Mood is a state of feeling associated with contentment, pleasure, happiness and ecstasy at one extreme, with sadness, dissatisfaction, irritability, anger or fear at the other. Mood is an overall orientation of the body-mind. It is both a symptom and a cause. There are a number of phrases used to describe this feeling of "downness, fed up, browned of, the downs, downs in the dumps, the blues, the glooms, the miseries, feeling low, at a low ebb, lifeless, flat" and so on. Writers have used words like melancholy and anomie determined by the amount of a given fluid (humor) in the body and people sometimes still talk of being out of humor. In melancholy, there was thought to be an excess of black bile in the body. Anomie implies a lack of energy or initial spirit in a person.

The word depression when applied to a state of mood shares with all those words and phrases, a sense of being down in spirit, low in energy, having a sense of loss, hopelessness and uselessness. It implies apathy and pessimism. The opposite mood would be typified by enthusiasm, joyfulness, elation, hopefulness and optimism.

The word 'depression' is used to describe everyday feelings of low mood which can affect us all from time to time. Feeling sad or fed up is a normal
reaction to experiences that are upsetting, stressful or difficult; those feelings will usually pass.

A depressed mood very often comes on after disappointment, in a sense of having lost something but often it can come out of the blue.

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Apparently, spontaneous shift of mood are said to be cyclothymic. It is often accompanied by feeling of anxiety. This is an unpleasant feeling of anticipated disturbance. The very fact of becoming depressed itself can spark off anxiety in susceptible persons. It may also arise in conjunction with anxiety or may be initiated by it.

Mood arises out of all kinds of experiences. An experience linked with a depressed mood is that of feeling devalued and losing a sense of being appreciated. This experience of losing something valuable can be associated with feeling of frustration and resentment. When one is depressed, he often wants to be quiet.

If depression is accepted as common human experience, the question may arise whether or not the experience is normal one. If depression is considered abnormal, something can be done or not is yet another question but abnormality as such implies an undesirable state. If depression is judged to be normal it may well have a therapeutic healing effect.

When the negative reactions to life’s situations become repetitively intense and frequent we develop symptoms of depression. Life throws up
innumerable situations, which we greet with both negative and positive emotions such as excitement, frustration, fear, happiness, anger, sadness, joy et al. Depression is prevalent among all age groups, in almost all walks of life.

Persons of any age—children or adults—may develop depression symptoms. Even minor stress events can stir up depression symptoms depending on the personality type. Symptoms such as intense sadness, loss of interest or pleasure in normal activities, sleep disturbances or oversleeping, change in appetite and decreased energy level; feelings of helplessness and thoughts of suicide are sequels to stress induced depression.

Everyone feels sad or irritable sometimes, or has trouble sleeping occasionally. But these feelings and troubles usually pass after a couple of days. When a man has depression, he has trouble with daily life and loses interest in anything for weeks at a time.

Both men and women get depression. But men can experience it differently than women. Men may be more likely to feel very tired and irritable, and lose interest in their work, family, or hobbies. They may be more likely to have difficulty in sleeping than women who have depression. And although women with depression are more likely to attempt suicide, men are more likely to die by suicide.

Many men do not recognize, acknowledge, or seek help for their depression. They may be reluctant to talk about how they are feeling. But depression is a real and treatable illness. It can affect any man at any age. With
the right treatment, most men with depression can get better and gain back their interest in work, family, and hobbies.

**History of Depression**

The Ancient Greek physician Hippocrates described a syndrome of melancholia as a distinct disease with particular mental and physical symptoms. The term depression itself was derived from the Latin verb *deprimere*, "to press down". From the 14th century, "to depress" meant to subjugate or to bring down in spirits. It was used in 1665 in English author Richard Baker's Chronicle to refer to someone having "a great depression of spirit", and by English author Samuel Johnson in a similar sense in 1753 (Wolpert 1999). The term also came in to use in physiology and economics. An early usage referring to a psychiatric symptom was by French psychiatrist Louis Delasiauve in 1856, and by the 1860s. It appeared in medical dictionaries to refer to a physiological and metaphorical lowering of emotional function (Berrios 1988). Since Aristotle, melancholia had been associated with men of learning and intellectual brilliance. The newer concept abandoned these associations and through the 19th century, became more associated with women (Radden 2003).

German psychiatrist Emil Kraepelin may have been the first to use it as the overarching term, referring to different kinds of melancholia as depressive states (Berrios 1988).
Meyer put forward a mixed social and biological framework emphasizing reactions in the context of an individual's life, and argued that the term depression should be used instead of melancholia (Lewis 1934).

The first version of the DSM (DSM-I, 1952) contained depressive reaction and the DSM-II (1968) depressive neurosis (APA 1968).

In the mid-20th century, researchers theorized that depression was caused by a chemical imbalance in neurotransmitters in the brain (Schildkraut 1965). The term Major depressive disorder was introduced by a group of US clinicians in the mid-1970s as part of proposals for diagnostic criteria based on patterns of symptoms (Spitzer, Endicott & Robins 1975) and was incorporated into the DSM-III in 1980 (Maier & Delmo 1994).

To maintain consistency, the ICD-10 used the same criteria, with only minor alternations, but using the DSM diagnostic threshold to mark a mild depressive mode episode, adding higher threshold categories for moderate and severe episodes (Spitzer, Endicott & Robbins 1975). The ancient idea of melancholia still survives in the notion of a melancholic sub-type.

**Depression : Conceptualization**

Psychologists have used several terms to describe problems, which are associated with emotional response system. Emotion, affect and mood
are some of the examples. Mood refers to a pervasive and sustained emotional response that can colour the person's perception of the world (APA, 1993).

Depression is a state of psyche characterized by a spectrum of negative feelings ranging in scope from minor unhappiness to overwhelming despair. Though generally associated with emotional or psychological symptoms, depression can be accompanied by severe pain or other physical symptoms as well; depression is capable of dramatically influencing the lives of those it affects.

Depression is a state of low mood and aversion to activity that can affect a person's thoughts, behaviour, feelings and physical wellbeing (Salmar 2001). Depressed people may feel sad, anxious, empty, hopeless, helpless, worthless, guilty, irritable, or restless. They may lose interest in activities that once were pleasurable, experience loss of appetite or overeating, or problems in concentrating, remembering, details or making decisions; and may contemplate or attempt suicide. Insomnia, excessive sleeping, fatigue, loss of energy, or aches, pains or digestive problems that are resistant to treatment may be present (National Institute of Mental Health 2010).

Depressed mood is a normal reaction to certain life events, a symptom of some medical conditions (e.g. Addison's disease, hypothyroidism), various medical treatments (e.g., hepatitis C drug therapy), and a feature of certain psychiatric syndromes.
Depression refers to either mood or clinical syndrome - a combination of emotional cognitive and behavioural symptoms. The feeling associated with a depressed mood includes disappointment, helplessness and hopelessness (Comer, 1995). Persons who are in severely depressed mood describe the feeling as overwhelming, suffocating or numbing. In the syndrome of depression which is also called clinical depression, a depressed mood is associated with several additional symptoms such as fatigue, loss of energy, sleeping difficulty and appetite changes. Clinical symptoms also involve a variety of changes in thinking and overt behaviour. The person may experience cognitive symptoms and behavioural symptoms.

Depression has been alluded to by a variety of names in both medical and popular literature for thousands of years. Early English texts refer to "melancholia", which was for centuries the generic term for all emotional disorders. Depression is now referred to as a mood disorder. It has been described as a feeling of helplessness, hopelessness and fatigue, all feelings associated with chronic unrelieved stress, as well. Chronic stress is often associated with depression, not the least because circumstances that lead to chronic stress often seen too massive and out of control ever to be alleviated. The effects of repeated acute stress may induce continued depression also, but it isn't clear whether the depression is a result of personality characteristics that predispose individuals to stress or to the stress itself.
In nutshell, depression is a low sad stage in which life seems bleak and challenging and its challenges are overwhelming (Comer, 1995). The extreme opposite of depression is mania, which is a state of breathless euphoria in which people have an exaggerated belief that the world is theirs.

Everyone experiences some unhappiness, often as a result of a change, either in the form of a setback or loss, or simply, as Freud said, "everyday misery", the painful feelings that accompany these events are usually appropriate, necessary and transitory and can even present an opportunity for personal growth. However, when depression persists and impair daily life, it may be an indication of a depressive disorder. Severity, duration and the presences of other symptoms are the factors that distinguish normal sadness form a depressive disorder.

