INTRODUCTION
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In the present day field of mental health, clinicians are concerned with disturbed behaviour of all sorts, severity, and duration. At the one extreme are grossly and visibly deranged people, once called insane, mad or lunatic, and now diagnosed as psychotic. At the other are unhappy people, unable to cope effectively with life demands, limited in their ability to love, work, or find meaning in their lives, either ever extended conditions of psychological dysfunction resulting from injury to the nervous system (brain syndromes), emotional problems resulting in somatic diseases (psychosomatic conditions) forms of delinquency and social deviance (alcoholism, drug addiction, criminality, etc.) as well as the great variety of lesser psychological problems (maladjustments, immaturity reactions). Despite manifest differences among these conditions, irrationality and incomprehensibility, unpredictability and loss of control, vividness and unconventionality and violation of moral and ideal standards are the elements of abnormality. The more of these elements that are present, and the more clearly they can be seen in behaviour of abnormal person. To anticipate the answers there are some issues embedded in each of these questions; some would reject the concept of "mental illness"
entirely, and others give diverse meanings to mental health or normality. There are many classes of abnormal behaviour and Depression is one of the important class.

Depression is obviously a cover term for several different kinds of things. Depression is that feeling state which seems to be found in many societies. But the question aims: Is it universal? to be universal suggests a "natural" phenomenon. While depression is widespread across continents and epochs, it is not "natural".

(Jenkinds, Good, and Kleinman shows, ethnopsychological categories differ greatly for different cultures. They all do not conceive of depressed emotion in the same way. But as a psychological phenomenon it is a lived experience - "to feel depressed" that is a result of physiological processes interacting with meaning systems and social relationships.

Depression is the most widespread psychological disorder and it is the common cold of mental illness. Almost everyone has felt depression, at least in its mild forms. Feeling blue, low, sad, downhearted, discouraged, and unhappy are all common depressive experiences. But familiarity does not produce its understanding; because it is only last two decades that major advances have been made. Today the great
The construct "depression" is not only the theoretically challenging, it is also diagnostically complex. Depression either in its clinical forms or as transient mood disturbance, represents a especially challenging and intriguing topic. The central symptoms of depression are sadness, pessimism grief denigration, along with a loss of energy, motivation, and concentration. As depression develops people become increasingly inefficient. Loss of interest, decrease in energy, inability to accomplish tasks, difficulty in concentration and the erosion of motivation and ambition all combine to impair efficient functioning. Acc. to Back - (1974) - "The instinct for self-perservation and the maternal instinct, appear to vanish. Basic biological drives such as hunger and sexual drives extinguished. Sleep the easier to all whose, is thwarted. Social instincts such as "attraction to other people and love and affection evaporate." There are two kinds of depressive disorders, Unipolar depression in which the individual suffers only depressive symptoms without ever experiencing mania, and biopolar depression (or manic depression) in which both depression and mania occur. Mania is defined by excessive elation, expansiveness, irritability,
talkativeness, inflated self-esteem and flight of ideas. Normal depression differ in degree from unipolar depression; both have the same kinds of symptoms, but the unipolar depressive has more symptoms, more severely, more frequently, and for a longer time. Biopolar depression. On the other hand, are clearly distinguishable from normal and unipolar depressions, they involve swings between episodes of mania and episode of depressions, and they probably have a genetic component. Biopolar depression develops at a younger age, and is often more crippling to the individual.

There are actually four sets of symptoms in unipolar depression. (i) Mood or Emotional symptoms as - "sad, blue, miserable, helpless, hopeless lonely, unhappy, downhearted, worthless, humiliated, ashamed, worried, useless, guilty" Sadness is the most salient and widespread emotional symptom in depression. (ii) Thought symptoms A depressed person thinks of himself in a very negative light. Depressed person has low self-esteem and views the future as being hopeless. He believed he is inferior, inadequate, and incompetent. He believes that he lacks the qualities necessary to succeed in these areas of his life that are important to him, be they intelligence, attractiveness, wealth, health, or talent. (iii) Motivational symptoms - depressed individual have great trouble getting started. This passivity or lack of response
initiation undermines working and loving. Difficulty in making a decision also seems to be a common symptom of depression (Hammen and Padesky, 1977). (iv) Physical symptoms as depression worsens, every biological and psychological joy that make life worth living is eroded. Loss of appetite is common, weight loss occurs in moderate and severe depression. Sleep disturbance also occurs.

