CHAPTER II

LITERATURE REVIEW 
AND 
AN OUTLINE PLAN
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Literature Review And An Outline Plan

Literature review is an essential and very significant part of any research. It helps the researcher to conceptualize the problem in a better way by showing various perspectives of the problem. It provokes thinking on various aspects of the problem. Literature review also gives an idea to hypothesize the problem correctly.

In the present study the findings of previous researchers on various aspects of the depression were reviewed. For the convenience of the readers the literature review has been classified and presented under following broad heads:

2.1 Symptoms Of Depression.
2.2 General Physical Health And Depression.
2.3 Prevalence And Epidemiology Of Depression.
2.4 Psychosocial Characteristics Of Depressed Patients.
2.5 Adolescence And Depression.
2.6 Old Age And Depression.
2.7 Eating Habits Of Depressed Patients.
2.8 Addiction And Depression.
2.9 Gender And Depression.
2.10 Self And Depression.
2.11 Interpersonal Relationship And Depression.
2.12 Other Relevant Studies.

2.1 Symptoms Of Depression:

Brummet et al., (2000) sought to evaluate the associations between depressive symptoms and social support in a sample of 115 depressed elderly patients using multi-measure approach to assess both depressive symptomatology and social support. They examined the baseline relations among a self-report measure of depressive symptoms, clinical assessments of depressive symptoms, and subjective and received social support, and also
the ability of social support to predict changes in clinical assessments of depressive symptoms at 6 months and 1 year. The findings showed that baseline subjective support was negatively related to self-reports of depressive symptoms, but unrelated to clinical assessments at baseline or follow-up. Conversely, received support was unrelated to self-reported depressive symptoms, but positively related to both clinical assessments at baseline. However, higher ratings of received support at baseline predicted decreases in clinical ratings of depressive symptoms at 6 months and 1 year. These results have important implications for interpreting clinical data in elderly depressed patients. Specifically, when depressive symptoms are assessed using clinician ratings, the most informative aspect of social support with respect to future clinical status appears to be received, rather than perceived, support measures.

Psychosocial coping resources have been found to protect against depressive symptoms in people with and without chronic diseases. To estimate the direct and buffer effects of psychosocial resources on depression, and to examine whether these effects are different for various chronic diseases. Bisschop et al., (2004) conducted a longitudinal study covering 2288 community-dwelling respondents aged from 55-85 using structured interview method for assessing depressive symptoms, social support and personal coping resources, physical functioning and socio demographic variables. Generalized estimating equation models were estimated for each disease, social support and personal coping resources. All resources, except social network size, showed a direct effect on depressive symptoms regardless of the presence of chronic diseases. Having a partner, high self-esteem, mastery, self-efficacy and feeling less lonely additionally buffered the negative effect of some, but not all, specific chronic diseases. Unexpectedly, in patients with cardiac disease, none of the psychosocial resources exerted a buffer effect on depressive symptoms. For instrumental and emotional support only direct (unfavorable) effects and no buffer effects could be observed. Finally they concluded that buffer effects of psychosocial resources are different across various chronic diseases. This
suggests that interventions to enhance specific resources may ameliorate depressive symptoms in specific chronic patients groups.

2.2 General Physical Health And Depression:

Chronic Painful Physical Condition (CPPC) lasting 6 months or more influences the frequency and severity of depressive symptoms in subjects with major depressive disorder (MDD). According to Ohayon (2004) CPPC is present in nearly half of subjects with MDD. CPPCs increase the severity of physical symptoms of depression (fatigue, insomnia nearly everyday, psychomotor retardation, weight gain). Moreover, CPPCs affect the duration of depressive episodes and their recurrence.

Sullivan et al. (2004) carried out a research on depression and health status among patients with coronary disease covering 113 outpatients with advanced heart failure of which 19.0% (n=21) had major depression or dysthymia, 9.0% (n=10) had minor depression, and 72.0% (n=82) had no current depression diagnosis. This study revealed that depressive group differed in severity of self-reported breathlessness, chest pain, and fatigue. Subject, and spouse-reported physical and role function also differed between the groups. Finally they concluded that depression is prospectively associated with poorer health status in patients with advanced heart failure. Physical and role function, symptom severity, and quality of life are all significantly affected.

The links between the psychological and physiological features of cancer risk and progression have been studied through psychoneuroimmunology. The persistent activation of the hypothalamic-pituitary-adrenal (HPA) axis in the chronic stress response and in depression probably impairs the immune response and contributes to the development and progression of some types of cancer. The consecutive stages of the multi step immune reactions are either inhibited or enhanced as a result of previous or parallel stress experiences, depending on the type and intensity of the stressor and on the
animal species, strain, sex, or age. In general, both stressors and depression are associated with the decreased cytotoxic T-cell and natural-killer-cell activities that affect processes such as immune surveillance of tumours, and with the events that modulate development and accumulation of somatic mutations and genomic instability (Reiche et al., 2004).

There is increasing evidence that major depression impacts the course of HIV infection to investigate predictors of depression (e.g., demographic and clinical variables, negative life events, and coping response) in people living with HIV/AIDS. Olley et al., (2004) carried out a research among outpatients with recently diagnosed HIV/AIDS patients in South Africa. One hundred forty-nine recently diagnosed HIV/AIDS patients (44 males and 105 females) were evaluated. Subjects were assessed using the Mini International Neuropsychiatric Interview (MINI), the Carver Brief COPE coping scale, and the Sheehan Disability Scale. In addition, previous exposures to trauma and past risk behaviors were also assessed. Three variables gender, confidence interval, impact of negative life events, and disability predicted current major depression. It is well known from non-HIV populations that female gender and increased negative life events predict depression. These data also emphasize the importance of these links in HIV.

Depression is a significant psychiatric condition of childhood and adolescence. Again people with a chronic medical problem are at increased risk for developing depression. In this area Wray et al., (2004) conducted a research on 'Depression in pediatric patients before and 1 year after heart or heart-lung transplantation' They administered the Mood and Feelings Questionnaire, a rating scale of depressive symptoms to 58 children before transplantation and to 46 children after transplantation. They found that children before transplantation suffer from more depression then children after transplantation. Transplantation is associated with a reduction in the prevalence of depressive symptomatology.

The study of Lichtenberger et al., (2003) examined the relationships between physiological function (i.e., both functional status and functional capacity),
depressive symptoms, and body image among maintenance cardiac rehabilitation participants. In order to achieve their objective they studied 72 men (mean age = 67.3 years) all of whom had experienced a traumatic cardiac event (i.e., myocardial infarction, valve replacement surgery, coronary artery bypass graft surgery, percutaneous transluminal coronary angioplasty), and had completed some type of physician-supervised acute cardiac rehabilitation. Measures of body image (social physique, anxiety and body appearance satisfaction), self-reported functional status, clinician-reported functional capacity, and depressive symptoms were collected. The findings revealed that both functional capacity and functional status explained significant variance in social physique anxiety, whereas only functional status was a significant predictor of body appearance satisfaction. On the basis of the results they inferred that both patient perceptions of functional status and clinical measures of functional capacity are important aspects of psychosocial well-being among cardiac patients.

Hysterectomy is a surgical procedure that significantly affects the quality in which the operated person views herself, lowers self-esteem and brings about changes in the quality of life. The course of the post-operative period and the return of the patients to full health are largely affected by their psychological state and the quality of life they experience. A successful (in a medical sense) surgical procedure is not a guarantee of the bringing back health in a holistic sense. Many studies (Jawor et al., 2001) and clinical observations show that half of the group of women operated suffer from anxiety-depressive disorders as a cause of the operation, and a quarter of all those operated require specialist help. No psychological preparation for the operation, absence of closest people in the decision making before the operation, lack of knowledge on the surgical operational-span, lacking psychological aid after the operation, all these can significantly affect the rehabilitation and the process of regaining the social functions. The appearance of depressive symptoms post-operatively as well as the earlier presence of affective disorder symptoms can be prognostic in the further development of the disorder. The early diagnosis of the affective disorder and the higher level of anxiety in women
post-hysterectomy and the fast application of appropriate treatment can inhibit further symptom elevation and persistence.