People in day-to-day life also experience various episode of depression. As we know, most people exhibit bad moods and they feel specially sad and unusually irritable. Usually, these moods do not last long and disappears very soon the individuals get past a difficult deadline or do something funny with a friend, neighbour, etc. They bounce back and more on. The following three point basically differentiate common experience of depression from a depressive disorder:

(i) Depressed mood seen in depressive disorder is not temporary or easily shaken off. It typically persists for a week, months or
sometimes even year.

(ii) A depressive disorder is severe enough to distort a person’s ability to work or interact with friends or family.

(iii) People suffering from depressive disorder demonstrate several others physical and behavioural symptoms, such as reduced appetite, sleep disturbance and loss of interests in or pleasure from their usual pursuit.

In nutshell, it can be said that persons suffering from depression experience profound unhappiness and they experience it much of the time. A part from this, such persons also report that they have lost interest in all the usual pleasures of the life. Also, persons suffering from depression often experience significant weight loss or gain. Depression may also involve fatigue, insomnia, feeling of worthlessness, a recurrent inability to think or concentrate and recurrent thoughts of death or suicide. A person who experiences five or more of these symptoms at once during the same two week period is classified by DSM-IV as undergoing a major depressive episode.

**Major Symptoms of Depression**

Depression of mood can be expressed in different people in different ways. However, the major symptoms associated with depression expands five areas of functioning. The emotional, motivational, behavioural, cognitive and somatic.
Emotional Symptoms include sadness among others. Along with the feeling of sadness, feeling of anxiety is very often present in depression (Fowles and Gersh, 1979). Activity which usually brings satisfaction, produce dullness and flatness in depressed person. Loss of interest usually starts in only a few activities such as work. But as depression advances in severity, it expresses through practically everything the individual does. Pleasure obtained from hobbies, recreation and family diminishes. In one study, it was estimated that 92% depressive patients no longer derive ratification from some major interest in their life and 64% persons lose their feelings in other people (Beck 1967; Clark, Beck and Beck, 1994).

Among cognitive symptoms, the negative thought colours the person's view of himself and the future. A depressed individual often has low self-esteem. He believes that he is inferior, inadequate, and incompetent. Depressed people have not only low self-esteem but also blame themselves and feel guilty that affect them negatively. When failure occurs, the depressed individual take the responsibility upon themselves (Seligman & Rosenhan, 1998).

Among motivational symptoms depressed people loose their desire to be participate in their accustomed activities. They usually show lack of drive, initiative and spontaneity and sometimes they may have to force themselves to go to work, converse with friends, eat meal and have
sex (Butchwald & Rudick-Davis, 1993).

In very extreme form this lack of response initiation is the paralysis of the will. In severe depression, there may be psychomotor retardation in which movements slow down. Difficulty in making decision also seems to a common motivational symptom of depression (Hammen & Padesky, 1977). For depressed individuals, making a decision may be overwhelming and frightening. Many depressed people are so indifferent to their life that they wish to die.

Among behavioural symptoms depressed people show lack of energy and reluctance to do a work (Parker et.al., 2011; Butchwald & Rudick-Davis, 1993). Even their speech may be slow, quiet and monotonous. It has also been found that the depressed patients made less direct eye contact with others than did non-depressed persons. Such persons also turn down their mouth and hung their heads (Waxer, 1974; Jainer, Sharma, Agrawal & Singh, 1992).

Among somatic symptoms severals type of physical ailments, headache, indigestion, constipation, unpleasant sensations and generalized pain are included. Disturbances in appetite and sleep are common (Kazes et.al., 1994; Buchwald & Rudick-Davis 1993; Spoov et.al., 1993).

The DSM-IV-TR (American Psychiatric Association [APA], 2001) describes depression as a persistent disturbance of mood lasting at least 2 weeks. Persistent feelings of shame, guilt, and low energy may exist. Emotional symptoms may be exhibited by sadness, fear and or anger. Cognitive
symptoms of the individual may include a labored thinking process, lack of concentration and a high level of distractibility. Somatic symptoms of depression may include physical problems without a medical cause, to include such symptoms as disruptions in sleep, fatigue, appetite changes and bodily pains. Lastly, behavioral symptoms may include slowed speech and movement.

People with depressive illnesses do not all experience the same symptoms. The severity, frequency, and duration of symptoms vary depending on the individual and his or her particular illness.

Depression varies from person to person, but there are some common signs and symptoms. It's important to remember that these symptoms can be part of life's normal laws. But the more symptoms you have, the stronger they are, and the longer they've lasted—the more likely it is that you're dealing with depression. When these symptoms are overwhelming and disabling, that's when it's time to seek help.

**Common signs and symptoms of depression**

**Feelings of helplessness and hopelessness.** A bleak outlook—nothing will ever get better and there's nothing you can do to improve your situation.

**Loss of interest in daily activities.** No interest in former hobbies, pastimes, social activities, or sex. Individual lost his ability to feel joy and pleasure.
**Appetite or weight changes.** Significant weight loss or weight gain - a change of more than 5% of body weight in a month.

**Sleep changes.** Either insomnia, especially waking in the early hours of the morning, or oversleeping (also known as hypersomnia).

**Anger or irritability.** Feeling agitated, restless, or even violent. Your tolerance level is low, your temper short, and everything and everyone gets on your nerves.

**Loss of energy.** Feeling fatigued, sluggish, and physically drained. Your whole body may feel heavy, and even small tasks are exhausting or take longer to complete.

**Self-loathing.** Strong feelings of worthlessness or guilt. You harshly criticize yourself for perceived faults and mistakes.

**Reckless behavior.** You engage in escapist behavior such as substance abuse, compulsive gambling, reckless driving, or dangerous sports.

**Concentration problems.** Trouble focusing, making decisions, or remembering things.

**Unexplained aches and pains.** An increase in physical complaints such as headaches, back pain, aching muscles, and stomach pain.

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**Effects of Depression on Body**
Insomnia; Inability to sleep. At times, the regular pattern of sleep is broken frequently with the person breaking up in the middle of the sleep, feeling restless. The person tends to wake up early and is not able to go back to sleep.

Weight fluctuations. The person begins to forego food, resulting in weight loss. In other occasions, he or she may begin to overeat or do less physical activity, resulting in weight gain.

Physical symptoms. The physical symptoms associated with depression include fatigue, headache, digestive related problems, body ache etc.

Depression affects people according to their ages. Children who are depressed may feel insecure, demanding, irritable while older people start developing physical disorders like stroke. Parkinson's disease, cardiovascular disease and chronic obstructive pulmonary disease.

Thyroid Disease. There is a definite connection between the thyroid disease and depression. Thyroid patients have the highest cases of depression than the average people.

Increased DHEA levels. Depression is when the stress makes the adrenal glands to break down, increasing cortisol levels and reducing DHEA levels in the glands. Due to high levels of cortisol in the blood, a person starts getting more worried, feels more anxious and even ends up being a schizophrenic.
Decline in libido. The person begins to experience a dip in libido and some of the common sexual problems like decreased potency, premature ejaculation and lack of vaginal lubrication happen due to depression.

Heart related problems and blood pressure. Depression worsens and increases the risk of coronary heart disease. It is also a leading cause of stroke and high blood pressure. The leading cause of heart disease is documented to be stress and depression.

Causes of Depression

Research spanning the last 20 to 30 years has examined a range of influences that contribute to depression. These include genetics, brain chemistry, early life trauma, negative thinking, one's personality and temperament, stress, and difficulty relating to other (Liu 2010). Moreover, emerging scientific research suggests that metabolic phenomenon such as inflammation, oxidative stress, and hormonal imbalances can cause or exacerbate depression as well (Maes 2011; Wolkowitz 2011).

Depression is a term which has a vast meaning. It varies from person to person and differs in causes and consequences for every individual. There are few known reasons behind its occurrence and few unknown reasons too. It is a mental state but leaves certain major physical drawbacks. It can cause severe illness if not treated well on time.
Depression usually isn't caused by one event or reason, but is usually the result of several factors. Causes vary from person to person.

Depression can be caused by lowered levels of neurotransmitters (chemicals that carry signals through the nervous system) in the brain, which limits a person's ability to feel good. Genetics are likely involved as depression can run in families, so someone with a close relative who has depression may be more likely to experience it.

