the suicides in the United States are committed by people
suffering from depression. Suicidal ideation is quite common in depressed youngsters (Mitchell et al., 1988; Ryan et al., 1987). Actual suicidal attempts occurred in 39.0% of the preadolescents and adolescent samples of Mitchell et al., (1988), with 6 - 12% of the Ryan et al., (1987) child and adolescent samples making moderate or severe attempts. These rates appear to be higher among depressed youngsters than among depressed adults.

Direct and/or first hand experienced people are the right kind of persons to suggest the remedial measures after the specialized professionals. In the present study, effort was made to understand the viewpoints of first-hand experienced people about the remedy to deal with depressive patients. They have suggested a number of measures. The most common measures as suggested by the family members include providing more love and affection, mental and social support to the patients so that they feel that they are accepted to the family members. They also asked for proper treatment of the patients including counseling by the trained counselor and medicine at affordable cost and/or free of cost. There is also a need of awareness of mental health problems among the patient’s parties as well as among general population as suggested by the family members.

**Conclusion:**

In fine, it may be stated that depressive patients differ significantly with their normal counterparts with regard to mental health variables like personality dispositions, self-esteem, emotional control and suicidal tendencies.

Further, gender-wise significant difference was observed in case of self-esteem and emotional control of depressive patients while no significant difference was obverted with regard to suicidal tendencies. However, in case of personality variables male and female depressive patients differed significantly only with regard to temperament and adjustment variables.
Findings also revealed that in case of all the mental health variables i.e., personality dispositions, self-esteem, emotional control and suicidal tendencies, depressive patients differ significantly across chronicity of the disease, irrespective of gender differences.

Findings of the present study also revealed that general population lack awareness about the mental health problems and there is shortage of professional services for the mentally disturbed people in our society. Findings also unearthed the type of problems encounter by the patient parities in dealing with depressive patients and explored the suggestions as to how to deal with depressive patients more effectively.

**Recommendations For Future Study:**

On the basis of the findings of the present study, the following studies are recommended for future researchers:

- One study should be carried out to understand the level of depression among general population across different social strata.

- Another study should be carried out to unearth whether mental depression is most responsible for family disturbances or vice versa.

- Efficacy of different psychological intervention programmes for prognosis of depression.

**Recommendations For Diagnosis Of The Disease And Intervention:**

On the basis of the findings of the present study and keeping the fact in mind that depression is the most common prevalent feature among all the mental health problems, the following steps have been recommended:

- There should be proper arrangements of psychodiagnosis in the Govt. and Non-Govt. hospitals for ascertaining the mental state especially about suicidal thoughts among the depressive patients so that timely intervention can be provided to the needy patients.
• Complete case history and psychiatric interview should be taken along with physical examination to determine if the cause of depression is physical or psychological.

• Proper mental status examination should be carried out by the trained Psychologist emphasizing on current stressors, support system, dependence on substances and suicidal ideation.

• The doctor may recommend medication, but treatment will vary according to the cause and severity of the depressive symptoms, as well as patient’s preference. If patient is taking other medications that could cause depression, these may need to be changed. Medications should not be changed without consulting the health-care provider.

• For mild depressive symptoms, counseling from experienced counsellor may be recommended.

• For moderate to severe depression, antidepressant medication may be prescribed. Psychotherapy may also be recommended. Several types of focused psychotherapies have been developed that are as effective as medication in treating depression. The choice of medications, psychotherapy, or both can be made based on patient’s preference and the availability of these treatments. In order to avoid recurrent bouts of depression, it is important to finish the course of treatment.

• For people who are so severely depressed as to be unable to function, or who are so acutely suicidal they cannot be safely cared for in the community, psychiatric hospitalization may be necessary.

• More mental support should be provided to the depressive patients in the home set up. For the said purpose there should be some arrangements for orientation of the family members in the Govt. and
Non-Govt. hospitals so that the family members can deal with the depressive patients more effectively.