Pincus et al., (1996) investigated the prevalence of self-reported depressive symptoms in a case-control study of patients with rheumatoid arthritis (RA) attending an outpatient clinic at the Middlesex Hospital. Patients selected their own controls, matched for age and sex. A total of 163 patients (77.0% of the sample) and 115 matched pairs completed the Hospital Anxiety and Depression Scale (HADS). The results indicated that RA patients are more depressed and anxious than controls. The prevalence of depression above the cut-point was 15 percent.

Several factors have been related to depression for people with diabetes, but mechanisms of depression in this population remain unclear. In this regard Bailey et al., (1996) carried out a research to test mastery and self-esteem as mediators of disease-related depression in people with diabetes. A sample of 180 adults ages 21 to 81 were participated in this cross-sectional, correlational study. Bailey found that effect of diabetes on daily activities had a significant, direct (i.e., non mediated) relationship to depressive symptoms. The entire model predicted 53.0% of variance in depression scores (p = .0001). These findings suggest nursing strategies for managing depression in patients with diabetes.

Depression is a common problem in patients with Parkinson’s disease. It is thought that neurochemical changes contribute to its occurrence, but it is unclear why some patients develop depression and others do not. So Schrag et al., (2001) investigated the contributions of impairment, disability and handicap to depression in Parkinson’s disease using a community-based sample of patients with Parkinson’s disease. Research findings revealed that depression in patients with Parkinson’s disease is associated with advancing disease severity, recent disease deterioration and occurrence of falls. Regression analysis suggests that depression in Parkinson’s disease is more strongly influenced by the patients’ perceptions of handicap than by actual...
disability. The treatment of depression should therefore be targeted independently of treatment of the motor symptoms of Parkinson's disease, and consider the patients' own perception of their disease.

Shnek et al., (2001) conducted a research on psychological factors and depressive symptoms in ischemic heart disease with the aim to determine whether learned helplessness, cognitive distortions, self-efficacy, and dispositional optimism assessed at Time 1 (T1; questionnaires mailed at 1 month post discharge) would predict depressive symptoms at Time 2 (T2; questionnaires mailed at 1-year follow-up) in a sample of 86 patients hospitalized with ischemic heart disease. Multiple regression results indicated that optimism and cognitive distortions at T1 were significantly associated with T1 depressive symptoms after controlling for confounding variables. When the T1 psychological factors were analyzed with T2 depressive symptoms, only optimism continued to predict depressive symptoms after controlling for confounds and T1 depressive symptoms.

Depression is associated with many physical problems. Wilson et al., (2002) conducted a prospective case-control study to determine whether patients with glaucoma have more depressive symptoms than patients without glaucoma. They administered the Center for Epidemiologic Studies Depression Scale (CES-D) and Composite International Diagnostic Interview, Short Form (CIDI-SF) questionnaires to all the study subjects to gather demographic information and medical history. The results showed that depression scores for patients with glaucoma do not differ significantly from scores of control patients. Having past or present mental illness is the only consistent predictor for depression in both the groups. Among glaucoma patients, visual acuity level, visual field severity, and use of topical beta-blockers are not predictors for depression. Finally on the basis they draw the conclusion that patients with glaucoma do not report being more depressed than patients without glaucoma as measured by the CES-D and the CIDI-SF questionnaires.
Stigmatization by the general population and their negative attitudes towards leprosy negatively impacts on patients’ mental health, and so does patients’ perception of that stigma too. Tsutsumi et al., (2004) conducted a study with the view to assess the depressive status of leprosy patients, the patient perception of that stigma, and its association with their depressive status in Dhaka, Bangladesh covering 140 patients, and a selected comparison group of 135 local people without any chronic diseases using Center for Epidemiologic Studies Depression Scale (CES-D) Bengali version. The findings of the study revealed that the depressive status in leprosy patients is greater than that of the general public. Further, actual experiences of discrimination are based on the stigma associated with the depressive status of leprosy patients. Tsutsumi et al., suggested that mental health care for patients, regulation of discriminatory action and education is important to decrease the social stigma among the general population about leprosy, for improving the mental health of Bangladeshi leprosy patients.

Silverstone et al., (1996) carried out a study covering 186 patients in a view to determining the prevalence of major depressive disorder in acutely ill medical inpatients, and the relationship of this to low self-esteem. The results showed that 18 patients (9.7%) were depressed. The depressed patients were significantly younger than the non-depressed patients and were significantly more likely to be female. The depressed patients had a significantly lower self-esteem than the non-depressed patients, whose self-esteem was no different from the general population. However, the depressed patients were not more severely ill than the non-depressed patients. The results also demonstrated that both nurses and physicians were poor at recognizing the presence of major depression. The findings also revealed that the prevalence rates for MDD in medical patients is between 5% to 10% rather than the previously accepted range of 20% to 40%.
2.3 Prevalence And Epidemiology Of Depression:

Epidemiological studies in western societies generally show that depressive episodes occur in 10-20% of pregnant women. Longitudinal studies have demonstrated that antenatal depression is one of the most powerful predictors of postnatal depression. There is also a growing literature that shows that antenatal psychological distress can adversely affect maternal and fetal well-being.

Lee et al., (2004) carried out a study on antenatal depression among 238 pregnant Chinese women (38 weeks of pregnancy) and found that a significant proportion of Chinese women suffer from psychiatric morbidity during pregnancy. Depressive disorders are by far the commonest morbidity in the study population. Given the scope of the morbidity and the potential impact on obstetric and neonatal outcomes, early screening and treatment are warranted.

O'Sullivan (2004) conducted a cross-sectional study on the psychosocial profile of patients with depressive patients comparing depressive risk factors within and between two Western community cohorts covering six hundred eight primary care patients from the rural population of Farranfore, Ireland, and the suburban population of Penrith, Australia. The survey included the Centre for Epidemiological Study Depression scale, Vulnerable Personality Style Questionnaire, Life Events Inventory, and Social Support Survey. Exposure to a range of early adverse childhood events was also assessed. The 3-month prevalence of depressive symptoms between Farranfore and Penrith respondents was 30% and 35%, respectively. O'Sullivan (2004) observed that the onset of depressive symptoms was positively associated with unfavorable childhood events, poorly perceived social supports, recent stressful life events, a vulnerable personality style, and previous depressive illness. The study identifies the person's social and internal world as a potent source of depressive risk over the lifespan.
2.4 Psychosocial Characteristics Of Depressed Patients:

In depressive disorders, there are psychopathological dimensions other than depressed mood and anxiety that deserve greater clinical recognition and research. Pasquini et al., (2004) attempted a research to assess the relevance of anger, irritability, aggressiveness, hostility, and psychomotor activation in major depressive disorder. A total of 222 newly admitted consecutive outpatients with major depressive disorder (mean age 48.9 years, 64.4% females) were enrolled in the study. They obtained a three-factor solution accounting for 47.4% of total variance. The factors were interpreted as 'anger/irritability', 'depression', and 'anxiety', respectively. The anger/irritability dimension was clinically relevant in 23% of patients. Anger/aggressiveness was especially frequent (21.6%), whereas psychomotor activation was infrequent (0.9%). Finally their study suggests that one of these symptom clusters (i.e. depressed mood & anxiety) includes anger, irritability, aggressiveness, and hostility.

Bienvenu et al., in the year 2004 observed that all of the lifetime disorders of interest (simple phobia, social phobia, agoraphobia, panic disorder, obsessive-compulsive disorder (OCD), generalized anxiety disorder, major depressive disorder (MDD), and dysthymia were associated with high neuroticism. Social phobia, agoraphobia, and dysthymia were associated with low extraversion and OCD was associated with high openness to experience.

