CHAPTER I

INTRODUCTION
Depression is listed as the chief complaint by more than half of all people coming to outpatient clinics. According to Secunda (1973): "Depression now rivals schizophrenia as the nation's number one mental health problem" (p. 3). That fact makes depression numerically significant, as well as important from a human standpoint. Estimating that 10% of the general population will have a significant depressive episode sometime in their lives, Friedman & Katz (1976) stated: "22,000 suicides were reported annually and about 80% were traced to a precipitating depressive episode". Thus, the possibility of suicide frequently exists, in which case treatment results are a matter of life and death. Prompt intervention - emergency psychotherapy - therefore plays a crucial role in the care and treatment of the depressed.

Depression has featured throughout history as perhaps the most pervasive of all psychopathology (Cf. Boyd et al. 1982). If clinical depression was experienced as the "Epidemic of the 70s" (Weissman & Paykel, 1974), then it must be said that the epidemic appears to be growing in the 80s. There is no evidence to indicate that the prevalence rates of depression are declining, and suicide appears to be on the increase, especially among young adults. A disorder that will affect 5% to 10% of all adult males and 10% to 20% of all adult females demands the attention of mental health services and practitioners. Further, as society faces the continuing prospect of high unemployment and other difficulties one may
suspect that depression will continue as a major mental health problem for years to come (Cf. Dobson, 1986, p. 187).

The construct "depression" is not only theoretically challenging, it is also diagnostically complex. Depression, either in its clinical forms or as a transient mood disturbance, represents an especially challenging and intriguing topic. The central symptoms of depression are sadness, pessimism, self-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. "The pleasure has gone out of my life", is at the center of the depressed patient's pervasive feelings of worthlessness, emptiness, and futility. The depressive expresses judgments of himself ranging from inadequacy and inefficiency to extreme guilt. With little or no basis in reality, and showing little or no response to reassurance, argument, and emotional appeal, he denies past achievements and abilities. The depressive regards himself as incompetent at best and disgustingly sinful at worst.

Some of the apparent paradoxes of depression are noted by Beck (1974): "The instinct for self-preservation and the maternal instincts appear to vanish. Basic biological drives such as hunger and sexual drive are extinguished. Sleep, the easer of all woes, is thwarted. Social instincts such as..."
attraction to other people, love, and affection evaporate. The "pleasure principle" and "reality principle", the goals of maximizing pleasure and minimizing pain, are turned around. Not only is the capacity for enjoyment stifled, but the victims of this odd malady appear to be driven to behave in ways that enhance their suffering" (pp. 3-4).

It has become customary to define depression in phenomenological terms rather than its meaning (Cholst, 1981; Depue & Monroe, 1978a; Spitzer, Sheehy, & Endicott, 1977; Blumenthal & Dielman, 1975). It makes sense to consider depression as disrupting a person's thinking processes, emotional reactions, and day-by-day behaviours (Williams, 1984; Farby, 1980). Schuyler (1974) suggested that depression could mean a lifestyle, a temporary reaction to some important event, an enduring symptom or feeling state, or a more serious disturbance. Zung (Farby, 1980, p. 590) proposed an operational definition of depression in a holistic sense and drew attention to the generalized disturbance or withdrawal of such functions as thought, feeling, experience, and emotion.

During the last few years, however, impressive progress has been made in the quality and quantity of clinical research on depression. As a result of impressive advances in research and therapeutics concerning depression, it has gained the attention of biologists, sociologists, psychologists, feminists and the educated public. Thus, the empirical literature on
the psychology of depressive states and conditions has burdened in recent years.

Despite the fact that depression has been described as a clinical syndrome for over 2,000 years, many of the most basic questions regarding its characterization, etiology, treatment and prevention remain answered in a definite manner. During the last few decades impressive progress has been made in the quality and quantity of research on clinical depression.* There are theories and research in the literature which stress or examine particular symptoms and factors related to depression.

Clinicians and researchers have debated whether the concept of depression refers to a single disease that varies from mild to severe along a continuum or whether it consists

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of a set of discrete subtypes that differ in phenomenology, pathophysiology, and ultimately etiology (Everitt, 1981; Kendall, 1968, 1976; Roth et al. 1972; Klerman, 1971; Eysenck, 1970; Hamilton & White 1959; Lewis, 1938). This debate has yielded a number of different methods for subtyping depressive disorders, such as endogenous vs reactive, psychotic vs neurotic, primary vs secondary and pure depressive disease vs depression spectrum disease (Nelson & Charney, 1980; Akiskal et al. 1978, 1979; Andreasen & Winokur, 1979a; Bhrolchain, 1979; Bhrolchain, Brown, & Harris, 1979; Winokur, Behar, Van Valkenburg, & Lowry, 1978; Lewis, 1971; Winokur, Cadorat, & Dorzab, et al. 1971; Kendall & Gourlay, 1970; Rosenthal & Klerman, 1966). Andreasen & Winokur (1979b) emphasized that "the multiplicity leads not to an embarrassment of riches but rather to a hodgepodge of competing and overlapping systems: psychotic vs neurotic, endogenous vs reactive, bipolar vs unipolar, agitated vs retarded, manic-depressive vs involutional" (p. 447). Although diagnostic sub-categories vary between countries and among investigators, three major classes of serious depression have stood the tests of time, of scientific enquiry (Akiskal & McKinney, 1975; Mendels & Cochrane, 1968), and that of differential treatment in the clinic. These three sub-classes of depression are manic-depressive (bi-polar) psychosis, endogenous (unipolar) depression, and reactive (unipolar) depression. Biological factors (biochemical, endocrine, genetic) appear to be more crucial for reactive depression.
More recently, Andreasen, Scheftner, Reich, Hirschfeld, Endicott, & Keller (1986) emphasised that the endogenous vs reactive distinction is perhaps the most widely accepted throughout the world (p. 246). In more recent times, the concept of depression has been broadened to include milder forms.