- For mild depressive symptoms, improving health habits to provide adequate and regular sleep and good nutrition may bring relief. Regular exercise is also helpful. Decreasing the use of alcohol and other drugs is also recommended, since these can aggravate depressive symptoms.

- Involvement in healthy pleasures such as recreation and creative activities, and staying involved with family and friends helps to lift a person's mood.

- Being reminded that other people care helps to relieve the isolation that often accompanies depressed feelings. Discussion with clergy or spiritual advisers may give meaning to painful experiences, and prayer or meditation can access internal sources of strength.

- If you recognize that your family member who is suffering from depression is chronically pessimistic and self-critical, self-help workbooks to combat depressive thinking may be helpful. These usually involve a program of exercises to identify distorted perceptions and substitute more realistic ones. But when you or a loved one cannot shake these feelings within a few weeks or with help from sources above mentioned, you may need to contact your doctor, because you may be suffering from major depression.

- Depression disrupts work and family life for more than two weeks. Depression is so severe that suicide is contemplated. Do not hesitate to call for help immediately! If your primary health-care provider can't be reached, many communities have telephone hotlines for such situations. If there is no such service nearby, call the nearest emergency room or health-care facility.
• Professional mental health services should be made available for the mentally disturbed individuals in all the Govt. and Non-Govt. hospitals and it should be a part of regular health services since in our country the incidence of various types of mental problems is increasing steadily.

• Social support system should be improved i.e., the depressive patients should be taken to different social occasions and should be allowed to take part in daily life activities under proper supervision.

• Arrangements of free treatment facilities should be made available in the Govt. Health Centres including free medicines for the poor people.

• There should be proper referral services in the Govt. and Non-Govt. hospitals i.e., the list of local psychiatrists, psychologists, family counselors, and rehabilitation homes for mentally disturbed people and list of emergency services should be available. This referral services will benefit the patient parties as and when required.

• Antidepressant medications are widely used, effective treatments for depression. Existing antidepressants influence the functioning of certain chemicals in the brain called neurotransmitters. The newer medications, such as the selective serotonin reuptake inhibitors (SSRIs), tend to have fewer side effects than the older drugs, which include tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs). Although both generations of medications are effective in relieving depression, some people will respond to one type of drug, but not another. Other types of antidepressants are now in development.

• Certain types of psychotherapy, specifically cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT), have been found helpful
for depression. Research indicates that mild to moderate depression often can be treated successfully with either therapy alone; however, severe depression appears more likely to respond to a combination of psychotherapy and medication. More than 80 percent of people with depressive disorders improve when they receive appropriate treatment (Source: National Institute of Mental Health, 2002).

- Treatment for Dysthymia Disorder consists of a combination of medication and therapy. The most common therapies are cognitive therapy and behavioral therapy. Often, higher doses of medications are necessary than for severe depression.

- Workshops and seminars should be organized to create awareness among general population about causes and consequences of various mental health problems with a view to eradicating the superstition and social stigma about the mental health problems.

**The Art Of Avoiding Depression:**

In every way, depression is a growing problem. Rates of depression have steadily climbed over the last 50 years and are significantly higher in those born after 1945 than in those born before. In addition, the average age of onset of a first depressive episode is steadily decreasing--it is now mid-20s whereas it once was mid-30s. Cross-cultural data show that the United States has a higher rate of depression than almost any other country, and that as Asian countries Westernize their rates of depression increase correspondingly.

The data make it abundantly clear that these changes are not the product of individual biochemistry or of family genetics but of pathology within our culture. There are many depressogenic factors operating in our culture. Information overload is one. Since 1945 we have accumulated at least as much information as we had throughout history until then. The more
information there is, the more we end up essentially skimming the surface. This leads to a style of thinking in which we see only the big picture and miss the depth of detail. As a result, when we are faced with difficult problems, we do not recognize the many small steps that solutions typically require; things feel overwhelming and insurmountable, leading us to give up before we even start.