In addition, they also found that lower-order factors of extraversion (E), openness (O), agreeableness (A), and conscientiousness (C) were associated with certain disorders (specifically, low assertiveness (E) and high openness to feelings (O) with MDD, low trust (A) with social phobia and agoraphobia, low self-discipline (C) with several of the disorders, and low competence and achievement striving (C) with social phobia). Neuroticism in particular was related to acuity of disorder.
Gunderson et al., (2004) investigate the longitudinal association of changes in Major Depressive Disorder (MDD) and borderline personality disorder among a sample of 161 patients with borderline personality disorder who have been followed with repeated measures at 6, 12, 24, and 36 months are investigated to see whether those with co-occurring MDD differ at baseline and in their course. Proportional hazard regression and cross-lagged panel analyses are used to demonstrate whether changes in the course of either disorder have predictable effects on the course of the other. They found that when borderline personality disorder and MDD co-occur, they can sometimes have independent courses, but more often improvements in MDD are predicted by prior improvements in borderline personality disorder. Their findings suggested that clinicians should not ignore borderline personality disorder in hopes that treatment of MDD will be followed by improvement of borderline personality disorder.

Depression is common among adolescents, and suicide is the third leading cause of death among 15 to 19 year olds. Hallfors et al., (2004) conducted a research on Adolescent depression and suicide risk association with sex and drug behavior. They studied the relationship among the health problems, which are associated with drug use and early sexual intercourse. They found that young individuals who abstain from risk behaviors; involvement in any drinking, smoking, and/or sexual activity is associated with significantly increased odds of depression, suicidal ideation, and suicide attempts. Odds ratios are highest among youth who engaged in illegal drug use. There are few differences between boys and girls who abstain from sex and drug behaviors. Girls are less likely than boys to engage in high-risk behaviors, but those who did tended to be more vulnerable to depression, suicidal ideation, and suicide attempt. Finally they concluded that teens engaging in risk behaviors are at increased odds for depression, suicidal ideation, and suicide attempts.

Clinical depression and other psychological disorders are associated with suicidal ideation, attempts, and deaths. Because of the link between suicide and mental illness, whenever discussion of "assisted suicide" arises, the possibility that major depression is affecting the decision arises. Werth et al.,
(2004) found that clinical depression is closely related to suicide, "assisted suicide," and other decisions that will hasten death (i.e. withholding and withdrawing treatment, terminal sedation, and voluntarily stopping eating and drinking).

According to Phillips et al., (2004) patients with both depression and drug dependence are at an elevated risk for suicide, yet suicide remains rare and difficult to predict. Female gender, violent behavior in the past thirty days and lifetime, and less education are correlated with a history of suicide attempts. Family conflict and depression severity is also correlated with current suicidal ideation.

Kuo et al., (2004) attempted a research with an aim to examine if hopelessness is a long-term predictor of suicidal behaviors using a longitudinal study design with a community sample of more than 3,000 participants. They assessed the association of hopelessness at baseline and incident suicidal behaviors in the 13-year follow-up period, adjusting for the presence of depression and substance use disorders. Suicide behaviors studied included completed suicide, self-reported attempted suicide, and suicide ideation. They found that hopelessness is predictive of all three types of suicidal behaviors in the follow-up period, even after adjustment. The association between suicidality and hopelessness is stronger and more stable than the association of suicidality with the presence of depression and substance use disorders. Finally they concluded that hopelessness is an independent risk factor for completed suicide, suicide attempts, and suicidal ideation.

Traumatic Brain Injury (TBI) is associated with psychiatric illness, suicidal ideation, suicide attempts, and completed suicide. Oquendo et al., (2004) investigated the relationship between mild TBI and other risk factors for suicidal behavior in major depressive episode. They hypothesized that mild TBI would be associated with suicidal behavior at least partly because of shared risk factors that contribute to the diathesis for suicidal acts.
Depressed patients (N = 325) presenting for treatment were evaluated for psychopathology, traumatic history, and suicidal behavior. Data were analyzed using Student t-test, chi-square statistic, or Fisher exact test. A backward stepwise logistic regression model (N = 255) examined the relationship between attempter status and variables that differed in the TBI and non-TBI patients. Forty-four percent of all subjects reported mild TBI. Subjects with TBI were more likely to be male, have a history of substance abuse, have cluster B personality disorder, and be more aggressive and hostile compared with subjects without TBI. They were also more likely to be suicide attempters, although their suicidal behavior was not different from that of suicide attempters without TBI. Attempt status was mostly predicted by aggression and hostility, but not the presence of TBI. For males, a history of TBI increased the likelihood of being a suicide attempter, whereas the risk was elevated for females regardless of TBI history.

Self-criticism is a unique personality dimension in different forms of psychopathology including depression. (Blatt, 1991). The study of Cox et al., (2000) revealed that depressive patients scored significantly higher on self-criticism dimension measured by the Depressive Experiences Questionnaire (DEQ).

Personality traits confer risk for suicidal behaviors in middle age and older adults. Useda et al., (2004) examined the contribution of personality traits to attempted suicide, the number of suicidal attempts, and suicidal ideation in a sample of depressed inpatients. They assessed Personality using the Revised NEO Personality Inventory (NEO-PI-R). Bivariate analyses showed that suicide attempters were more self-conscious, self-effacing, impulsive, and vulnerable to stress, and less warm, gregarious, and inclined to experience positive emotions. Multivariate regression analyses controlling for age, gender, severity of depression, and psychiatric comorbidity showed that patients with a lifetime history of attempted suicide were less inclined to experience positive emotions and be more self-effacing. Patients with more severe suicidal ideation were less warm and more self-effacing.
2.5 Adolescence And Depression:

To verify the hypothesis that family stress variables are associated with the effects of maternal depression on offspring diagnoses and also to examine whether such factors may be differentially associated with disorders in offspring of depressed and never-depressed women, Hammen et al., (2004) conducted a study on eight hundred sixteen (816) mothers and their 15-year-old children in an Australian community. Significant interaction effects were found between maternal depression and family discord/stress variables such that high levels of environmental risk factors were significantly associated with youth depression in children of depressed women compared with low levels of adverse conditions and were generally less associated with depression in children of nondepressed women. Nondepressive disorders were associated with adverse family and stress factors for both groups of children. The results suggest that psychosocial factors may contribute to diagnoses in offspring of depressed women in community samples.

Starling et al., (2004) examined changes in prevalence of psychological disturbance over time in adolescents referred for treatment. They measured the type and severity of emotional and behavioural problems using the Youth Self-Report and Child Behaviour Checklist in 4495 clinic-referred adolescents aged 12-17 years, born in a 21-year period (1966-1986). The findings revealed that there are significant increases in reports of self-harm and suicidal ideation (5% and 4% increase in odds per year, respectively) according to the parents of the referred adolescence. In contrast, there are no changes over time in the adolescents' reports. Neither parents nor children reported an increase in depressive symptoms. Finally they concluded that perceptions of a secular increase might reflect increasing parental awareness of some behaviour, particularly self-harm and suicidal ideation.
Otsuki et al., (2003) tested the relationship of self-esteem and depression with alcohol, tobacco, and other drug (ATOD) use in a California statewide sample of more than 4,300 Asian American high school students comprising five subgroups: Chinese, Japanese, Korean, Filipino, and Vietnamese. Estimated prevalence rates of alcohol, tobacco, and marijuana use among males and females from these Asian American subgroups are presented. Correlations revealed that cigarette, alcohol, and marijuana use were generally more related to high depression and low self-esteem in females than in males. The results of the study indicated that for females, depression was significantly related to alcohol and tobacco use, but self-esteem was not. Neither self-esteem nor depression was a significant contributor to marijuana use.

The survey of Angold and Costello (1993) on depression revealed important difference between preadolescents and adolescent groups. Their findings revealed that depression is fairly rare – affecting 2% to 3% of the youngsters who are below age 12. On the other hand adolescents have higher rates (6% to 8%).