The endogenous vs exogenous distinction in depression, called by DSM-III depression with melancholia vs. depression without melancholia. Endogenous (biological - with melancholia) means "coming from within the body", and exogenous (psychological - without melancholia) means "coming from outside the body". The implication of these terms is not on exogenous depression. It precipitated by a life stressor, while on endogenous depression arises from biological disorders.

Types of Depression: Mood disorder have been classified according to four different conceptual models.

(a) Endogenous depression -

Strictly a biological event unrelated to any environmental force.
(b) Reactive depression -

Psycho-socially triggered and may be devoid of any biological factors.

(c) Unipolar depression -

Manifests when the patient suffers from depression symptoms without ever experiencing mania.

(d) Bipolar depression -

When both depressive and manic symptoms occur. DSM-III produces mood, thought, motivational and physical deficits. DSM III adopted the most reliable and basic distinction in depression: The unipolar-bipolar distinction, which are defined above. In addition to the unipolar-bipolar distinction, however DSM-III also distinguishes between episodic and chronic depression.

Episodic depression - Episodic depression is more common, is of less than two years duration and has a clear onset which distinguishes it from previous nondepressed functioning.

Chronic Depression - In chronic depression, the individual has been depressed for at least two solid years without having had a remission to normality of at least two month in duration.
Models of Depression:

There are mainly four following Models for depression:

1. The Biological Model
2. The Psychodynamic Model
3. The Behavioural Model
4. The cognitive model

The Biological Model -

According to the biological model, depression is a disorder of the body or could be caused by a problem in any bodily organ - the liver, the blood, the stomach - specially has centered almost entirely on the brain, and in particular on depletion of those substances (biogenic amines) that help transmit nerve impulses across the gaps (synapses) between nerve cells (neurons). There are main four cues that the body intimately involved in depression (schuyler, 1974). First of all, depression occurs with same frequency following the periods of natural physiological change in women after giving birth to a child, at menopause, and just before mensturation. Second, there is similarity of symptoms across cultures, sexes, ages, and races which indicate on underlying biological process. Third, somatic therapies, in particular drugs like tricyclic antidepressants and MAO inhibitors, and electroconvulsive shock, are effective treatment of
depression. Fourth, depression is occasionally induced in normal individuals as a side effect of medications as by reserpine, a high blood pressure reducing drug (Schuyler, 1974).

The Neurochemical Basis of Depression - According to the biological model, depression is a disorder of motivation caused by insufficiencies of the biogenic amines. The biogenic amines are neurochemicals that facilitate neural transmission. These are divided into two groups as - The catecholamines - which include norepinephrine (NE), epinephrine, and dopamine, and The indoleamines - which include serotonin and histamine. These amines play significant role in neural transmission in the medial forebrain bundle (MFB) and the periventricular system (PVS). Neural transmission runs through these two major pathways to the lower centers of the brain. MFB may function as a go system, that facilitate active behaviour, whereas the PVS may act as a "stop" system.

Two groups of drugs are used to treat depression - tricyclic antidepressants and MAO inhibitors each affects the availability of NE in the brain, the catecholamine hypothesis claims that, as a result, more norepinephrine was available the tuberculosis become less depressed. MAO inhibitors have been successfully used in treating depression.

Somatic Therapies for Depression - According to the
biological model approach the treatment of Unipolar depression, particularly when it is severe, in two ways as -

1. To treat the patient with drugs like the tricyclics and the MAO inhibitors.

2. To administer electroconvulsive shock.

Drug Treatment - Tricyclic antidepressants, block the reuptake of norepinephrine, which result, less NE is absorbed, more NE is available, and the patient becomes less depressed.

MAO inhibitors prevent the breakdown of norepinephrine by inhibiting the enzyme of MAO with more NE available, the patient becomes less depressed. Most studies show that MAO inhibitors to be superior to placebos in alleviating depression. When tricyclics fail to treat, then MAO inhibitors should be tried.