The depressed brain is different from the brain of a person who is not depressed. Two of the neurotransmitters in the brain, norepinephrine and serotonin, are scarce during depression. Researchers have found in numerous studies that the brain of a depressed person tends to be less active. Myers (2004) says, "The left frontal lobe, which is active during positive emotions, is likely to be inactive in depressed state" (p. 642).

Significant life events such as the death of a loved one, a divorce, a move to a new area, and even a breakup with a girl friend or boy friend can bring on symptoms of depression. Stress also can be a factor, and because the teen years can be a time of emotional and social turmoil, things that are difficult for anyone to handle can be devastating to a teen.

Also, chronic illness can contribute to depression, as can the side effects of certain medicines or infections.
Depression shows up in various form. In some cases people become short tempered. They lose their temper easily and quickly. Few patients like to stay alone. They don't want to mix with people or to have a social circle. Symptoms of depression vary from person to person.

Depression can be caused due to several reasons. These reasons could be biological factors, genetic factors, and environmental factors. A person's mind is easily affected by its surrounding. What we see, what we experience gives us an outlook towards life and if this outlook goes in negative direction it causes depression.

Our body has its own chemical composition. If this composition gets disturbed then there are certain abnormalities we suffer. One such abnormality is depression which results from the fluctuation in biochemical composition in our body. These chemicals we are referring here are commonly known as neurotransmitters.

Apart from these chemicals, our own genes are responsible for causing depression. Heredity could be one reason too for depression. It is difficult to say which genes are responsible for causing depression but research is going on for knowing the exact causes.

Most likely, depression is caused by a combination of genetic, biological, environmental, and psychological factors.
Depressive illnesses are disorders of the brain. Longstanding theories about depression suggest that important neurotransmitters - chemicals that brain cells use to communicate - are out of balance in depression.

Brain-imaging technologies, such as magnetic resonance imaging (MRI), have shown that the brains of people who have depression look different than those of people without depression. The parts of the brain involved in mood, thinking, sleep, appetite, and behavior appear different. But these images do not reveal why the depression has occurred. They also cannot be used to diagnose depression.

Some types of depression tend to run in families. However, depression can occur in people without family histories of depression too. Scientists are studying certain genes that may make some people more prone to depression. Some genetics research indicates that risk for depression results from the influence of several genes acting together with environmental or other factors. In addition, trauma, loss of a loved one, a difficult relationship, or any stressful situation may trigger depressive episode. Other depressive episodes may occur with or without an obvious trigger. Depression is one such mental instability that is beyond anyone's control.

Types of Depression and Associated Symptoms
Contrary to the common notion that there is only one type of depression, there are actually several. Some of these types of depression are more severe than others, and may require different treatment procedures. Depression is distinguished into various forms. The most common are major depressive disorder and dysthymic disorder.

**Major depressive disorder (Major Depression)**

Major depressive disorder can be very disabling, preventing the patient from functioning normally. A combination of symptoms sabotages the patient's ability to sleep, study, work, eat, and enjoy formerly pleasurable activities. Some people may experience only a single episode, while others experience recurrent episodes.

**Dysthymic disorder (Dysthymia)**

Dysthymia, also known as chronic mild depression, lasts longer than two years. Symptoms are not disabling or as severe as those of major depression, however the patient finds it difficult to function normally and does not feel well. A person with dysthymia may also experience periods of major depression.

**Psychotic depression**

Psychotic depression is a severe depressive illness that includes hallucinations, delusions, or withdrawal from reality. Psychotic
depression, which occurs when a person has severe depression plus some form of psychosis, such as having disturbing false beliefs of a break with reality (delusions), or hearing or seeing upsetting things that others cannot hear or see (hallucinations).

**Postpartum depression (Postnatal depression)**

Postpartum depression, also known as postnatal depression (PND), affects 10% to 15% of all women after giving birth. This is not to be confused with the "baby blues", which a mother may feel briefly after giving birth. The development of a major depressive episode within a few weeks of giving birth likely indicates PND. Sadly, many of these women go undiagnosed and suffer for long periods without treatment and support.

Seasonal affective disorder (SAD), which is characterized by the onset of depression during the winter months, when there is less natural sunlight. The depression generally lifts during Spring and Summer. SAD may be effectively treated with light therapy, but nearly half of those with SAD do not get better with light therapy alone. Antidepressant medication and psychotherapy can reduce SAD symptoms, either alone or in combination with light therapy. Accumulating evidence points to vitamin D deficiency as a contributing factor in SAD and in other form of depression (Parker 2011 et.al.).
Bipolar disorder (manic-depressive illness), also called manic-depressive illness, is not as common as major depression or dysthymia. Bipolar disorders characterized by cycling mood changes - from extreme highs (e.g. mania) to extreme lows (e.g. depression). A patient with bipolar disorder experiences (oftentimes extreme) highs (mania) and lows (depression) in mood. The frequency at which an individual reverts from mania to depression, and vice-versa.

Theoretical Models of Depression

There are some models which have been developed to explain depressive behaviours. Important ones are: Biological Model, Behaviour Model, Psychodynamic Model and Cognitive Model.

According to biological model, depression is the disorder of the body. This model focuses entirely on the brain and in particular upon the depletion of a class of chemical in the brain (biogenic amines), that help transmit nerve impulses across the gaps (synapses) between the nerve cells (neurons). In brief, biological model holds that depression is due to depletion of certain central nervous system neurotransmitters like serotonin or norepinephrine (Maas, 1975; McNeal and Cimbolic, 1986; Potter Manji, 1994). Some have hypothesized that major depression results from low norepinephrine supplies (Schild Kraut, 1965; Bounney & Davis, 1965). As norepinephrine belongs to the class of chemical called catecholamine, this hypothesis is also known as catecholamine hypothesis. British
researchers have also developed a parallel explanation and have held that low supplies of neurotransmitter serotonin causes depression. This is called indolamine hypothesis because serotonin belongs to the class of chemical known as indolamine (Coppen, 1967).

There are also some evidences that genetic is also involved in depression. First degree of relative of patients with depressive disorder are about two to five times more at risk for depression, than are those in general depression (Weisman, Kidd and Prusoff, 1982; Keller, Beards Dorer, Lavori, Samuelson and Kelerman, 1986). Some neuroanatomical basis of depression have shown that overactivity of the right frontal lobe in the brain produces depression (Davidson, Schaffer and Saron, 1985; Sackein, Greenberg, 1982).

*Psychodynamic Model* which was developed by Sigmund Freud and his students Carl Abrahams concentrate on the personality that predisposes a person to depression. This model further holds that depressions stem from the anger turned upon the self and that individual who predisposes to depression are overdependent on other people for this self-esteem and that they feel helpless to achieve their goals. (Arieti and Bempord, 1978). Bibring (1953) has claimed that depression results when the ego feels helpless before its aspirations. Infact, perceived helplessness at achieving the ego's high goals produces loses of self-esteem, which is one of the central features of depression. Some
Psychodynamic researches have expressed their view that depression is often triggered by major loss and that people who experience early loss and early dependent relationship are more vulnerable to losses later in life. Separation from the mother before the age of six years often brings a depressive pattern called _anaclitic depression_ (Bowlby, 1980, 1977, 1973, 1969).

The _behavioural view_ suggest that for some persons rewards that ordinarily reinforce positive behaviour start to dwindle and gradually, then they respond by performing fewer and fewer positive behaviour and ultimately develop a depressive style of functioning (Lewinsohn et.al. 1984). They also report that a person's number of reinforcements is related to the presence or absence of depression. Not only do depressed subject report a lower number of reinforcement, but when reinforcement increases, the mood of depressed subject improves as well, Lawinsohn, Youngren & Grosscup (1979). Some behaviourists believe that social reinforcements, are particularly important because depressed subjects tend to experience fewer social positive reinforcement than non-depressed (Peterson, 1993; Coyne, 1985; Lewinsohn, et.al. 1984).

_Cognitive view_ points out that negative thinking rather than underlying conflict or fewer positive reinforcement results in depression (Sethi, 1985; Young, Beck & Weinberger, 1993; Beck, 1991, 1967). Some others cognitive theorists hint that maladapative thinking often results in
depression (Ellis, 1991). Following Beck, the maladaption attitude, the cognitive triad errors in thinking and automatic thoughts are combined to produce the state of depression. In cognitive triad since thinking takes three forms, it is so named. Persons here repeatedly interpret (a) their experience, (b) themselves and (c) their future in negative way that leads them to a depressed state.