Adult-onset cases of DSM-III-R Major Depressive Disorder (MDD) often have had a history of mood disturbances and allied clinical features during childhood or adolescence. The study of Wilcox et al., (2004) seeks to illuminate these early-life disturbances, as recalled and reported by adult-onset MDD cases (i.e. those whose first episode of MDD occurred after age 18) and non-cases covering 1920 patients. Of the 1920 participants, 150 were found to have a history of adult-onset MDD; 1755 were sub-threshold with respect to DSM criteria or reported few or no depression-related problems. Survival analysis was used to plot and study the cumulative occurrence of each clinical feature of depression from age 6 through 18 years for cases of adult-onset MDD versus non-cases. Results indicated that the earliest and most frequently occurring forerunners of adult-onset MDD were persistent depressed mood, anhedonia, feelings of worthlessness, and thoughts of death or suicide, with persistent anhedonia and worthlessness having a special prognostic value. One-third of adult-onset cases of MDD reported at least one clinical feature before age 19 versus only 7.3% of non-cases.
Associations between parenting style and depressive symptomatology in a community sample of young adolescents (N = 2596) were investigated by Martin et al., (2004). They used self-report measures including the Parental Bonding Instrument and the Center for Epidemiological Studies Depression Scale. They compared the 25-item 2-factor and 3-factor models by Parker et al., (1979), Kendler et al., (1996) 16-item 3-factor model, and Parker et al., (1983) quadrant model for the Parental Bonding Instrument. Data analysis included analysis of variance and logistic regression. Reanalysis of Parker et al.'s original scale indicates that overprotection is composed of separate factors: intrusiveness (at the individual level) and restrictiveness (in the social context). All models reveal significant independent contributions from paternal care, maternal care, and maternal overprotection (2-factor) or intrusiveness (3-factor) to moderate and serious depressive symptomatology, controlling for sex and family living arrangement. Additive rather than multiplicative interactions between care and overprotection were found. Finally they concluded that regardless of the level of parental care and affection, clinicians should note that maternal intrusiveness is strongly associated with adverse psychosocial health in young adolescents.

2.6 Old Age And Depression:

The article of O'Connor et al., (2001) examined some of the factors responsible for older patients' decision to report current depressive symptoms to their general medical practitioner. They conducted this survey on a stratified sample of 1,021 patients aged 70+ years of 30 GPs in Melbourne, Australia, to measure the prevalence of depressive symptoms, the frequency with which patients had informed GPs of their symptoms, and GPs' recognition of major depressive episodes. Patients and informants were questioned using the Canberra Interview for the Elderly, which generates rigorous ICD-10 research diagnoses. Logistic regression analysis showed that symptom disclosure was associated in descending order of importance with higher depressive scores, previous contact with a psychiatrist, and female
gender. Even so, 48% of persons with ICD-10 moderate or severe depressive episode had not reported any current complaints to their doctor at the time of interview. Finally they inferred that older patients often do not report depressive symptoms to their medical practitioner. Men and patients lacking 'psychological mindedness' may be at special risk.

A number of studies have concluded that the perceived quality of support is more strongly associated with mental health than with the actual structure of personal networks. The study of Lynch et al., (1999) examined clinical, historical, and phenomenological variables associated cross-sectionally and longitudinally with perceived social support. Participants included elderly, middle-aged, and young-adult depressed samples were derived from the Duke Clinical Research Center for the Study of Depression in Late Life. Cross-sectional multivariate analyses revealed that perceived social support was: (1) for the elderly associated with pessimistic thinking, being divorced, having strange ideas, the degree of social interaction, and instrumental support; (2) for middle-age associated with dysthymia, divorce, pessimistic thoughts, social interaction, and instrumental support; and (3) among young adults with instrumental support only. Longitudinal multivariate analyses indicated that only perceived social support at Time 1 predicted perceived social support 1 year later among elderly and middle-aged subjects, whereas only instrumental support predicted perceived social support 1 year later among the young-adult sample. The findings of this study indicate that in addition to whatever else clinicians do for depressed patients, they must endeavor to address relationship or social support difficulties, especially in the elderly.

Post-traumatic stress disorder (PTSD) and major depression are frequently comorbid. Age and major depression are associated with higher cortisol levels and dexamethasone resistance, whereas PTSD is associated with lower cortisol and dexamethasone supersensitivity. Some researchers found that cortisol levels increase with age in depressed patients without PTSD but not in depressed patients with PTSD or in healthy volunteers (Sher et al., 2004).
The study of Sher et al., highlighted the importance of considering age in psychobiology.

Wallace and O'Hara (1992) studied changes in depressive symptoms in a rural sample of people aged 65 and over. They found significant increases overtime in depressive symptoms—especially among the very old, age 85 and above—suggesting that late life may be a time of increased depression risk.

2.7 Eating Habits Of Depressed Patients:

Fava et al., (1997) carried out a study on one hundred thirty-nine outpatients (82 women and 57 men) with Major Depressive Disorder (MDD) in a view to evaluate the relationship between eating disorder symptomatology and severity of depression in depressed outpatients before and after antidepressant treatment and also to assess the effect of treatment on eating disorder symptomatology. On the basis of the study findings Fava et al., suggest that several symptoms characteristic of eating disordered patients are linked to the severity of depressive symptoms. Decreases in eating disorder symptomatology following antidepressant treatment may be related to changes in depressive symptoms.

Both depressive disorders and eating disorders are multidimensional and heterogeneous disorders. The paper of Casper et al., (1998) examines the nature of their relationship by reviewing clinical descriptive, family-genetic, treatment, and biological studies that relate to the issue. The studies confirm the prominence of depressive symptoms and depressive disorders in eating disorders. Other psychiatric syndromes, which occur with less frequency, such as anxiety disorders and obsessive-compulsive disorders in anorexia nervosa, or personality disorders, anxiety disorders, and substance abuse in bulimia nervosa, also play an important role in the development and maintenance of eating disorders.
Diet may affect mood and cognitive functions. But Hakkarainen et al., (2003) found no consistent association between dietary intake of amino acids and low mood or depressed mood and risk of suicide.

### 2.8 Addiction And Depression:

Depression and co-morbid substance abuse disorders are a major public health problem. Again depression among patients with substance abuse problems is a common problem. In this regard Manwell et al., conducted a study in the year 2004 on 30-day and lifetime prevalence of major depression among heavy drinking population (227) selected from 12 Polish primary care clinics. They defined heavy drinking as more than 20 drinks per week for males, or more than 13 drinks per week for females, or consumption of more than four drinks five or more times in the previous 30 days, or two or more positive replies to the CAGE questions. Criteria from the Diagnostic and Statistical Manual were used to assess lifetime and past 30-day depression. Results showed that 35% of women and men met criteria for depression in the 30 days prior to the interview. Lifetime rates were 45% for women and 52% for men. Men and women with a CAGE score of 4 were at higher risk for both 30-day (67%) and lifetime (78%) depression. Recreational drug users and patients reporting symptoms of anti-social personality disorders were at increased risk for lifetime depression. Subjects reporting symptoms of a childhood conduct disorder were at higher risk for 30-day depression.

Many researches have highlighted the relationship between cigarette smoking and depressive symptoms. Again in the year 2004, Brook et al., examined the relationship between cigarette smoking and depressive symptoms in a longitudinal sample of 688 adolescents and young adults through surveys conducted over 13 years. The results of their study indicate that a history of earlier cigarette smoking in adolescence predicts later depressive symptoms in the late twenties. The study also suggests that depressive symptoms during adolescence predict cigarette smoking in the late twenties but not above and beyond prior smoking. These results help to clarify and expand current
knowledge on the links between cigarette smoking and depression and also focus on several clinical implications for treatment of both cigarette smoking and depressive symptoms among both adolescents and young adults.

Friedman et al. (2004) conducted a research on depression, negative self-image, and suicidal attempts as effects of substance use and substance dependence. The main purpose of their study was to compare, separately by gender, the degree to which cocaine use/abuse, marijuana use/abuse, and alcohol use/abuse each predict to developing either: a state of depression, or a negative self-image, or a negative personal outlook or for making a suicidal attempt covering 431 subjects, at average age of 37. They found that female alcoholics and drug addicts have strong negative self-image as well as negative personal outlook, while males are relatively more predicted to making suicide attempts. Of the three types of substances, cocaine use/abuse predicted to the greatest number of negative outcomes; and alcohol use/abuse predicted to no negative outcomes.