Electroconvulsive Shock (ECT) - ECT is administered by a medical term consisting psychiatrist, anesthesiologist, and a nurse. Metal electrodes are taped to either side of the patients forehead, and the patient is anesthetized. The patient is given drugs to induce muscular relaxation in order to prevent the breaking of bones during the convulsion. A high current is then passed through the brain for approximately a half second. How ECT works to break up
depression is unclear. It probably increases availability of norepinephrine and other biogenic amines, but it is such a gross technique, shocking the entire brain - and has so many other effects, including memory loss and motivational changes, that the affective ingredient of ECT is quite difficult.

The psychodynamic model of Depression:

Psychoodynamic theorists have stressed three causes of depression as - anger turned against the self, excessive dependence on other for self-esteem, and helplessness at achieving one's goals.

Anger Turned upon the self - Sigmund Freud (1917) in his classic paper, "Mourning and Melancholia" both stressed the importance of anger turned inward upon the self in producing depression. For Freud, the main clue to their inner state come from the difference between normal bereavement (mourning) and depression (melancholia). The depressive will begin to feel a powerful sense of worthlessness and self blame. He will feel rotten and guilty and will accuse himself of being a failure. This self approach is usually moral, grossly unjustified, and most remarkable, publicly and shamelessly declared. It provide the clue that anger turned against the self is actively motivated and generates the low self esteem of depression.
The Depressive -personality - Psychodynamic theorists Sigmund Freud have emphasized a personality style that may make individuals especially vulnerable to depression; the depressive depends excessively on others for his self-esteem. When he is disappointed he has difficulty tolerating frustration, and his losses upset his self regard and result in immediate and frantic efforts to relieve discomfort. So depressive are seen love addicts and beyond receiving such love, however, the depressive cares little for the actual personality of the person he loves (Rado, 1928 and Bemporad, 1978)

Helplessness at Achieving one's goals - Edward Bibring (1953) claim that depression results when the ego facts helpless before its aspirations. Perceived helplessness at achieving the ego's high goals produces loss of self esteem, which is the central feature in depression. The depression prove individual has extremely high standards, and this increases his vulnerability to feeling helpless in the face of his goals.

Psychodynamic theory emphasizes the long term disposition to depression, rather than the losses that happen to set it off in the short-term. Similarly psychodynamic therapies are directed toward long term chang, rather than short term alleviation of depression. several therapies follow the main
three causes of psychodynamic theorizing about depression as:

I. Psychodynamic therapists follow the anger turned inward theory of depression, that make the patient conscious of his misdirected anger and early conflicts that produced it.

II. Psychodynamic therapists who deal with the depressives strong dependence on others for self esteem will attempt to get the patient to discover and then resolve the conflicts that make him greedy for love and esteem from others.

III. Therapists, who work within Bibring's helplessness approach try to end the patients depression by getting him to again perceive his goals as being within reach, to modify his goals so that they can realize to give up their goals altogether.

**Behavioural Models of Depression:**

The behavioural models of depression concentrate on the most obvious behavioural symptoms of depression; the reduction in active behaviour, which we called the motivational deficit. All of the behavioural models explain the reduction in active responding as a deficiency in operant behaviour and claim that therapies, which increase operant behaviour will reverse depression.
Lewinsohn (1974) suggests that these behaviours have been extinguished by a low rate of response contingent positive reinforcement that is, depressed individuals cannot cause good events to happen to them at a rate that infrequent enough to motivate active behaviour. He emphasizes that the cause of depression is not simply too few pleasement events but also a lack of control over reinforcement.

Lewinsohn and his colleagues developed a pleasant events scale and found that depressed patients do engage in fewer pleasant event and find these events less enjoyable than nondepressed patients. The major reason for this is that depressive often lack of social skills - psychologist Charles Ferster (1976) view is that the reduction in instrumental behaviours as the main symptom of depression. Depressed individual fail to stay in effective contact with the rewards of their environment and fail to avoid its aversive aspects.

Behavioural theories of depression see the reduced frequency of operant behaviour and the low rate of reward as the key symptoms of depression. Because behavioural therapies are designed to obtain rewards. A variety of other behaviour therapies are also directed toward increasing social reinforce for the depressed individual. Behaviour therapist recognise the most important aspect of the depressives life as
his inability to bring about the love, affection, admiration and esteem of others by his own actions. Social skills training and assertiveness training are two techniques used to increase the personal affectiveness of depressed individual. (Lewinsohn and Shaw, 1968; Liberman and Raskin, 1971 and Klein and Miller, 1976). Graded task assignment is another technique to increase the depressives actions by reinforcing for taking one small step at a time, rather than allowing to become discouraged at the prospect of too overwhelming a task.