Vulnerability to Depression

Researches have revealed that some groups are more vulnerable and susceptible to this common cold of mental illness, that is depression. A review of literature reveals some important fact regarding this:

Depression in women

Depression is more common among women than among men. Biological, life cycle, hormonal, and psychosocial factors that women experience may be linked to women's higher depression rate. Researchers have shown that hormones directly affect the brain chemistry that controls emotions and mood. For example, women are especially vulnerable to developing postpartum depression after giving birth, when hormonal and physical changes and the new responsibility of caring for newborn can be overwhelming.
Some women may also have a severe form of premenstrual syndrome (PMS) called premenstrual dysphoric disorder (PMDD). PMDD is associated with the hormonal changes that typically occur around ovulation and before menstruation begins.

During the transition into menopause, some women experience an increased risk for depression. In addition, osteoporosis - bone thinning or loss - may be associated with depression. Scientists are exploring all of these potential connections and how the cyclical rise and fall of estrogen and other hormones may affect a woman's brain chemistry.

Finally, many women face the additional stresses of work and home responsibilities, caring for children and aging parents, abuse, poverty, and relationship strains. It is still unclear, though, why some women faced with enormous challenges develop depression, while others with similar challenges do not.

Studies suggest that women experience depression up to twice as often as men. Hormonal factors may contribute to the increased rate of depression in women; such as menstrual cycle changes, pregnancy, miscarriage, postpartum period, pre-menopause, and menopause. Women may also face unique stressors such as responsibilities both at work and home, single parenthood, and caring for children and for aging parents.

Many women are particularly vulnerable to depression after the birth of a baby. The hormonal and physical changes, as well as the
added responsibility of a new life, can be factors that lead to postpartum depression in some women. Some periods of sadness are common in new mothers; but a full depressive episode is not normal and requires intervention. Treatment by a sympathetic health care provider and emotional support from friends and family are important in helping her to recover her physical and mental well-being and her ability to care for and enjoy her baby.

Females, seems to have risk twice for depression as males (Nonel-Hoeksemal 1988, Weissuman & Offson 1995). Studies of patients undergoing therapies and community studies have indicated that females are significantly more depressed than males (None-Hoekseman 1987, 1999). This happens so probably because women are reinforced for passivity and crying while males are more reinforced for anger or indifference (Wisseman & Paykel 1974; Novel-Hoekseman & Gircus 1994). An alternative expression has grown out of the learned helplessness theory of depression according to which depression is related to helplessness. If so, then to some extent, women learn to be more helpless than men, depression will naturally appear more frequently in women than in men.

Rates of depression in women are twice as high as they are in men. This is due in part to hormonal factors, particularly when it comes to premenstrual syndrome (PMS), premenstrual dysphoric disorder (PMDD), postpartum depression, and perimenopausal depression. As for signs and
symptoms, women are more likely than men to experience pronounced feelings of guilt, sleep excessively, overeat, and gain weight. Women are also more likely to suffer from seasonal affective disorder.

**Depression in Men**

Men may be more likely than women to turn to alcohol or drugs when they are depressed. They also may become frustrated, discouraged, irritable, angry, and sometimes abusive. Some men throw themselves into their work to avoid talking about their depression with family or friends, or behave recklessly. And although more women attempt suicide, many more men die by suicide in the United States.

Depression is a loaded word in our culture. Many associate it, however wrongly, with a sign of weakness and excessive emotion. This is especially true with men. Depressed men are less likely than women to acknowledge feelings of self-loathing and hopelessness. Instead, they tend to complain about fatigue, irritability, sleep problems, and loss of interest in work and hobbies. Other signs and symptoms of depression in men include anger, aggression, violence, reckless behavior, and substance abuse. Even though depression rates for women are twice as high as those in men, men are a higher suicide risk, especially older men.

Men often experience depression differently than women. While women with depression are more likely to have feelings of sadness, worthlessness, and excessive guilt, men are more likely to be very tired,
irritable, lose interest in once-pleasurable activities, and have difficulty sleeping.

Men are less likely to suffer from depression than women, but three to four million men in the United States are affected by the depression. Men are less likely to admit to depression, and doctors are less likely to suspect it. More women attempt suicide, but more men actually commit suicide. After age 65, the rate of men's suicide increases, especially among white men older than 85.

Depression also can affect the physical health in men differently from women. One study showed that men suffer a high death rate from coronary heart disease following depression. Men's depression may be masked by alcohol or drugs, or by working excessively long hours. Rather than feeling hopeless and helpless, men may feel irritable, angry, and discouraged.

Even if a man realizes that he is depressed, he may be less willing than a woman to seek help. In the workplace, employee assistance professionals or worksite mental health programs can help me to understand and accept depression as a mental health disorder that needs treatment.

Unfortunately, studies are still inconclusive, and researchers still are not completely sure what as to the causes of depression in men. Nonetheless, they have made advances, and believe that both genetics environmental factors can cause men to suffer from depression. Though they do believe it is related to genetics, even those who have no family.
Genetic Factors

Some depression runs in families, Researchers believe that it is possible to inherit a tendency to get depression. This seems to be especially true for bipolar disorder (manic depression). Studies of families with several generations of bipolar disorder (BPD) found that those who develop the disorder have differences in their genes from most who don't develop BPD. Some people with the genes for BPD don't actually develop the disorder, however. Other factors, such as stresses at home, work, or school, are also important.

Major depression also seems to run in families, but it can also develop in people who have no family history of depression. Either way major depressive disorder is often associated with changes in brain structures or brain function.

People who have low self-esteem who are consistently pessimistic, or who are readily overwhelmed by stress are also prone to depression. Physical changes in the body can also trigger mental health problems such as depression. Research demonstrates that stroke, heart attack, cancer, Parkinson's disease, and hormonal disorders can cause depression. A severe stressor such as a serious loss, difficult relationship,

financial problem can also trigger a depressive episode. A combination of genetic, psychological, and environmental factors is often involved in the onset of depression.
Social class and depression

Social class has also emerged as one of the antecedents of depression. Poor people develop somewhat more affective disorder (Kessler, McGonagle & Zhao et al., 1994). It has also been reported that depression may have different manifestations according to person's social class. For example, lower class people may show more feeling of powerlessness and helplessness for expressing depression, Middle class person may show stronger feeling of loneliness and anger for expressing depression and upper class person may show greater pessimism and social withdrawal for expressing depression (Schwab, et al., 1967).

Depression in Children

Children who develop depression often continue to have episodes as they enter adulthood. Children who have depression also are more likely to have other more severe illnesses in adulthood.

A child with depression may pretend to be sick, refuse to go to school, cling to a parent, or worry that a parent may die. Older children may sulk, get into trouble at school, be negative and irritable, and feel misunderstood. Because these signs may be viewed as normal mood wings typical of children as they move through developmental stages, it may be difficult to accurately diagnose a young person with depression.
Before puberty, boys and girls are equally likely to develop depression. By age 15, however, girls are twice as likely as boys to have had a major depressive episode.

Depression during the teen years comes at a time of great personal change - when boys and girls are forming an identity apart from their parents, grappling with gender issues and emerging sexuality, and making independent decisions for the first time to their lives. Depression in adolescence frequently co-occurs with other disorders such as anxiety, eating disorders, or substance abuse. It can also lead to increased risk for suicide.

**Depression in teens**

While some depressed teens appear sad, other do not. In fact, irritability-rather than depression-is frequently the predominant symptom in depressed adolescents and teens. A depressed teenager may be hostile, grumpy, or easily lose his or her temper. Unexplained aches and pains are also common symptoms of depression in young people.

**Depression in older adults**

It's not normal for elderly people to feel depressed. Most older people feel satisfied with their lives. Depression in the elderly is sometimes dismissed as a normal part of aging, causing needless suffering.
for the family and for the individual. Depressed elderly persons usually tell their
doctor about their physical symptom but may be hesitant to bring up their emotions.

Some symptoms of depression in the elderly may be side effects of medication the person is taking for a physical problem, or they may be caused by a co-occurring illness. If a diagnosis of depression is made, treatment with medication and/or psychotherapy will help the depressed person return to a happier, more fulfilling life. Psychotherapy is also useful in older patients who cannot or will not take medication.

The difficult changes that many older adults face—such as bereavement, loss of independence, and health problems—can lead to depression, especially in those without a strong support system. However, depression is not a normal part of aging. Older adults tend to complain more about the physical rather than the emotional signs and symptoms of depression, and so the problem often goes unrecognized. Depression in older adults is associated with poor health, a high mortality rate, and an increased risk of suicide, so diagnosis and treatment are extremely important.