Many psychiatric interviews with opiate addicts are characterized by three features: 1) the patient has a very factual and objective conversation, 2) the evaluation of the autobiographical memory is very difficult, 3) there is a high prevalence of affective disorders responsible for an impairment in cognitive functions. Eiber et al., (1999) conducted a research on a group of opiate addicts with the aim to estimate the impact of depression on the ability to produce autobiographical recollection in a population of opiate addicts and also to compare episodic and semantic autobiographical memory among opiate addicts and healthy controls. Participants were consecutive attendees of a methadone outpatient clinic who are multiple drug dependent patients consuming mainly heroine. The first investigation took place in entry and after two months. Eiber et al., selected 21 patients with a mean duration of intoxication of 11 years. Ten of these patients have been investigated again after 2 months and 8 of them have been included in a methadone maintenance program. The patients' investigation comprised two parts: first, the evaluation of autobiographical memory (only assessed at entry of the
study) with an autobiographical fluency test and the semi-structured autobiographical memory interview of Kopelman; second, the psychiatric assessment included self-rating questionnaires and observer-rating questionnaires. They noticed that opiate addicts showed a decrease in episodic autobiographical memory but an increase in semantic affective memory and objective modalization. In the fluency test, there was no difference in the number of evoked items between opiate addicts and healthy controls. This study suggests the implication of the drugs in the emergence of memory deficits. The improvement of depressive symptomatology after two months occurring without psychotropic drugs suggests the transient feature of depression and emphasises on non-pharmacological aspects of treatment.

Cornelius et al., (1995) made an attempt to provide a comprehensive description of the clinical features of patients who presented to an intake psychiatric setting with major depression and alcohol dependence and to determine which clinical features distinguished this dual-diagnosis group from patients with the two relevant single diagnoses. The findings revealed that the psychiatric symptom that most strongly distinguished the depressed alcoholics from the two comparison groups was the level of suicidal. The depressed alcoholics differed significantly from the non alcoholic depressed patients on only two depressive symptoms, suicidality (59% higher) and low self-esteem (22% higher); they were also significantly distinguished from the nonalcoholic depressed patients by factors such as greater impulsivity, functional impairment, and abnormal personal and social history markers.

2.9 Gender And Depression:

Williams et al., (1995) carried out a study on gender differences in the frequency and manifestation of depression in primary care. They found that more women than men were diagnosed as having a mood disorder (31% vs. 19%; p < 0.01), and an antidepressant was newly prescribed only for women (p < 0.001). There were no gender differences in physician ratings of patients' health, but women rated their health significantly more poorly than did men.
Similarly, functional impairment scores were significantly lower in women than in men. Finally they concluded that women are much more likely than men to have depressive disorders, and when these disorders are diagnosed, to receive a prescription for antidepressant medication.

Studies investigating the correlates of adolescent depression and suicidal tendencies have found that the probability of such tendencies vary from race to race and from gender to gender. Sen (2004) conducted a research on 'Adolescent Propensity for Depressed Mood and Help Seeking: Race and Gender Differences' with the aim to test whether there are significant differences between genders, and between non-Hispanic whites, non-Hispanic blacks, Hispanics and Asians in the likelihood of seeking help, and from whom, when depressed on a sample of more than 9000 adolescents enrolled in grades 6-10. He used Multinomial logit models to estimate the likelihood of being depressed or at self-injury risk, and help-seeking behavior in event of depressed mood. Models are estimated for the full sample and sub-samples who report depressed mood or are at self-injury risk. In addition to race and gender, all models control for additional demographic characteristics such as age, family structure, and family socio-economic status. Results showed that adolescent females are significantly more likely than adolescent males to suffer from depressed mood. However, adolescent males are less likely to ask for help than females (odds ratio: 0.72). All minority groups are more likely to suffer from depressed mood compared to non-Hispanic whites, but blacks are at lower self-injury risk. Blacks and Asians are especially prone not to ask for help, with the problem being particularly acute in case of black males and Asian males.

Prochazka and Agren (2003) carried out research on aggression and cerebral monoaminergic turnover covering sixty-six patients (40 women and 26 men) with Persistent Depressive Disorder (PDD). The study subjects were compared with 497 control subjects from the general Swedish population using the Aggression Questionnaire - Revised Swedish Version (AQ-RSV) to patients and
control subjects. They found PDD patients more hostile than the general population. The results also suggest a clinically meaningful sex difference in a positive relationship between hostility and serotonergic/noradrenergic turnover in PDD patients.

Depression is associated with significant impairment and physical conditions and, thus, clearly constitutes a significant public health problem. 10 to 25 percent of patients seen by primary care providers have some type of depressive disorder that affects not only their functioning and well-being, but also their physical health. The emergence of sex differences at puberty has generated a great deal of research into the biological (in particular, reproductive hormones) and psychosocial factors that may account for this difference and contribute to depression in women across the life cycle. The lifetime prevalence of major depression in women ranges from 10% to 23%, twice the rate among men; until puberty, however, rates are similar among boys and girls (Bromberger 2004).

2.10 Self And Depression:

Bookless et al., (2002) conducted a prospective study on personal appraisal of the experience of a depressive disorder covering 61 patients suffering from depressive disorder who are receiving treatment for Major Depression using the Personal Appraisal Inventory (PAI) (Bookless, Clayer and McFarlane, 2000). They examined the subjects over a period of 7 months. They also examined the initial (Time 1) association between the individual items of the PAI and self-reported levels of depression, anxiety, disability, self-esteem and psychological distress. They found that these variables related to some items pertaining to appraisal of the harm and threat engendered by the disorder, but did not relate to appraisal of the positive and negative options for managing the disorder. Seven months later (Time 2) few significant changes were found in the way people appraised the impact of the disorder however, levels of depression, anxiety, disability and distress at Time 2 were predicted by several appraisal items.
Erectile dysfunction always has a psychological component in addition to the underlying physical cause. The extent of depression and reduced self-esteem in patients who present with erectile dysfunction are explored by Intili et al., (1998).

Dependency and self-criticism reflect relatively stable personality dimensions in patients with a mood disorder. According to Rosenfarb et al., (1998) dependency needs in depressed women are heavily influenced by mood state. Women with bipolar disorder in remission report fewer dependency needs than women with no history of psychiatric disorder. On the other hand self-criticism appears to be a characterological trait in both major depression and bipolar disorder.

De Bonis et al., (1998) made a comparative study to investigate the relationship between depressed mood and Borderline Personality Disorder (BPD) on self and others descriptions, with a special emphasis on the self-structure's valence, that is, its affective, negative and/or positive content covering seventeen unipolar depressed patients with associated BPD and twelve unipolar depressed patients without BPD. Further they compared this experimental group to a group of eighteen non-psychiatric controls on four measures of evaluation and of affective discrepancy of descriptions of self and others. The analysis of the findings showed that depressed patients with and without BPD differed from the non-psychiatric controls with regard to negativity of the descriptions. As compared with the two other groups, depressed patients with BPD showed a distinctive pattern characterized by the joint presence of a negative view of self and a larger affective discrepancy for others, with others being conjunctively assigned positive and negative attributes.

Young women seen in public care gynecology clinics are at very high risk for depression. In this regard Alvidrez et al., (1999) conducted a study to examine
the rates and predictors of self-recognition of depression in a sample of 95 depressed public care women's clinic patients. They found that fewer than half of the women (44%) identified their problems as depression, but majority of them were not likely to receive treatment for their problems. Predictors of self-recognition included being told by a doctor in the past that they were depressed, endorsing medical/psychiatric causes of mental illness, and use of the coping strategies of facing a problem, alcohol or drug use, and prayer. These findings indicate the need for gynecology settings to (1) provide education about depression to women, (2) encourage them to discuss emotional problems with their physicians, and (3) provide increased education and training to physicians and staff about depression detection and assessment.

Mood disorders are characterized by manic and depressive episodes alternating with normal mood. Serretti et al., (1999) attempted a research to focus on self-esteem and social adjustment in remitted mood disorders patients comparing patients with mood disorders (99 bipolar and 86 major depressive subjects, in remission) with a group of 100 control subjects using the self-esteem scale (SES) and the social adjustment scale (SAS) to measure self-esteem and social adjustment, respectively, in both groups of subjects. The results showed that patients with mood disorder exhibited worse social adjustment and lower self-esteem than control subjects, which again strongly confirm the previous findings that social functions are heavily impaired among patients with mood disorders.