**Cognitive models of depression**

The two cognitive models of depression view particular thoughts as the curivial cause of depressive symptoms. The first developed by Aaron T. Beck (1974) and it views depression as caused by negative thoughts about the self, about ongoing experience, and about the future. The second developed by Martin EP Seligman (1976) and it views depression as caused by the expectation of future helplessness. A depressed person expects bad events to occur and he believes that there is nothing to prevent them occurring.

**Beck's Cognitive Theory of Depression**

Beck founded a new type of therapy, called cognitive therapy. According to Beck there are two mechanisms - (a) the
cognitive triad and error (b) in logic, produce depression.

(a) The Cognitive Triad -

The Cognitive triad consists of negative thoughts about the self, about ongoing experience, and about the future. The negative thoughts about the self consist of the depressive's belief that he is defective, worthless, and inadequate. The symptom of low self-esteem comes from his belief that he is defective. When he has unpleasant experiences, he attributes them to personal unworthiness. Since he believes he is defective, he believes that he will never attain happiness.

The depressive's negative thoughts about experience consist in his interpretation that what happens to him is bad. He misinterprets neutral interaction with people around him as a meaning defect. Finally, the depressive's negative view of future is one of hopelessness. When he thinks of his future, he believes that negative things will be continue unabated because of his personal defects.

(b) Errors in logic:

According to Beck, depressive makes five different logical errors in thinking, and each of those darkens his experience arbitrary inference, selective abstraction,
overgeneralization, magnification and minimization, and personalization.

Arbitrary inference - refers to drawing a conclusion when there is little or no evidence to support it.

Selective abstraction - Consists of focusing on one insignificant detail while ignoring the more important features of a situation.

Overgeneralization - refers global conclusions about worth, ability, or performance on the basis of a single fact.

Magnification and minimization - are gross errors of evaluation, in which small bad events are magnified and large good events are minimized.

Personalization - refers to incorrectly taking responsibilities for bad events in the world.

Beck's cognitive theory of depression indicates that depression is due to negative thoughts of self, ongoing experience, and future and by errors in logic. Beck's theory aim is to identify and correct the distorted thinking and dysfunctional assumptions underlying depression (Rehm, 1977, and Beck et al 1979). Cognitive therapy differs from most other forms of psychotherapy. In contrast to the psychoanalyst, the cognitive therapist is continually active in order to guide the patient into recognizing his thinking and his actions.

Cognitive therapy uses such behavioural therapy
techniques as activity raising, graded task assignment, and assertive training against depressive symptoms there are five specific cognitive therapy techniques: reality testing, automatic thoughts, training in reattribution, searching for alternatives, and changing depressogenic assumptions.

Back argues that there are discrete, negative sentences that depressed patients to themselves quickly and habitually. These automatic thoughts maintain depression. Cognitive therapy help the patients to identify such thoughts.

Once the patient has learned to identify such thoughts, the cognitive therapist engages in a dialogue with the patient he encourage the patient to use the reasonable standards of self evaluation that nondepressed people use.

Depressed patients tend to blame themselves for bad events for which they are not, in fact, responsible, to remove such irrational blame, the therapist and the patient review the events, applying the standards of nondepressed individuals in order to come up with an assignment of blame. Such reattribution training enables patients to find sources of blame other than themselves and raises their low self esteem.

The search for Alternative- 

The search for alternative technique of cognitive therapy attacks patients closed system in which all problems are seen as unsolvable. The patient believed that getting C
grade meant he was incompetent and no alternative explanations were given and patient was said to prepare to act based on his most catastrophic interpretation of the situation. Once alternative were furnished and the patient gained realistic information, both the depressed mood and the self destructive actions of the patient were reversed.

Beck outline main six assumptions that depressed individuals base their life upon, thereby predisposing themselves to sadness, despair, and disappointment.

1. In order to be happy, I have to be successful in whatever I undertake;

2. to be happy, I must be accepted by all people at all times;

3. If I make a mistake, it means I am inept,

4. I can’t live without love;

5. If somebody disagrees with me, it means he doesn’t like me; and

6. My value as a person depends on what other’s think of me when the patient and therapist identify one of these assumptions, it is vigorously attacked.
The learned Helplessness Model of Depression -

The second cognitive model of depression is the learned helplessness model and it hold the basic cause of depression in an expectation. The individual expects that bad events will occur to him and there is nothing to prevent their occurrence.