It can be tempting to use alcohol to deal with physical and emotional pain as you get older. It may help you take your mind off an illness or make you feel less lonely. Or may be you drink at night to help you get to sleep.
While alcohol may make you feel better in the short term, it can cause problems over time. Alcohol makes symptoms of depression, irritability, and anxiety worse and impairs your brain function. Alcohol also interacts in negative ways with numerous medications, including antidepressants. And while drinking may help you nod off, it can impair the quality of your sleep.

**Aging and Depression**

Depression is not a normal part of aging. Studies show that most seniors feel satisfied with their lives, despite having more illnesses or physical problems. However, when older adults do have depression, it may be overlooked because seniors may show different, less obvious symptoms. They may be less likely to experience or admit to feelings of sadness or grief.

Sometimes it can be difficult to distinguish grief from major depression. Grief after loss of a loved one is a normal reaction to the loss and generally does not require professional mental health treatment. However, grief that is complicated and lasts for a very long time following a loss may require treatment. Researchers continue to study the relationship between complicated grief and major depression.

Older adults also may have more medical conditions such as heart disease, stroke, or cancer, which may cause depressive symptoms. Or they may be taking medications with side effects that contribute to
depression. Some older adults may experience what doctors call vascular depression also called arteriosclerotic depression or subcortical ischemic depression. Vascular depression may result when blood vessels become less flexible and harden over time, becoming constricted. Such hardening of vessels prevents normal blood flow to the body's organs, including the brain. Those with vascular depression may have, or be at risk for, co-existing heart disease or stroke.

Although many people assume that the highest rates of suicide are among young people, older white males age 85 and older actually have the highest suicide rate in the United States. Many have a depressive illness that their doctors are not aware of, even though many of these suicide victims visit their doctors within 1 month of their deaths.

Most older adults with depression improve when they receive treatment with an antidepressant, psychotherapy, or a combination of both. Research has shown that medication alone and combination treatment are both effective in reducing depression in older adults. Psychotherapy alone also can be effective in helping older adults stay free of depression, especially among those with minor depression. Psychotherapy is particularly useful for those who are unable or unwilling to take antidepressant medication.
Mental and physical health status are closely related

People who are depressed tend to be less physically healthy than people who are not depressed. Half of the population with depression is in fair to poor physical health, compared to only 12 percent of the population without depression (see Figure 1). Adults with depression are not satisfied with their physical health. Among 51 to 61 year olds, for example, less than one-fifth—19 percent—of those with depression are satisfied with their physical health, compared to 89 percent of those without it.

Figure - 1.1
Physical Health Status of Adults, by Depression Status

Differences between those with and without depression with respect to emotional health are also large. Among 51 to 61 year olds, for example. 91 percent of those who are depressed report their emotional health as fair to poor, compared to only 6 percent of those who are not depressed (see Table-1).

**Table - 1.1**

<table>
<thead>
<tr>
<th>Emotional Health Status of 51 to 61 Year Olds, by Depression Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Very Good of Excellent</td>
</tr>
<tr>
<td>Fair to Poor</td>
</tr>
</tbody>
</table>

**Source:** National Academy on an Aging Society analysis of data from the 1992 Health and Retirement Study.

**The Stressful Behaviour and Depression**

Several research studies have shown that experience of stressful life event is associated with depression (Pestonjee, 1992; Lovallo 1997; Levine & Sctoch 1970; Agrawal, 2001). The correlations have been demonstrated many times (Paykel et.al., 1984). In fact, stressful life events leads to depression but being depressed in itself also leads to high level of stress, especially with regard to interpersonal instances such as marital conflicts (Sriram, 1987; Srivastava & Sinha, 1989; Hammen, 1991). Thus, relationship between stressful life events and depression is not entirely one way rather it runs in both directions (Oltamass & Emery, 1995; Monroe & Simon, 1991). Rao (1985) also reported a close link between stressful life events and depressive symptoms.
**Personality and Depression**

Some personality factors do also act as antecedents of depression. Personality factors like a responsibility, dominance, self-concept, ego-strength and emotional stability, seem to be associated with depressive symptoms. Observation has been that persons who have poor sense of responsibility, negative self-concept, poor ego-strength, are likely to exhibit stronger depressive tendency than those who have comparatively better sense of responsibility stronger ego-strength and positive self-concept. Likewise poor emotional-stability also show higher degree of depression. Dominance is least likely to make persons prone to the depression. Needless to say, low quality of judgemental and decisionness traits also make the persons prone to the depressive tendency.

Adjustments are also associated with depressive tendency. Poor and inadequate adjustments tend to cause stronger depressive tendencies as compared to proper and satisfactory level of adjustment. In fact, the persons having poor and inadequate adjustments tend to surrender before the demands of the environment and find them helpless and hopeless (Sharma, Satija & Nathawat, 1985; Vaillant, 1977; Westefeld & Furr, 1987; French, Rodgers & Cobb, 1974). Frustration and anxiety also are related with the depression. Higher frustration would eventually lead to some form of aggression which, if persists, would lead to depressive symptoms thus a positive correlation (Brown, 1984). So, also anxiety would contribute to the
onset of depression. Anxious people are generally fearful and apprehensive about the outcome of behaviour which, if persists leads to depression (Zinberg & Barlow, 1996).

**Medical conditions can cause depression in the elderly**

It’s important to be aware that medical problems can cause depression in older adults and the elderly, either directly or as a psychological reaction to the illness. Any chronic medical condition, particularly if it is painful, disabling, or life-threatening, can lead to depression or make depression symptoms worse.

These include:

* Parkinson’s disease
* thyroid disorders
* stroke
* Vitamin B 12 deficiency
* heart disease
* dementia and Alzheimer’s disease
* cancer
* lupus
* diabetes
* multiple sclerosis

**Prescription medications and depression in the elderly**

Symptoms of depression are a side effect of many commonly prescribed drugs. Multiple medication may cause serious problem. While the mood-related side effects of prescription medication can affect anyone, older adults are more sensitive because, as we age, our bodies become less efficient at metabolizing and processing drugs.
Medications that can cause or worsen depression include:

* Blood pressure medication (clonidine)
* Beta-blockers (e.g. Lopressor, Inderal)
* Sleeping pills
* Tranquilizers (e.g. Valium, Xanax, Halcion)
* Calcium-channel blockers
* Medication for Parkinson's disease
* Ulcer medication (e.g. Zantac, Tagamet)
* Heart drugs containing reserpine
* Steroids (e.g. cortisone and prednisone)
* High-cholesterol drugs (e.g. Lipitor, Mevacor, Zocor)
* Painkillers and arthritis drugs
* Estrogens (e.g. Premarin, Prempro)
Figure - 1.2
The Populations With and Without Depression


EMOTIONAL INTELLIGENCE

Since the publication of the best selling book *Emotional Intelligence* by Daniel Goleman (1995), the topic of emotional intelligence has witnessed unparalleled interest. Programs seeking to increase emotional intelligence have been implemented in numerous settings, and courses on developing one's
emotional intelligence have been introduced in universities and even in elementary schools throughout the United States. But what exactly is emotional intelligence? As is the case with all constructs (i.e. intelligence or personality), several schools of thought exist which aim to most accurately describe and measure the notion of emotional intelligence. At the most general level, emotional intelligence (E.I.) refers to the ability to recognize and regulate emotions in ourselves and others (Goleman, 2001). Peter Salovey and John Mayer, who originally used the term "emotional intelligence" in published writing, initially defined emotional intelligence as:

_A form of intelligence that involves the ability to monitor one's own and others' feelings and emotions, to discriminate among them and to use this information to guide one's thinking and actions_ (Salovey & Mayer, 1990).

Later, these authors revised their definition of emotional intelligence, the current characterization now being the most widely accepted. Emotional intelligence is thus defined as:

_The ability to perceive emotion, integrate emotion to facilitate thought, understand emotions, and to regulate emotions to promote personal growth_ (Mayer & Salovey, 1997).

Another prominent researcher of the emotional intelligence construct is Reuven Bar-On, the originator of the term "emotion quotient". Possessing a
slightly different outlook, he defines emotional intelligence as being concerned with understanding oneself and others, relating to people,

and adapting to and coping with the immediate surroundings to be more successful in dealing with environmental demands (Bar-On, 1997).