Sheppard et al., (1996) examined the alternative explanations for the changes in thinking associated with depression. According to them depressive thinking could reflect a generalized increase in accessibility of negative constructs and memories, previously associated with depression. Alternatively, depressive thinking could reflect changes at a more generic level of cognitive representation, related to schematic mental models. To investigate contrasting predictions from these two explanations, depressed patients and
non-depressed controls completed sentence stems involving social approval or personal achievement e.g. 'If I could always be right then others would-be'. Construct accessibility views predict that depression will be associated with more negative completions (e.g. 'dislike'). By contrast, the schematic model view predicts patients may give more positive completions (e.g. 'like'). This is because schematic models reflect inter-relationships between constructs, and, it is suggested, depression is associated with use of schematic mental models that imply closer dependence of personal worth/acceptance on success/approval than the models used in the non-depressed state. The results suggest that depressive thinking reflects changes in the high level mental models used to interpret experience.

Hayward et al., (2002) conducted an exploratory study on Stigma and self-esteem in patients with manic depression. This study suggests a relationship between mood and self-esteem, while feelings of stigmatisation seem to be relatively independent of mood.

Studies of rumination suggest that self-focused attention is maladaptive and perpetuates depression. Conversely, self-focused attention can be adaptive, facilitating self-knowledge and the development of the alternative functional interpretations of negative thoughts and feelings on which cognitive therapy of depression depends. Increasing evidence suggests there are distinct varieties of self-focus, each with distinct functional properties. The study of Watkins et al., (2004) supports the differentiation of self-focus into distinct modes of self-attention with distinct functional effects in depression. They also support the usefulness of training recovered depressed patients in adaptive experiential forms of self-awareness, as in mindfulness-based cognitive therapy.

2.11 Interpersonal Relationship And Depression:

Stern et al., (1997) carried out a study on interpersonal perceptions among patients with borderline personality disorder (BPD). The objective of their study was to investigate the validity of object relation's theories. They
compared depressed patients with BPD to patients with major depressive disorder (MD) without BPD. Subjects were 77 male and female inpatients (BPD = 55, MD = 22). The mean ages were 30.5 for BPD subjects and 36.3 for MD subjects. Results showed consistency with the object relation's theory. Findings also revealed that BPD patients saw themselves as hostile, labile, and unstable where as MD patients avoid acknowledging and responding to relatives criticality.

Lam et al., (2003) postulated that depressed patients who engaged in self-focused rumination on their depressive symptoms may experience more hopelessness, more interpersonal distress and poorer social functioning while patients who distract themselves may experience less severe hopelessness and better social functioning. They selected One-hundred and nine (109) outpatients suffering from Major depressive disorders to understand their response style to depression, hopelessness and interpersonal style and also their levels of social functioning. Lam et al. found that rumination was associated with higher levels of depression and distraction was associated with lower levels of depression. Furthermore when levels of depression and gender were controlled for, rumination contributed to higher levels of hopelessness and distraction contributed to lower levels of hopelessness. Both rumination and levels of depression contributed significantly to higher levels of interpersonal distress when gender was controlled for. Ruminators were rated to have significantly more severe problems in intimate relationships while distracters were rated to have significantly higher social functioning.

2.12 Other Relevant Studies:

Marmorstein et al., (2004) conducted a community based study on twins and their parents in a view to explore whether major depression and/or antisocial behavior tended to occur more frequently among partners of depressed mothers (compared to partners of non-depressed mothers) and to examine
how these paternal disorders related to offspring psychopathology. They interviewed depressed and non-depressed mothers, their partners (the biological fathers of the twins), and their 17-year-old offspring. The results showed that depressed mothers are tended to partner with antisocial fathers. Depression in mothers and antisocial behavior in fathers are both significantly and independently associated with offspring depression and conduct disorder.

Abi Daoud et al., (2004) examined depression, self-esteem, and mastery in the family caretakers of a group of males with Duchenne muscular dystrophy in comparison to a control group. A questionnaire based on the National Population Health Survey from Statistics Canada, a survey to collect information on the health of the Canadian population and related sociodemographic information, was conducted by telephone with 42 parents. The results were compared with the national data from the National Population Health Survey (1994 and 1999), matched for province of residence, number of children in the household, age, and marital status of the respondents. Parents of children with Duchenne muscular dystrophy had a higher probability of going through a major depressive episode and had significantly lower self-esteem and mastery scores than the national control group. Parents without a partner had lower scores on the mastery scale, and parents of males older than 13 years of age were more likely to experience distress that interfered with life.

Major depressive disorder is the most frequent comorbid condition in Obsessive-Compulsive Disorder (OCD). The study of Hong et al., (2004) investigated factors associated with the development of Recurrent major Depressive Disorder (RDD) in patients with OCD covering 80 OCD cases and 73 control subjects. Two experienced psychiatrists independently reviewed all clinical materials and made final consensus diagnoses using DSM-IV criteria. Family history of OCD and RDD, additional comorbid disorders, OCD
symptoms and illness severity were compared between persons with OCE alone (n=21) and OCD with RDD (n=41). Compared to OCD probands without RDD, OCD probands with RDD had earlier age at first diagnosis, more severe obsessive-compulsive symptoms, and were more likely to have a family history of RDD. Social phobia, separation anxiety disorder, and body dimorphic disorder occurred more frequently in the comorbid group. In a multiple logistic regression model, only early age of OCD diagnosis was significantly associated with RDD. Early age at onset of OCD increases the risk of depressive disorder in individuals with OCD.

Lobentanz et al., (2004) conducted a study in a series of 504 patients with Multiple Sclerosis (MS), to assess their quality of life, disability, depressive mood, fatigue severity and sleep quality in comparison with healthy individuals using Quality of Life Index, Expanded Disability Status Scale Self-rating Depression Scale, Fatigue Severity Scale, and Pittsburgh Sleep Quality Index. They found that most patients were severely disabled; almost half were mildly to severely depressed, suffering from reduced sleep quality and/or fatigue. The multiple sclerosis patients had significantly lower quality of life. Finally they concluded that depressive mood is the main factor influencing QOL. The disability status, fatigue and reduced sleep quality have an impact mainly on physical domains of life quality.

The Beck Depression Inventory (BDI) is the most often used self-rating instrument for depressive symptoms. The study of Svanborg et al., (2001) compared the Beck Depression Inventory with a self-rating version of the Montgomery Asberg Depression Rating Scale (MADRS-S) among 86 psychiatric patients with mainly affective and anxiety disorders. They found that both the instruments were about equal in differentiating between different Axis-I diagnoses and did not differ according to sensitivity to change during anti-depressive treatment. Although the scales were highly intercorrelated (r=0.869), the BDI was demonstrated to tap more maladaptive personality traits compared to the MADRS-S. Finally Svanborg et.al. concluded that the MADRS-S is equivalent to the BDI as a self-assessment
instrument for depression, but the MADRS-S focuses on core depressive symptoms, and is less influenced by maladaptive personality traits.

According to Iqbal et al., (2000) session in the acute stage remitted in line with the psychosis and that 36% of patients developed Post-psychotic depression (PPD). Again in the year 2000 Iqbal et al. apply their cognitive framework to PPD and chart the appraisal of self and psychosis and their link with the later emergence of PPD covering 105 Schizophrenic patients, who were followed up over 12 months following the acute episode, taking measures of depression, working self-concept, cognitive vulnerability, insight and appraisals of psychosis. Results of this study showed that before developing PPD, these patients felt greater loss, humiliation and entrapment by their illness than those who relapsed or did not become depressed, and were more likely to see their future selves in 'lower status' roles. Upon becoming depressed, participants developed greater insight, lower self-esteem and a worsening of their appraisals of psychosis. Finally they inferred that depression in psychosis arises from the individual's appraisal of psychosis and its implications for his/her perceived social identity, position and 'group fit'. Patients developing PPD feel forced to accept a subordinate role without opportunity for escape.