The classification of depression, however, remains a controversial subject despite many recent attempts at clarification. In response to the confusion, several newer experimental systems for classifying depressive disorders have arisen. The present study will not, however, further discuss this important issue because the aim of the present study is not related to the classification of depression. The purpose of this study is to investigate correlates of depressive symptomatology in married employed and non-employed women. It refers to milder forms of depression which may befall almost anybody (presence of depressive symptoms rather than depression as a disorder or illness).

Clinical theorists from diverse backgrounds have written extensively on the relationship between personality and depression. Ten models of depression reflecting five dominant schools of thought have been summarized by Akiskal & McKinney (1975). Psychoanalysts have described the depression-prone personality as one characterized by high dependency on others for support and approval, low frustration tolerance, and labile self-esteem (Chodoff, 1972). The earlier psychoanalytic theorists (Abraham, 1948) emphasized obsessionality. More recent writers
(Chodoff, 1972) have underscored the importance of undue interpersonal dependency, describing depressed individuals as inordinately and almost exclusively dependent on narcissistic supplies derived directly or indirectly from other people for maintenance of their self-esteem. Their frustration tolerance is low and they may employ various techniques - submissive, manipulative, coercive, piteous, demanding or placating - to maintain their desperately needed but essentially ambivalent relationships with the external or internalized objects of their demands (Chodoff, 1972). More recently Hirshfeld, Klerman, Clayton, & Keller (1983) failed to find support for the earlier psychoanalytic theories emphasizing obsessionality.

Cognitive theorists have described a pessimistic, negative perception of self and the world (Beck, 1972). Social learning theorists have emphasized constricted social skills and behaviours (Lewinsohn, 1976), and other behavioural psychologists have focused deficits in learning mastery (Freidman & Katz, 1976). Lewinsohn (1976) has reported that depressives lack social skills, at least during depressive episodes. Lewinsohn and associates at the University of Oregon Depression Research Unit have relied on social learning theory to understand and to treat depression. As social learning theorists, they have attempted to integrate stimulus response theory and cognitive theory. For example, Lewinsohn & Arconad (1981) argued that one must examine the interactions among personal factors (e.g., cognitive processes, expectancies), behavioural factors, and environmental factors to understand
depression. They maintained that these factors are interdependent and that the relative impact of any one factor varies depending upon the setting and behaviour involved. Seligman's learned helplessness theory (Friedman & Katz, 1976) describes depressives as reacting passively to all kinds of noxious stimuli. The recent investigation (Hirschfeld, Klerman, Clayton, & Keller, 1983) found results consistent with cognitive and social learning theories.

The sociologist regards depression as the outcome of a social structure that deprives individuals with certain roles, e.g., middle class, middle-aged housewives, from control over their destiny (Bart, 1974). For the existentialist, depression supervenes when the individual discovers that his world has lost its meaning and purpose (Becker, 1964). Finally, the biological psychiatrist conceptualizes depression as the behavioural output of a genetically vulnerable central nervous system (CNS) depleted from biogenic amines (Lapin & Oxenkrug, 1969; Coppen, 1967; Bunney & Davies, 1965; Schildkraut, 1965) and characterized by hyperarousal (Whybrow & Mendels, 1969). More recent hypotheses emphasize cholinergic dominance (Janowsky, El-Yousef, Davis, & Sakerke, 1972) or reversible deficits in the diencephalic mechanisms of reinforcement (Akiskal & McKinney, 1973).

The literature in the specific area of depression reveals:

1. There is a considerable agreement regarding depression as a common problem for the general population and the client in psychotherapy in particular.
2. There are numerous and conflicting theories and studies about symptoms and correlates of depression. Each theoretical framework has generated its own therapeutic modalities that unfortunately, tend to be competitive rather than complementary. They range from psychoanalysis to behaviour therapy, from sociopolitical activism to pharmacotherapy, and electric convulsive therapy (ECT).

3. The literature regarding possible symptoms and correlates of depression is extensive and sometimes conflicting. The investigation of the correlates of depression, however, has been obscured by four factors which have been incorporated in the present study as potentially important refinements* into the methodology.

4. Men and women with untreated depression may suffer from considerable impairment in their major roles as wives and husbands, mothers and fathers, workers and friends. The understanding of the correlates of depression would have direct implications in the treatment of depression. Keeping in view these aspects, an attempt has been made in the present study to understand the correlates of depressive symptomatology among employed and non-employed married women.

* Discussed in Chapter II concerning review of related literature.
The present study which is in line with the recent trends in this specific area of research, however, aspires to be unique because several potentially important refinements have been incorporated into the methodology.