EMOTIONAL INTELLIGENCE (E.I.) MODELS

Early theorists such as Thorndike and Gardner paved the way for the current experts in the field of emotional intelligence. Each theoretical paradigm conceptualizes emotional intelligence from one of two perspectives: ability or mixed model. Ability models regard emotional intelligence as a pure form of mental ability and thus as a pure intelligence. In contrast, mixed models of emotional intelligence combine mental ability with personality characteristics such as optimism and well-being (Mayer, 1999). Currently, the only ability model of emotional intelligence is that proposed by John Mayer and Peter Salovey. Two mixed models of emotional intelligence have been proposed, each within a somewhat different conception. Reuven Bar-On has put forth a model based within the context of personality theory, emphasizing the co-dependence of the ability aspects of emotional intelligence with personality traits and their application to personal well-being. In contrast, Daniel Goleman proposed a mixed model in terms of performance, integrating an individual's abilities and personality and
applying their corresponding effects on performance in the workplace (Goleman, 2001).

Salovey and Mayer: An Ability Model of Emotional Intelligence

Peter Salovey and John Mayer first coined the term "emotional intelligence" in 1990 (Salovey & Mayer, 1990) and have since continued to conduct research on the significance of the construct. Their pure theory of emotional intelligence integrates key ideas from the fields of intelligence and emotion. From intelligence theory comes the idea that intelligence involves the capacity to carry out abstract reasoning. From emotion research comes the notion that emotions are signals that convey regular and discernable meanings about relationships and that at a number of basic emotions are universal (Mayer, Salovey & Caruso, 2002). They propose that individuals vary in their ability to process information of an emotional nature and in their ability to relate emotional processing to a wider cognition. They then posit that this ability is seen to manifest itself in certain adaptive behaviours (Mayer, Salovey & Caruso, 2000).

Mayer and Salovey's conception of emotional intelligence is based within a model of intelligence, that is, it strives to define emotional intelligence within the confines of the standard criteria for a new intelligence (Mayer, Salovey, Caruso & Sitarenios, 2003). It proposes that emotional intelligence is comprised of two areas: experiential (ability to perceive, respond, and manipulate emotional information without necessarily understanding it) and strategic (ability to understand and manage emotions.
without necessarily perceiving feelings well or fully experiencing them). Each area is further divided into two branches that range from basic psychological processes to more complex processes integrating emotion and cognition. The first branch, *emotional perception*, is the ability to be self-aware of emotions and to express emotions and emotional needs accurately to others. Emotional perception also includes the ability to distinguish between honest and dishonest expressions of emotion. The second branch, *emotional assimilation*, is the ability to distinguish among the different emotions one is feeling and to identify those that are influencing their thought processes. The third branch, *emotional understanding*, is the ability to understand complex emotions (such as feeling two emotions at once) and the ability to recognize transitions from one to the other. Lastly, the fourth branch, *emotion management*, is the ability to connect or disconnect from an emotion depending on its usefulness in a given situation (Mayer & Salovey, 1997). A depiction of this four-branch model is illustrated in Figure 3, which outlines the four branches and the corresponding stages in emotion processing associated with each branch.
Figure 1.3

Mayer and Salovey's (1997) Four-Branch Model of Emotional Intelligence
scores correlate with existing intelligences while accounting for unique variance, and scores increase with age (Mayer et.al., 2003).

Bar-On : A Mixed Model of Emotional Intelligence

The director of the Institute of Applied Intelligences in Denmark and consultant for a variety of institutions and organizations in Israel, Reuven Bar-On developed one of the first measures of emotional intelligence that used the term "Emotion Quotient". Bar-On's model of emotional intelligence relates to the potential for performance and success, rather than performance or success itself, and is considered process-oriented rather than outcome-oriented (Bar-On, 2002). It focuses on an array of emotional and social abilities, including the ability to be aware of, understand, and express oneself, the ability to be aware of, understand, and relate to others, the ability to deal with strong emotions, and the ability to adapt to change and solve problems of a social or personal nature (Bar-On, 1997). In his model, Bar-On outlines 5 components of emotional intelligence: intrapersonal, interpersonal, adaptability, stress management, and general mood. Within these components are sub-components, all of which are outlined in Table-2. Bar-On posits that emotional intelligence develops over time and that it can be improved through training, programming, and therapy (Bar-On, 2002).

Bar-On hypothesizes that those individuals with higher than average E.Q.’s are in general more successful in meeting environmental demands and pressures. He also notes that a deficiency in emotional intelligence can mean a lack of success and the existence of emotional
problems. Problems in coping with one's environment is thought, by Bar-On, to be especially common among those individuals lacking in the subscales of reality testing, problem solving, stress tolerance, and impulse control. In general, Bar-On considers emotional intelligence and cognitive intelligence to contribute equally to a person's general intelligence, which then offers an indication of one's potential to succeed in life (Bar-On, 2002).

Table 1.2
Bar-On’s Model of Emotional Intelligence

<table>
<thead>
<tr>
<th>Components</th>
<th>Sub-Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrapersonal</td>
<td>Self Regard</td>
</tr>
<tr>
<td></td>
<td>Emotional Self-Awareness</td>
</tr>
<tr>
<td></td>
<td>Assertiveness</td>
</tr>
<tr>
<td></td>
<td>Independence</td>
</tr>
<tr>
<td></td>
<td>Self-Actualization</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>Empathy</td>
</tr>
<tr>
<td></td>
<td>Social Responsibility</td>
</tr>
<tr>
<td></td>
<td>Interpersonal Relationship</td>
</tr>
<tr>
<td>Adaptability</td>
<td>Reality Testing</td>
</tr>
<tr>
<td></td>
<td>Flexibility</td>
</tr>
<tr>
<td></td>
<td>Problem Solving</td>
</tr>
<tr>
<td>Stress Management</td>
<td>Stress Tolerance</td>
</tr>
<tr>
<td></td>
<td>Impulse Control</td>
</tr>
<tr>
<td>General Mood Components</td>
<td>Optimism</td>
</tr>
<tr>
<td></td>
<td>Happiness</td>
</tr>
</tbody>
</table>
Goleman : A Mixed Model of Emotional Intelligence

Daniel Goleman, a psychologist and science writer who has previously written on brain and behaviour research for the New York Times, discovered the work of Salovey and Mayer in the 1990's. Inspired by their findings, he began to conduct his own research in the area and eventually wrote *Emotional Intelligence* (1995), the landmark book which familiarized both the public and private sectors with the idea of emotional intelligence. Goleman's model outlines four main emotional intelligence constructs. The first, self-awareness, is the ability to read one’s emotions and recognize their impact while using gut feelings to guide decisions. Self-management, the second construct, involves controlling one's emotions and impulses and adapting to changing circumstances. The third construct, social awareness, includes the ability to sense, understand, and react to other's emotions while comprehending social networks. Finally, relationship management, the fourth construct, entails the ability to inspire, influence, and develop others while managing conflict (Goleman, 1998).

Goleman includes a set of emotional competencies within each construct of emotional intelligence. Emotional competencies are not innate talents, but rather learned capabilities that must be worked on and developed to achieve outstanding performance. Goleman posits that individuals are born with a general emotional intelligence that determines their potential for learning emotional competencies. The organization of the competencies
under the various constructs is not random; they appear in synergistic clusters or groupings that support and facilitate each other (Boyatzis, Goleman, & Rhee, 1999). Table-3 illustrates Goleman's conceptual model of emotional intelligence and corresponding emotional competencies. The constructs and competencies fall under one of four categories: the recognition of emotions in oneself or others and the regulation of emotion in oneself or others.

**Table-1.3**

Goleman’s (2001) Emotional Intelligence Competencies

<table>
<thead>
<tr>
<th>SELF</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Competence</td>
<td>Social Competence</td>
</tr>
<tr>
<td><strong>Self-Awareness</strong></td>
<td><strong>Social Awareness</strong></td>
</tr>
<tr>
<td><strong>RECOGNITION</strong></td>
<td></td>
</tr>
<tr>
<td>Emotional Self-Awareness</td>
<td>Empathy</td>
</tr>
<tr>
<td>Accurate Self-Assessment</td>
<td>Service Orientation</td>
</tr>
<tr>
<td>Self-Confidence</td>
<td>Organizational Awareness</td>
</tr>
<tr>
<td><strong>Self-Management</strong></td>
<td><strong>Relationship</strong></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Control</td>
<td>Developing Others</td>
</tr>
<tr>
<td>Trustworthiness</td>
<td>Influence</td>
</tr>
<tr>
<td>Conscientiousness</td>
<td>Communication</td>
</tr>
<tr>
<td>Adaptability</td>
<td>Conflict Management</td>
</tr>
<tr>
<td>Achievement Drive</td>
<td>Leadership</td>
</tr>
<tr>
<td>Initiative</td>
<td>Change Catalyst</td>
</tr>
<tr>
<td></td>
<td>Building Bonds</td>
</tr>
<tr>
<td></td>
<td>Teamwork and Collaboration</td>
</tr>
</tbody>
</table>
EMOTIONAL INTELLIGENCE IN APPLIED SETTINGS

This section will focus on how emotional intelligence has been applied in various settings. First, research on the gender differences in emotional intelligence will be outlined in an effort to examine if the application of emotional intelligence to different settings varies as a function of gender. Second, the application of emotional intelligence to everyday living will be explored. Finally, the applicability of E.I. to the workplace will be discussed, focusing on the economic value of higher emotional intelligence in the workplace, the success rate of those high in E.I. relative to others, and various avenues for training of E.I. competencies.