Bodlund (2000) stated that about 15% of primary care attendents suffer from depression, yet only a minority are identified and treated. It is of major importance to spread knowledge of the prevalence of depression and tools for recognizing the disorder. Most patients can be successfully treated in a primary care setting. Studies have shown that educational efforts and close cooperation between psychiatrists and general practitioners (GPs) lead to an increase in the proportion of depressed patients that are identified and properly treated. The use of diagnostic self-reports can facilitate this process for the GP. It is crucial to identify and treat the disorder early on, in order to improve prognosis, decrease the risk of complications and reduce costs for society and the health care system.
Although depression can be a feature of acute psychosis and an aftermath of a psychotic episode (post psychotic depression), data indicate that depressive syndromes in schizophrenia can be found years after the immediate post acute phase. Researchers acknowledge the clinical importance of recognizing that depressive symptoms are frequently described in patients diagnosed with schizophrenia. Using the framework of Antonovsky's (1972, 1987, 1992) Sense of Coherence as a guide, the article of Menzies (2000) explores what nurses can do to facilitate development of Generalized Resistance Resources (GRRs) in the physical, psychological, and emotional armamentarium of those diagnosed with schizophrenia, mood disorder not otherwise specified (NOS).

Alexander et al., (1999) administered a self-report measure of proneness to shame and guilt among 86 patients with moderate to severe depression, with the prediction that there would be a positive correlation of shame with severity of depression. But they found that guilt but not shame was associated with levels of depression. Shame-proneness demonstrated a unique association with a stable attributional style for negative outcomes, global negative self-evaluation, submissive behaviour and internalized anger.

King et al., (1997) studied the diagnostic Interview Schedule for Children (DISC-2.3) on a sample of 265 adolescent inpatients to determine type and concurrent validity of depressive symptoms and depressive disorder. The Children's Depression Rating Scale--Revised, Reynolds Adolescent Depression Scale (RADS), Suicide Ideation Questionnaire--Junior, Spectrum of Suicide Behavior Scale, and clinical consensus diagnoses were used to assess concurrent validity. Results indicated that (1) parents, compared to adolescents, reported a higher prevalence of all depressive symptoms with the exception of weight change; (2) DISC-2.3 depressive and suicidal symptoms were related positively to independent validating criteria for all informant conditions, suggesting good concurrent validity; (3) the DISC-2.3 both informant condition correctly identified the most depressive disorders; and (4) the parent, but not the adolescent, DISC-2.3 Informant condition contributed
to the prediction of clinical consensus diagnoses of depression after taking into account RADS scores.

In the year 1996, Power et al., conducted a study where they used Emotional Priming Paradigm (Power and Brewin (1990) Cogn. Emotion 4, 39-51) on a group of currently depressed patients and a group of non-depressed controls. They revealed that the depressed patients showed significant facilitation effects on both the speed and rate of endorsement of negative trait adjectives when these were preceded by negative emotional primes. On the contrary the control subjects failed to show such facilitation effects.

Dysthymia (DD) may be thought of as depression associated with personality disorder, a phase in the pleomorphic natural history of unipolar depression or a result of exposure to chronic physical illness. Prevalence, clinical features, risk factors and prognosis may change with age. Beekman et al., (2004) conducted a study on large (n=3056) representative sample of elderly (55-85 years) in the Netherlands. They collected data on 277 depressed elderly to assess the 6-year prognosis of DD. The prevalence of DD (4.61%) was higher in women and it declined with age. The symptom profiles of DD and MDD were very similar. Those with DD were very likely to have had MDD earlier in life (44% in pure DD and 80% in those with double depression). The average age at onset (31 years) was earlier than in MDD (53 years). Environmental and personal vulnerability dominated the risk factors. Finally Beekman et al., (2004) concluded that although the prevalence declines with age, Dysthymia (DD) remains common in later life.

Gongora et al., (2004) attempted to carry out a research on personality disorders, depression, and coping styles in Argentinean bulimic patients. This study investigates the coping styles of bulimic patients with personality disorders (PDs) and the effects of the level of depression on the relations between PDs and coping covering 75 Argentinean bulimic outpatients engaged in treatment. They found no differences in the coping styles of bulimic patients with or without a personality disorder. When three specific PDs were considered-Avoidant, Obsessive-Compulsive, or Borderline PDs-
clear differences in the coping styles of the bulimics were found. However, the differences disappeared when depression was controlled. Regarding the severity of the three specific PDs, coping styles were only found to be associated with the Avoidant PD. Depression showed to affect the relations between coping styles and two specific PDs-Avoidant and Borderline PDs-in bulimic patients.

Depressive episodes are significant in bipolar illness since patients can spend up to one-third of their lives in depression. Although the treatment of bipolar depression remains an understudied area, new data from randomized, controlled trials and naturalistic studies have expanded the range of treatments available. The main aim in the treatment of bipolar depression is the prevention of the patient switching to mania and cycle acceleration, and antidepressant therapy may be contraindicated because of the risk for switching. Guidelines for the acute treatment of bipolar depression emphasize treatment with a mood stabilizer, of which lithium has been the most thoroughly studied in randomized, controlled trials in acute bipolar depression. Lamotrigine has also demonstrated significant efficacy in recent studies and has been approved by the FDA (Oral et al., 2004).

Dentists encounter numerous sources of professional stress, beginning in dental school. This stress can have a negative impact on their personal and professional lives. Dentists are prone to professional burnout, anxiety disorders and clinical depression, owing to the nature of clinical practice and the personality traits common among those who decide to pursue careers in dentistry. Many researchers suggest that to enjoy satisfying professional and personal lives, dentists must be aware of the importance of maintaining good physical and mental health (Rada RE, et al., 2004).
2.13 Outline Plan Of The Study:

2.13.1 Title Of The Proposed Study: A Study On Personality Dispositions, Self-Esteem, Emotional Control And Suicidal Tendencies Of Depressive Patients.

2.13.2 Context: Depression is one of the major mental health disorders affecting a large number of population especially younger generations across the world. It is estimated that in the next two/three years this disease will affect maximum number of population. 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.

The term depression is used in everyday language to describe a range of experiences from a slightly noticeable and temporary mood decrease to a profoundly impaired and even life-threatening disorder. When used to describe a mood, the term conveys a temporary state of dysphoria that may last a few moments, hours, or even a few days. As such, it is usually a normal reaction to an upsetting event, or even an exaggerated description of a typical event.

Depression typically begins in late adolescence or early adulthood, and the younger it starts the worse course there may be. US data on major depression by decade of age based on epidemiological study indicate that highest rate of current depression among the youngest group (6.1%), and the lowest rate among the oldest group (3.6%) (Burke, Burke, Regier, and Rae, 1990). Not only are the rates of onset and current depression highest among those in their late teens and early 20s, but several studies have now suggested an intriguing possibility: depression is on the increase among the young. Klerman and Weissman (1989) were among the first to note that rates of depressive disorder were relatively higher in those born more recently.
In addition to age differences in who is affected by depression, 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).

Generally most depressive episodes clear up in 4 – 6 months even if not treated. However, most people who have had one episode will have another, and sometimes multiple recurrences, with about 25% developing chronic depression. Depression – even mild persistent depression – takes a severe toll on work, parental and marital relationships. The consequences of depression in terms of impaired functioning can set the stage for further depression in a self-perpetuating cycle.

So far as prevalence of different types of depression, there is no reliable published data. According to a review by Smith and Weissman (1992), the rates of current depression in various European countries ranged between 4.6 – 7.4%. In various US cities, rates based on the DSM criteria for major depression within the past six months were somewhat lower, ranging between 1.5 – 2.8%.

Most forms of psychological disorder affect individuals' interpersonal lives, impairing their social functioning by altering interpersonal behaviours and the quality of relating to others. Depression is no exception, because the symptoms of depression interfere with normal relationships. Sometimes depression is the cause of difficulties in interpersonal relationships. On the contrary, sometimes people suffer from depression as a result of interpersonal problems.

Difficulties in maintaining usual social transactions and discharging social responsibilities and relationships may be a key element of many depressions: disrupted social connectedness may cause depression, and depression
disrupts relationships, potentially causing further depression. Negative early childhood experiences, in the form of insecure attachment relationships between parent and child and in learning maladaptive skills and cognitions, may contribute to vulnerability to depression. In fact, depression affects the family in adverse ways, especially contributing to marital discord, family burden, and poor adjustment in children.