Our growing reliance on technology also contributes to depression. One of technology's main values is speed. But speed has warped our perspective of time so that we expect things to happen at ever-faster rates. Embracing speed as a cultural value has advantages when we are dealing with things that can actually be done quickly, such as electronic mail, but it is a profound disadvantage when applied to other domains of life, like building a relationship. We can't instantly learn to be a good judge of other people's character or instantly build good relationships with our colleagues at our new job. But people want a good relationship, and they want it now, without having a clue what the steps are and how long it takes to achieve each one. They expect instant intimacy and fool themselves into thinking they've achieved it by sleeping with somebody before they know who the person is.

It has become fashionable to call depression a disease, to medicalize it. And certainly neurotransmitters like serotonin and norepinephrine are involved in depression. But if we ask more critical question -- is biology the cause of depression? -- the best data suggest that genes account for about one in five cases. The idea that a chemical imbalance causes depression, rather than reflects it, ignores the fact that the brain's biochemistry responds to our ways of thinking -- in short, to life experience.

Depression is an organized, patterned way of responding to events and experiences. For example, some people develop the tendency to take things personally, even when things are not personal or they tend to engage in
ail-or-nothing thinking. Either way, the result is that they draw wrong conclusions about events and make the mistake of believing those conclusions rather than testing them. A person whose relationship has broken up tells himself, "No person will ever love me, I'll never fall in love again." And he doesn't, unless somebody comes along and challenges that false belief.

It has long been assumed that when depression runs in families the cause is defective genes. But parents also transmit their general patterns of perception and thinking to their children. Some children are programmed early in life to make grossly negative interpretations about themselves. They bring home an A-minus grade and their father says, "You're a lazy kid. You're grounded until you get an A." Just like that they learn that they're nothing without the A, that it's all or nothing.

Depression is helped most when we encourage people to be active on their own behalf, to challenge their own thinking, to find out whether the thoughts that hurt them are true or not. That's why psychotherapy outperforms medication in the long run. In studies comparing drug therapy to psychotherapy for depression, after about a month medications are ahead; they provide a reduction of symptoms more quickly and more reliably than therapy does. After a couple of months, antidepressants and psychotherapy are running neck and neck; at 12 weeks, therapy is actually slightly ahead. Clients feel better about themselves when they're taking action on their own behalf and learning the principles that will help insulate them from later episodes of depression. As a result, relapse occurs 50 percent more often among patients receiving medication alone than among those receiving both drugs and therapy.

Cognitive therapy, behavioral therapy, interpersonal therapy, and medication all work. But, no matter what, you do need a variety of skills in order to avoid depression. Here are some of them:
Perhaps the most important skill is the ability to recognize and tolerate ambiguity. In many situations there is no single correct answer but a variety of possibilities. Life is inherently ambiguous; an experiential Rorschach. It is in response to ambiguity that we're most likely to make the negative interpretations that can lead to depression.

Critical thinking is crucial for overcoming depression. It means the ability to examine the evidence and correctly assess the truth of our beliefs, to discriminate between things that we're responsible for and things that we're not. People tend to underestimate or overestimate the amount of control they actually have over situations. If they assume they're helpless when they're not, they don't even try. The ability to recognize what you are and are not responsible for is directly related to how much guilt you experience.

You need to discriminate between ways in which you are defined by your achievements and ways that you are not. Times when it's okay to get in touch with your feelings, and those when you'd better get out of touch with them, when it's okay to focus on the present, and when it's better to concentrate on the future.

Another crucial skill is the ability to clearly articulate goals. Wanting to be happy is not an unreasonable goal. But what exactly do you mean by happy? You should know your goal and you should have proper planning for achieving the goal.

A highly important skill for warding off depression is learning to discriminate between what you feel versus what is objectively true. Good mental health requires you to juggle the interplay between what's going on within you and what is going on out there.