Learned helplessness was found in dog, rats and people. This is failure to learn that responding can be successful, even once a response is made and it succeeds in controlling the outcome, dogs and rats, who first had inescapable shock, when later placed in the shuttle box, after sit for three or four trials and fail to escape shock. On the fifth trial, the animal may stand up, cross the barrier, and successfully terminate shock.

Learned helplessness also occur in normal human being with human, the triadic design is used with nondepressed volunteers who receive loud noise delivered through earphones, and the results are parallel those in animals.

The deficits produced by learned helplessness in humans are quite general experience with inescapable noise produces deficits at later noise escape, deficits in cognitive task such as the solution of anagrams, deficits in seeing pattern in anagrams and lowered expectancy change following success in inescapable noise.
and failure in skilled tasks. The inducing events for helplessness in men need not be adverse. This theory argues that the basic cause of all the deficits observed in humans and animals after uncontrollable events occur is the expectation of future noncontingency between responding and outcomes.

Attributions in human helplessness-

There are three attributional dimensions that govern when and where future helplessness deficits will be displayed (Abramson, Seligman, and Teasdale, 1978).

Internal external dimension - Consider an individual who received unsolvable problem in an experiment and when he discover responding is ineffective then he can either conclude that he is stupid but the problem is solvable or that the problems are rigged to be unsolvable and he is not stupid. The first attribution for his failure is internal (stupidity) and the second is external (unsolvable problem). This evidence suggests that when individuals fail at important tasks and make internal attributions for their failure, passivity appeals and self esteem drop markedly. But when individuals make external attributions for failure, passivity ensues but self esteem stay high (Abramson, 1978).

Stability - An individual who has failed may decide that the cause of the failure is stable and that it will persist into
the future. The above examples factor stupidity (which is internal as well as stable), or the difficulty of the task (which is stable but external. An individual who has failed an exam can believe that the cause who his bad nights sleep the night before, an unstable cause that is internal. He also decide that he gailed because it was an unlucky day, an unstable cause that is external. According to be attributional model of learned helplessness, stable attribution lead to permanent deficits, and unstable attributions to transient deficits.

Global Specific — is the third and final dimension when an individual finds that he has failed, he must ask himself whether or not the cause of his failure is global — a factor that will produce failure in a wide variety of circumstances — or specific a factor that will produce failure only in a similar circumstances. When individuals make global attributions for their failure, helplessness deficits will occur in a wide variety of situations. When individuals believe that specific factors cause their failures the expectation of response ineffectiveness will be narrow, and only a narrow band of situations will produce helplessness deficits.
Bipolar Depression (manic Depression)

90 to 95 percent of depression are unipolar depression and occur without manic. Remaining 5 to 10 percentage of depressions that occur as a part of manic depression. There called bipolar depressions.

We classify bipolar depressions in the following way. An individual is judged to be manic depressive if he has had one or two more depressive episodes in the past. On the other hand, he is diagnosed as having experienced only a manic episode, if he has never had a depressive episode. Manic itself occur without depression, although this is very rare. A chronic form of mania is called chronic hypomanic disorder or hypomanic personality.

The depressive component of manic depression is highly similar to unipolar depression. There is only need to clear what an individual will feel in the manic state of a manic depressive disorder.

Symptoms of Mania-

The manic episode usually occurs fairly suddenly, and the euphoric mood, racing thoughts, frenetic acts, and the resulting insomnics stand in marked to the person usual functioning. Monics represent four set of symptoms; mood, thought, motivational and physical symptoms.
Mood and emotional symptoms - The mood of an individual in a manic state is euphoric, expensive, and elevated. Mania is not wholly the apposite state of depression, but that a strong depressive element coedcists with it.

Thought Symptoms - The manic cognitions are appropriate to the mood. The manic does not believe in limits to his ability and worse, he does not recognize thepalgal consequences that will cause when he carries out his plans.

Flight of ideas - A manic thoughts or ideas racing through his mind faster than he can write or say them. He has delusional ideas about himself; he may believe that he is a special messenger of God and he believe that he is an intimate friend of famous political and show business figures.