Depressive people may have certain personality problems and behavioural traits that affect their relationships even when not depressed, including dependency, introversion and possibly, dysfunctional social skills and cognitions.

Findings of Jambunathan, Jaylakshmi (1992) indicate that lack of continued financial and emotional support from spouses and other family members can act as influencing factors in development of depression. Mitchell et al., 1993 found that only certain sub-dimensions of life satisfactions and withdrawal are related to depression.

Margo et al., (1993) in an attempt to compare defensive styles in depressed psychiatric patients could show that depressed men were more likely to use internalized defenses and the depressed women were more likely to use externalized defenses than their respective non-depressed comparison groups, showing thereby that there exists a relationship between depression severity and the amount of negatively biased self perception.

A number of studies have been carried out among children and adolescents in regard to their depression. While assessing depression among children, developmental considerations should be taken into account. For instance, irritability may be substituted for depressed mood because it is recognized both that irritability is a common expression of distress in depressed youngsters. According to recent study of dysthymic disorder in children, it differs from major depression primarily in the emphasis on gloomy thoughts and other negative affect, with fewer symptoms such as loss of interest, social
withdrawal, fatigue, and reduced sleep and poor appetite (Kovacs, Akiskal, Gatsonis, and Parrone, 1994). Goodyer and Cooper (1993) found that 80% of their sample of 11–16 year-old girls with major depressive episode reported irritability, while Ryan et al., (1987) observed irritability or anger in 83% of a child and adolescent clinic sample.

Suicidal thoughts and attempts are among the diagnostic criteria for major depression. As many as half of the suicides in the United States are committed by people suffering from depression (Greenberg, 1982). Suicidal ideation is quite common in depressed youngsters, occurring in about two-thirds of pre-scholars, preadolescents, and adolescents (Mitchell et al., 1988; Ryan et al., 1987). Actual suicidal attempts occurred in 39% 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.

2.13.3 Diagnosis Of Depression:

The present study will cover depressive patients following DSM-IV criteria.

2.13.4 Justification Of The Study:

Literature indicates that not much study has been carried out among depressive patients to understand the personality dispositions, self-esteem, emotional control, and suicidal tendencies among depressive patients. This apart, the local Mental Health Care professionals working with depressive patients and the family members encounter different problems. For want of proper guidelines and sensitive screening tool for ascertaining suicidal tendencies among depressive patients sometimes they are unable to undertake a just-in-time early intervention programme for depressive patients in the family.
Hence the present study is aimed to carry out an investigation to understand the personality dimensions, self-esteem, emotional control, and suicidal tendencies among depressive patients. For ascertaining the suicidal tendencies and emotional control among depressive patients there are no locally adopted tests to meet the local needs. The present study will also adopt two new tests to understand suicidal tendencies and emotional control among depressive patients.

2.13.5 Objectives: To study the

1. Socio-economic and demographic background of depressive patients.
2. Personality dispositions of depressive patients.
4. Emotional control of depressive patients.
5. Suicidal tendencies of depressive patients.
6. Perceived problems of family members in dealing with depressive patients,
   and
7. To suggest need-based measures for family members for better care and management of depressive patients.

2.13.6 Hypotheses:

1. Personality dispositions of depressive patients and normal population of same age group differ significantly, irrespective of gender differences and chronicity of the disease.
2. Personality dispositions of male and female depressive patients differ significantly, irrespective of age or chronicity of the disease.
3. Personality dispositions of depressive patients differ significantly across chronicity of the disease, irrespective of gender.
4. Self-esteem of depressive patients and normal population of same age group differs significantly, irrespective of gender differences and chronicity of the disease.
5. Self-esteem of male and female depressive patients differs significantly, irrespective of age or chronicity of the disease.

7. Emotional control of depressive patients and normal population of same age group differs significantly, irrespective of gender differences and chronicity of the disease.

8. Emotional control of male and female depressive patients differs significantly, irrespective of age or chronicity of the disease.

9. Emotional control of depressive patients differs significantly across chronicity of the disease, irrespective of gender.

10. Suicidal tendencies of depressive patients and normal population of same age group differ significantly, irrespective of gender differences and chronicity of the disease.

11. Suicidal tendencies of male and female depressive patients differ significantly, irrespective of age or chronicity of the disease.

12. Suicidal tendencies of depressive patients differ significantly across Chronicity of the disease, irrespective of gender.

2.13.7 Proposed Methodology:

i) Target Group: For the purpose of the present study the following categories of respondents will be covered:

- Depressive patients, irrespective of gender and category (to be selected following DSM –IV criteria)
- Normal population (matched group in terms of age and gender)
- Family Members, either of the parents or guardian

ii) Sample And Sampling:

The different categories of subjects will be selected purposively from different Government and Private Mental Health Clinics. In short, the sample structure is given below:

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressive patients</td>
<td>100</td>
</tr>
<tr>
<td>Normal population (matched group)</td>
<td>100</td>
</tr>
<tr>
<td>Family Members</td>
<td>100</td>
</tr>
<tr>
<td>Total:</td>
<td>300</td>
</tr>
</tbody>
</table>
iii) Study Tools: In order to achieve the objectives of the proposed study, the following study tools will be used:

1. Background Information Schedule (to be developed)
2. Multi-dimensional Personality Inventory by K.M. Manju Agarwal
3. Self-esteem Inventory by M.S. Prasad and G.P. Thakur
4. Emotional Control Inventory (to be adapted)
5. Suicidal Tendencies Inventory (to be adapted)

iv) Data Collection And Analysis: First, permission from the authorities of different institutions for mental patients will be sought for data collection and then a tentative time schedule will be developed for data collection. Data will be collected from the respondents following face-to-face interview method.

For analysis of quantitative data SYSTAT package will be used while for processing qualitative data content analysis method will be carried out.

v) Tentative Steps To Be Followed:

- Development and adaptation of study tools.
- Finalization and printing of study tools.
- Selection of Mental Health Centres for data collection and obtaining permission from the authorities of those centers.
- Development of tentative time schedule for data collection from the depressive patients, normal population, family members and mental health care professionals.
- Literature review.
- Data scrutiny and entry in computer for analysis and application of statistical tests.
- Interpretation of data and verification of hypotheses.
- Writing the thesis.
- Presentation of findings in a public seminar.
- Submission of thesis for evaluation.
vi) Operational Definition: In the present study patients of major depression and dysthymic depression were covered following DSM-IV criteria. However, in the following section, simple operational definition of all the key issues like depression, major depression, dysthymic depression, personality disposition, self-esteem, emotional control and Suicidal Tendencies have been provided below:

**Depression:** A mental state characterized by a pessimistic sense of inadequacy and a despondent lack of activity.

**Major Depression:** This is the most severe category of depression. In a major depression, more of the symptoms of depression are present, and they are usually more intense or severe. A major depression can result from a single traumatic event of our life, or may develop slowly as a consequence of numerous personal disappointments and life problems.

**Dysthymic Depression:** A type of depression involving long-term, chronic symptoms that are not disabling, but keep a person from functioning at 'full steam' or from feeling good. Dysthymia is a less severe type of depression than what is accorded the diagnosis of major depression. However, people with dysthymia may also sometimes experience major depressive episodes, suggesting that there is a continuum between dysthymia and major depression.

**Personality Disposition:** The term 'personality' refers to the total functions of an individual who interacts with his environment. In the present study the factors of 'personality disposition', which are explored, include introversion/extroversion, self-concept, independence/dependence, temperament, adjustment and anxiety.

**Self-esteem:** Self-esteem can be defined as a positive feeling and respect for ourself. It is essentially a measure of self worth and importance. In the
Present study 'self-esteem' means socially perceived self of the individual i.e., individual's perception as to how the society perceives him/her.

**Emotional Control:** In the present study 'emotional control' means stress tolerance level of an individual.

**Suicidal Tendencies:** In the present study 'suicidal tendencies' means thoughts of self-destruction of an individual.