Gender Differences in Emotional Intelligence

Competing evidence exists surrounding whether or not males and females differ significantly in general levels of emotional intelligence. Daniel Goleman (1998) asserts that no gender differences in E.I. exist, admitting that while men and women may have different profiles of strengths and weaknesses in different areas of emotional intelligence, their overall levels of E.I. are equivalent. However, studies by Mayer and Geher (1996), Mayer, Caruso, and Salovey (1999), and more recently Mandell and Pherwani (2003) have found that women are more likely to score higher on measures of emotional intelligence than men, both in professional and personal settings.
The discrepancy may be due to measurement choice. Brackett and Mayer (2003) found that females scored higher than males on E.I. when measured by a performance measure (the Mayer-Salovey-Caruso Emotional Intelligence Test). However, when using self-report measures such as the Bar-On Emotion Quotient Inventory (EQ-i) and the Self-Report Emotional Intelligence Test (SREIT), they found no evidence for gender differences. Perhaps gender differences exist in emotional intelligence only when one defines E.I. in a purely cognitive manner rather than through a mixed perspective. It could also be the case that gender differences do exist but measurement artifacts such as over-estimation of ability on the part of males are more likely to occur with self-report measures. More research is required to determine whether or not gender differences do exist in emotional intelligence.

**Applicability to Everyday Living**

Several studies have found that emotional intelligence can have a significant impact on various elements of everyday living. Palmer, Donaldson, and Stough (2002) found that higher emotional intelligence was a predictor of life satisfaction. Additionally, Pellitteri (2002) reported that people higher in emotional intelligence were also more likely to use an adaptive defense style and thus exhibited healthier psychological adaptation. Performance measures of emotional intelligence have illustrated that higher levels of E.I. are associated with an increased likelihood of attending to
health and appearance, positive interactions with friends and family, and owning objects that are reminders of their loved ones. Mayer, Caruso, and Salovey (1999) found that higher emotional intelligence correlated significantly with higher parental warmth and attachment style, while others found that those scoring high in E.I. also reported increased positive interpersonal relationships among children, adolescents, and adults (Rice, 1999; Rubin, 1999).

Negative relationship have likewise been identified between emotional intelligence and problem behaviour. Mayer, Caruso, and Salovey (2000) found that lower emotional intelligence was associated with lower self-reports of violent and trouble-prone behaviour among college students, a correlation which remained significant even when the effects of intelligence and empathy were partialled out. Lower emotional intelligence (as measured by the MSCEIT) has been significantly associated with owning more self-help books (Brackett & Meyer 2003), higher use of illegal drugs and alcohol, as well as increased participation in deviant behaviour (i.e. involvement in physical fights and vandalism). No gender differences were observed for these associations (Trinidad & Johnson, 2002; Brackett and Mayer, 2003). Finally, a study of 15 male adolescent sex offenders (15-17 years old) found that sex offenders have difficulty in identifying their own and others' feelings, two important elements of emotional intelligence (Moriarty, Stough, Tidmarsh, Eger, & Dennison, 2001).
Emotional Intelligence in the Workplace

As previously discussed, advanced emotional intelligence can be beneficial in many areas of life. However, the application of its usefulness has been most frequently documented in the professional workplace. Cherniss (2000) outlines four main reasons why the workplace would be a logical setting for evaluating and improving emotional intelligence competencies:

1- Emotional intelligence competencies are critical for success in most jobs.
2- Many adults enter the workforce without the competencies necessary to succeed or excel at their job.
3- Employers already have the established means and motivation for providing emotional intelligence training.
4- Most adults spend the majority of their waking hours at work.

A strong interest in the professional applications of emotional intelligence is apparent in the way organizations have embraced E.I. ideas. The American Society for Training and Development, for example, has published a volume describing guidelines for helping people in organizations cultivate emotional intelligence competencies which distinguish outstanding performers from average ones (Cherniss and Adler, 2000).

As previously noted, considerable research in the emotional intelligence field has focused on leadership, a fundamental workplace quality.
Even before research in the area of E.I. had begun, the Ohio State Leadership studies reported that leaders who were able to establish mutual trust, respect, and certain warmth and rapport with members of their group were more effective (Fleishman and Harris, 1962). This result is not surprising given that many researchers have argued that effective leadership fundamentally depends upon the leader's ability to solve the complex social problems which can arise in organizations (Mumford, Zaccaro, Harding, Jacobs, & Fleishman, 2000).

The cost-effectiveness of emotional intelligence in the workplace has been an area of interest. Several studies have reported the economic value of hiring staff based on emotional intelligence. In a report to Congress, the Government Accounting Office (1998) outlined the amount saved when the United States Air Force used Bar On's Emotional Quotient Inventory (EQ-I) to select program recruiters. By selecting those individuals who scored highest in emotional intelligence as recruiters, they increased their ability to select successful recruiters by threefold and saved $3 million annually. A similar study by Boyatzis (1999) found that when partners in a multinational consulting firm were assessed on E.I. competencies, partners who scored above the median on nine or more competencies delivered $1.2 million more profit than did other partners.

Cherniss and Goleman (1998) estimated that by not following training guidelines established to increase emotional intelligence in the
workplace, industry in the United States is losing between $5.6 and $16.8 billion a year. They found that the impact of training employees in emotional and social competencies with programs which followed their guidelines was higher than for other programs, and by not implementing these programs companies were receiving less of an impact and consequently losing money.

**Are Individuals with High E.I. More Successful?**

Research on the predictive significance of E.I. over I.Q. was spurred by Goleman's initial publication on the topic which claimed that emotional intelligence could be "as powerful, and at times more powerful, than I.Q." (Goleman, 1995, p. 34). Much of this claim was based on past research revealing that the predictive nature of I.Q. on job performance was not promising, with I.Q. accounting from 10-25% of the variance in job performance (Hunter & Hunter, 1984; Sternburg, 1996). The results of longitudinal studies further implicated emotional intelligence as being important. One study involving 450 boys reported that I.Q. had little relation to workplace and personal success; rather, more important in determining their success was their ability to handle frustration, control emotions, and get along with others (Snarey & Vaillant, 1985). Although this study did not attend to emotional intelligence directly, the elements which it addressed (the ability to regulate one's emotions and understand the emotions of others) are some of the central tenants of the emotional intelligence construct.

While research exists supporting the contention that emotional intelligence does contribute to individual cognitive-based performance over and
above the level attributed to general intelligence (Lam & Kirby, 2002), current theories tend to be more judicious regarding the incremental benefits of E.Q. over I.Q. Both Goleman (1998) and Mayer, Salovey and Caruso (1998) emphasize that emotional intelligence by itself is probably not a strong predictor of job performance. Instead, it provides a foundation for emotional competencies which are strong predictors of job performance.

In later work, Goleman (2001) attempts to theoretically clarify the relationship between I.Q. and E.Q., and their respective applicability to job performance. He describes I.Q. as playing a sorting function, determining the types of jobs individuals are capable of holding. He theorizes that I.Q. is a strong predictor of what jobs individuals can enter as well as a strong predictor of success among the general population as a whole. For example, in order to become a medical doctor, an individual requires an above average I.Q. Emotional intelligence, on the other hand, is described by Goleman as a stronger predictor of who will excel in a particular job when levels of I.Q. are relatively equal. When the individuals are being compared to a narrow pool of people in a particular job in a certain organization, specifically in the higher levels, the predictive power of I.Q. for outstanding performance among them weakens greatly. In this circumstance, E.Q. would be the stronger predictor of individuals who outperform others. Thus, the doctors in a particular clinic would all have similarly above average I.Q.’s. Goleman would hypothesize that what would distinguish the
most successful doctors from the others would be their levels of emotional intelligence.