Motivational Symptoms - Manic behaviour is hyperactive the manic engages in frenetic activity, be it in his occupation, in political or religious circles or in sexual relationship.

Physical Symptoms - With all this flurry of activity comes a greatly fessened need for sleep. Such hyposommmia virtually always occurs during mania.

The Etiology of Depression:

Factors leading to depression may be divided into those that predispose to depression over a long period and
those that are immediate precipitants. This is not a
categorical separation, because there are times when it is
not clear into which clear a particular effect falls.

The current position on the etiology of depression
has recently been summarized by Akiskal 1979, 1984, and
Jashjian, 1983.

Stress and Strain -

Most studies are agreed that an episode of
depression is increased five or sixfold in the six months
following the occurrence of stressful "Life events" (Lloyd,
1980). The stressors most commonly associated with depression
are "exit" events, particularly separation, and
"undesirable" events, such as marital arguments (Fance et al
1981). In other words, stress is in the experience of the
stressed person, rather than being an intrinsic property of
the stressor.

The stressful life events is arising from a varicinity
of sources, including problems in the construction of the
measuring instruments (Tennant et al 1981) and the possibility
that valuerable people face trouble by their life style,
alienating others and causing the breakdown of relationships
(Briscoe and Smith, 1975). Distortions of recall found in
depressed people. It has been also examined that recent
bereavement is responsible to increase the incidence of depression (Lloyd 1980 b).

Although the relationship between life events and depression is not particularly strong. The incidence of depression following bereavement is only about 5% (Clayton, 1979), and 50% of depression occurs in the absence of stressful life events of any kind (Lloyd, 1980 b). Due to life events appear to account at most 10% of the variance in the incidence of depression. so it is concluded that "stress" "strain" may be "powerful predisposing factor.

Prolonged unemployment, which in addition to its adverse effects on self-esteem also generates financial and other difficulties which carries a high risk of depression (Jahoda, 1979) Almost 40% of subjects reporting a high level of marital, financial or work-related strain were clinically depressed (Aneshensel and Stone, 1982)

Other predisposing factors:

In addition to high level of strain there are a number of other factors which put a person at risk for depression including as - Sex, caste, socio-economic status. Early parental loss, and Heredity, these factors interact with events in bringing about the psychological change that constitute the onset of an episode of depression.
A number of environmental factors have been described which place a person at risk for depression.

Absence of social support - Brown and Harris (1978) reported that among women suffering high level of stress, the incidence of depression was increased fourfold due to the absence of an intimate, confiding relationship. It is seen that a supportive environment protects against a wide variety of stressor (Caplan, 1981, Cobb, 1976).

There is also clear evidence that the absence of social support predispose to depression in its own right even under condition of low stress (Williams et al, 1981). Social reinforcement contributes to psychological well being.

A characteristic "depressive style" of thinking, consisting of a tendency to accentuate the negative aspect of life and suppress the positive. Prospective studies have been rather unsuccessful in identifying a "depressive cognitive style" in people who were later to become depressed. At the very least, therefore, introversion must provide fertile ground on which depressive thinking might grow.

A confounding factor in personality studies is that most of them have been retrospective, and they fail to distinguish with personality traits but predispose to depression. It is
possible that a number of traits reliably identified in previously depressed people, such as dependency, pessimism and low self confidence (Altman and Wittenborn, 1980). may be residuals rather than predispositions (cossano et al 1983).

Parental, particularly material loss in childhood was associated with a two to threefold increase in the likelihood of adult depression. Furthermore, in most studies there was also a strong relationship between childhood loss and severity of depression (Lloyd 1980)

Parental loss is a predisposing factor in approximately a third of all adult depressives but is particularly prominent in the "character spectrum disorder" subgroup of characterological depressions (Rosenthal et al 1981). It is reported from number our studies that childhood reparation events, particularly bereavement, were related to subsequent suicide attempts, this is due to the effect of childhood loss on severity of depression (Birtchnell, 1970).

Bowlby (1977) suggest that childhood parental loss leads to "unstable" personality characteristics such as insecurity and social incompetence, which predispose toward depressive symptoms, but not to severe endogenous depression.

Women generally and working class women in particular are at higher risk for both major and minor depressions than men,