Finally, relationship skills are important for preventing depression. We've known for decades that relationships serve as buffers against
illness and emotional disorders. The people who are at the greatest risk for depression are those who are most lonely. Demographically, single women face the highest risk; married men, the lowest. So it's crucial to know how to meet people, assess them, communicate with them, let them know you're interested in them. And once you're in a relationship, you need to take steps to keep it healthy, such as asserting personal boundaries and setting up the rules by which the relationship will operate (Yapko, Michael. D., 1997).

**Love Needs:**

Love is as critical for our mind and body as oxygen. It's not negotiable. The more connected we are, the healthier we will be both physically and emotionally. The less connected we are, the more we are at risk.

It is also true that the less love we have, the more depression we are likely to experience in our life. Love is probably the best antidepressant because one of the most common sources of depression is feeling unloved. Most depressed people don't love themselves and they do not feel loved by others. They also are very self-focused, making them less attractive to others and depriving them of opportunities to learn the skills of love.

There is a mythology in our culture that love just happens. As a result, the depressed often sit around passively waiting for someone to love them. But love doesn't work that way. To get love and keep love you have to go out and be active and learn a variety of specific skills.

Most of us get our ideas of love from popular culture. We come to believe that love is something that sweeps us off our feet. But the pop-culture ideal of love consists of unrealistic images created for entertainment, which is one reason so many of us are set up to be depressed. We think it is love when it's simply distraction and infatuation.
One consequence is that when we hit real love we become upset and disappointed because there are many things that do not fit the cultural ideal. Some of us get demanding and controlling, wanting someone else to do what we think our ideal of romance should be, without realizing our ideal is misplaced.

It is not only possible but necessary to change one's approach to love to ward off depression. Follow these action strategies to get more of what you want out of life—to love and be loved.

➤ Recognize the difference between limerance and love. Limerance is the psychological state of deep infatuation. It feels good but rarely lasts. Limerance is that first stage of mad attraction whereby all the hormones are flowing and things feel so right. Limerance lasts, on average, six months. It can progress to love. Most love in fact starts out as limerance, but most limerance never evolves into love.

➤ Know that love is a learned skill, not something that comes from hormones or emotion particularly. Erich Fromm called it "an act of will." If you don't learn the skills of love you virtually guarantee that you will be depressed, not only because you will not be connected enough but because you will have many failure experiences.

➤ Learn good communication skills. They are means by which you develop trust and intensify connection. The more you can communicate the less depressed you will be because you will feel known and understood.

➤ Focus on the other person. Rather than focus on what you are getting and how you are being treated, read your partner's need. What does this person really need for his/her own well-being? This is a very tough skill for people to learn in our narcissistic culture. Of course, you don't
lose yourself in the process; you make sure you’re also doing enough self-care.

➢ Help someone else. Depression keeps people so focused on themselves they don’t get outside themselves enough to be able to learn to love. The more you can focus on others and learn to respond and meet their needs, the better you are going to do in love.

➢ Develop the ability to accommodate simultaneous reality. The loved one’s reality is as important as your own, and you need to be as aware of it as of your own. What are they really saying, what are they really needing? Depressed people think the only reality is their own depressed reality.

➢ Actively dispute with yourself internal messages of inadequacy. Sensitivity to rejection is a cardinal feature of depression. As a consequence of low self-esteem, every relationship is interpreted far too personally as evidence of inadequacy. Quick to feel rejected by a partner, you then believe it is the treatment you fundamentally deserve. But the rejection really originates in you, and the feelings of inadequacy are the depression speaking.

➢ Recognize that the internal voice is strong but it’s not real. Talk back to it. "I’m not really being rejected, this isn’t really evidence of inadequacy. I made a mistake." Or "this isn’t about me, this is something I just didn’t know how to do and now I’ll learn." When you reframe the situation to something more adequate, you can act again in an effective way and you can find and keep the love that you need (Ellen McGrath, 2002).