**SOCIAL INTELLIGENCE**

Social intelligence describes the exclusively human capacity to use very large brains to effectively navigate and negotiate complex social relationships and environments. Psychologist and professor at the London School of Economics Nicholas Humphrey believes it is social intelligence or the richness of our qualitative life, rather than our quantitative intelligence, that truly makes humans what they are - for example what it's like to be a human being living at the centre of the conscious present, surrounded by smells and tastes and feels and the sense of being an extraordinary metaphysical entity with properties which hardly seem to belong to the physical world. Social scientist Roos Honeywill believes social intelligence is an aggregated measure of self and social awareness, evolved social beliefs and attitudes, and a capacity and appetite to manage complex social change. A person with a high social intelligence quotient (SQ) is no better or worse than someone with a low SQ, they just have different attitudes, hopes, interests and desires.

Social intelligence is the ability to get along well with others, and to get them cooperate with others. Sometime referred to simplistically as "people
skills". Social Intelligence includes an awareness of situations and the social dynamics that govern them and a knowledge of interaction styles and strategies that can help a person achieve his or his objectives in dealing with others. It also involves a certain amount of self insight and a consciousness of one's own perceptions and reaction patterns.

Social intelligence according to the original definition of Edward Thorndike, is "the ability to understand and manage men and women, boys and girls, to act wisely in human relations". It is equivalent to interpersonal intelligence, one of the types of intelligences identified in Howard Gardner's Theory of multiple intelligences, and closely related to theory of mind. Some authors have restricted the definition to deal only with knowledge of social situations, perhaps more properly called social cognition or social marketing intelligence, as it pertains to trending socio-psychological advertising and marketing strategies and tactics. According to Sean Foleno, Social intelligence is a person's competence to comprehend his or her environment optimally and react appropriately for socially successful conduct.

SI is one of a cluster of intelligences according to theory of multiple intelligences advanced by Professor Howard Gardner of Harvard University. Gardner's MI theory has become widely accepted in recent years, particularly in the area of public education. Many researchers now accept Gardner's proposition that intelligence is multi-dimensional and many believe that
each of the key dimensions of intelligence can continue to increase throughout one's life, given the appropriate experiences, challenges and growth opportunities.

Measuring SI involves identifying key interaction skills and then assessing them behaviourally. All interaction takes place with some context or other, and effectiveness involves mastering the contexts within which one is called upon to interact. So, according to this reasoning, SI means understanding contexts so as to achieve one's objectives. In other words, SI is inferred from behaviour so we use various observable behaviours as indicators of SI. SI is a combination of skills expressed through learned behaviour, and then assessing the impact of one's behaviour on others - the degree to which one is successful in dealing with others - one can experiment with new behaviours and new interaction strategies. In simplest term this is the ability to "get along with people" which it is assumed people learn as they grow up mature, and gain experience in dealing with others. It is quite clear that adults who lack insight and competence in dealing with others can make significant improvements in their SI status as a result of understanding the basic concepts and assessing them selves against a comprehensive model of interpersonal effectiveness.

Social Intelligence Quotient (SQ)

The social intelligence quotient or SQ is a statistical abstraction similar to the 'standard score' approach used in IQ tests with a mean of 100. Unlike the standard IQ test however it is not a fixed model. It leans more to Piaget's
theory that intelligence is not a fixed attribute but a complex hierarchy of information-processing skills underlying an adaptive equilibrium between the individual and the environment. An individual can, therefore, change their SQ by altering their attitudes and behaviour in response to their complex social environment.

Social intelligence is closely related to cognition and emotional intelligence, and can also be seen as a first level in developing systems intelligence. Research psychologists studying social cognition and social neuroscience have discovered many principles which human social intelligence operates.

More recently, Daniel Goleman has drawn on social neuroscience research to propose that social intelligence is made up of social awareness (including empathy, attunement, empathic accuracy, and social cognition) and social facility (including synchrony, self-presentation, influence, and concern) (Goleman 2003). Goleman's immense research indicates that our social relationships have a direct effect on our physical health and the deeper the relationship the deeper the impact. Goleman states that some physical effects of our relationships upon our health are

the blood flow of one's body, one's breathing, one's mood (such as fatigue and depression), and even decreased power of one's immune system (Goleman 2003).
Educational researcher Raymond H. Hartjen asserts that expanded opportunities for social interaction enhances intelligence. Traditional classrooms do not permit the interaction of complex social behavior. Instead children in traditional settings are treated as learners who must be influenced with more and more complex forms of information. Few educational leaders he adduces have taken this position as a starting point to develop a school environment where social freedom, and justice," which by themselves can be agreed upon or not by discussing those terms philosophically in Wikipedia, as though they represent a universal reality. Instead, consider the information formally and literally contained within a structure that is revealed through ritual (procedures) as truth (debatable truth) but formally asserted and that functions as an evolving physical symbol system by which a population exerts and identifies itself collectively. What we're talking about here is the design and evolution of social organisms.

**The Social Intelligence Profile**

The Social Intelligence Profile (SIP) analyzes SI through three different and compatible "lenses". Each lens shows you a picture of your social interaction from a particular point of view. Two of these lenses, or dimensions, involve evaluations or judgments you yourself make about your effectiveness in dealing with others. The third is your self-description of your interaction style, which is your preferred pattern of behavior for a large number of situations. The interaction style is not subject to judgment or evaluation - it is merely your acquired preference.
(1) **Social Skills - the "S.P.A.C.E." formula**

Part 1 of the SIP presents you with a list of various behaviors, divided into five basic skill categories - (1) Situational Awareness, (2) Presence, (3) Authenticity, (4) Clarity and (5) Empathy. **Situational Awareness** (or social awareness) is your ability to observe and understand the context of a situation you may find yourself in and to understand the ways in which the situation dominates or shapes the behavior of the people in it. **Presence**, also known simplistically as "bearing", is the impression, or total message you send to others with your behavior. People tend to make inferences about your character, your competence and your sense of yourself based on the behaviors they observe as part of your total presence dimension. **Authenticity** is the extent to which others perceive you as acting from honest, ethical motives, and the extent to which they sense that your behavior is congruent with your personal values - i.e. "playing straight". **Clarity** is the ability to express ideas clearly, effectively and with impact. It involves a range of "communicating" skills such as listening, feedback, paraphrasing, semantic flexibility, skillful use of language, skill in using metaphors and figures of speech, and the ability to explain things clearly and concisely. **Empathy** is the skill of building connections with people - the capacity to get people to meet you on a personal level of respect and willingness to cooperate. Empathy, in this case, goes beyond the conventional
definition of having a feeling toward another person; here, it means creating a mutual feeling between yourself and another person.

The person taking the SIP for self-assessment answers a series of self-rating questions dealing with various behaviors classified as either toxic or nourishing. He or she adds up the scores for each S.P.A.C.E. category and plots the five scores as dots on the five axes of a radar chart, illustrated in Figure-4.

**Figure-1.4**

Social Skills - "S.P.A.C.E." Formula (Karl Albrecht)

(2) Self-Insight
Part II of the SIP presents a series of adjective pairs, representing contrasting descriptions others might give of the person who is answering the questions. Contrasts like "Cold-Warm", "Inarticulate - Articulate" and "Long-winded - Concise" challenge the user to reflect carefully on how others might see him or her, to try to guess accurately how they might use these various contrasting adjectives. The user circles a number on a five-point scale between the two opposing adjectives, to show the score he or she thinks others could give. The highest and lowest-rated adjectives provide a starting point for thinking about how one is influencing others.

(3) Interaction Style

Part III of the SIP invites the user to read a series of scenarios, or situations in which he or she might encounter others. Each scenario provides four options for behaving, corresponding to four primary interaction styles one might use as his or her preferred "home base". The underlying model of social interaction styles involves two primary dimensions: social energy and results focus. Social energy is the impulse to engage other people, to interact with them, to influence them and be influenced by them. Results focus is the preference for getting things done either through people or by one's own effort. The two extremes of
these two variables - high and low social energy and task focus vs. people focus - provide four basic combinations which we can think of behavioral preferences across a range of situations. Each pattern has a shorthand name that suggests its primary orientation. Some people mix these four patterns almost equally, while others may tend to prefer one pattern as the favorite. Again, the purpose of the social styles dimension is insight rather than judgment or self-criticism.

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