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A STUDY OF ANXIETY AND MENTAL HEALTH ON DEPRESSION

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The word depression is part of our everyday language. How often have you said you felt depressed or blue ? These feelings occur in all of us. They may occur in rainy weather, during an annoying cold, or after and argument with a friend. Often an event that is usually expected to be happy ends with such feelings. People may experience the blues after such holidays as Christmas or New Year's Day or after moving to a new home. These feelings of depression based on temporary situations usually fade away quickly. The are quite different from the feelings of being under a black cloud that accompany a depressive episode or major depressive disorder (Hamilton, 1982).

The term depression covers a variety of negative moods and heavier changes. Some are normal mood fluctuations and other meet the definition of clinical problems. The mood change may be temporary or long lasting. It may range from a relatively minor feeling of melancholy to a deeply negative view of the world and an inability to function effectively. In this section we discuss several aspects of depression – temporarily depressed mood, long-lasting downward or negative mood that may interfere only mildly with effective behaviour, and severely depressed mood accompanied by a marked but usually temporary inability to function effectively. (Davison & neale, 1996; Sarason & Sarason, 1996).

These same symptoms may be the result of any other kind of important loss. For example, the breakup of a dating relationship, or divorce or separation, may also bring about these feelings; they are likely to occur regardless of who wanted to end the relationship. Such feelings often represent a short-term response to stress. (Abramson et al. 1989, Beck, 1967).

Perhaps because the term depression is so much a part of our language and because virtually everyone has experienced "the blues" at one time or another, many people do not regard depression as a problem needing treatment. In a poll of a representative smaple of Americans sponsored by the National Mental Health Association, those contacted were divided as to whether depression, defined as a mental disorder that "interferes with one's emotional and physical well-being'' was a health problem (46 percent) or a personal weakness (43 percent) or a personal weakness (43 percent) Psychiatric News, June 3, 1992, p.9). About two- thirds of those who believed they had had such a depression reported they had not sought treatment. (Sarason & Sarason, 1996; Schwarth, 1974).

It is evident that any person may develop a particular disorder is related to that person's biological vulnerabilities, other risk factors in the environment, and the presence or absence of factors that promote resiliency, Risk factors affecting depression include heredity, age, gender, and lack of social support. (Seligman, 1973; Tsuang & Faraone, 1990, Weissman et al. 1984).

An important risk factor is genetic makeup. Studies of twins and of families clearly suggest a genetic component in both major depression and bipolar disorders. There is a much greater risk of developing a major depression if one's identical twin has had this disorder than if one's parent, brother, or sister has experienced it. The

chances of developing the disorder are even less if a person has no close relatives that have ever been given this diagnosis. (Klein et al. 1976 ; Mirza , 1983 ; Rorsman and stone, 1990)

Different research workers studied the problem of depression among college students, Seligman (1973) holds that depression is most common among students. Schwartz (1974) studied relationship between goal discrepancy and depression on 40male undergraduates. Subjects and higher depression scores, were less accurate in goal settings. The negative self-feelings associated with unrealistic goal setting appears to be related to the negative self-concept of the depressed individuals, Beck (1967) argued similarly that the premorbid depressive is an individual who makes logical error in interpreting reality. For example, the depressed – prone individual over generalizes; a student regards his poor performance in a single class on one particular day as final proof of his stupidity. The study of (Klein et I. 1976) on normal college undergradustes showed that the learned helplessness model of depression predicts that compared with the non-depressed, the depressed persons demonstrate psychomotor deficits. They provide lower evaluation of their performance that non-depressives. Sarason & Sarason (1996) further found the depressives to be more sensitive than to positive reinforcement.

Hamilton (1982) who also studied the problem of depression among college students found 58 per cant college students whowing depressive behaviour and 25 per cent suicidal wishes, where there were broken love affairs. Beck (1967) made a study of 8206 New York students who used drugs over a year. He found that users of illicit drugs at the beginning were more in depressives. Those who used more drugs were less depressed. He further found that use of drugs was a means to overcome depression. Davison & Neale (1996) found suicide rate higher among the single, the widowed and the divorced, than among the married. Hamilton (1982) in a comparative study between depressed and non-depressed college female students clearly found that the depressed students evaluated their personal qualities negatively and showed strong reactions to failure. Beck's (1976) study too supports this finding who found that depressed persons blame themselves for negative outcomes. Hamilton & Abramoson (1983) studied 100 married women on the problem of depression. It was found that housework, attitude towards child care, pay dissatisfaction in working women and, above all, differences with husbands over sex role expectation were important causes of depression. Abramson et al. (1989) conducted a study on relationship between depression and working women. It was studies on 501 professional women throughout the United States. Those with relatives with a bipolar diagnosis have almost three times as great a chance of developing a major depression as those who have no family member with either a diagnosis of depression or bipolar disorder. (Mirza, 1983).

Family studies have shown that the young people are when their first major depression occurs, the more likely it is that their relatives will also experience periods of depression. Relatives of people whose first depressive episode had occurred before the age of 20 had an eight-times greater chance of becoming depressed than relatives of normal subjects. Relatives of prople who were over 40 when they first had a major depression had little more than the normal risk of deperession. This increased risk was found both for relatives of patients who were hospitalized and for relatives of individuals who did not need to be hospitalized (Weissman et al. , 1984; Tsuang & Faraone, 1990).

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Although major depression has been consistently shown to run in families (Tsuang & Faraone, 1990) much less is known about how heredity affects the clinical features of the disorder such as number and type of symptoms, age at which the first depression occurs, and length of period of severely depressed mood. A sample of 176 pairs of female twins chosen from the Virginia Twin registry was used to study these questions (Kendler et al., 19992). Use of such a twin registry provides nonbiased information because – rather than being selected from those who have sought treatment – the names on the register are gathered from a systematic review of all birth certificates over a long period of time. A comparison of the results for monozygotic (MZ) an dizygotic (DZ) twins showed that whether depression was recurrent or not seemed to be affected by genetic factors. However, within the group experiencing recurrent episodes, the actual number of episodes seemed to be related to stressful life experiences not shared by the other twin in the pair rather than the heredity. MZ twins were more likely than DZ twins to be similar in what are called negative symptoms of depression (changes in weight, appetite, and sleep). In contrast, treatment-seeking appeared to be related to environmental or family variables rather than to any genetic pattern. (Rorsman & Stone, 1990).

Although genetic factors seem important in many cases of depression, the exact mechanism of inheritance of depression is not clear and may even vary from one family to another. Nogenetic factors, either physical or related to a person's environment of relationships, may be required to produce depression even in people with a genetic vulnerability. (Beck, 1967, 1976).

Another risk factor for depression is age. The risk for a first episode of any degree of depression is highest in women between the ages of 20 and 29. The men, the similar risk period is between the ages of 40 and 49 (Rorsman et al. 1999) . In addition to age, another factor is year of birth or the birth cohort to which a person belongs. (Abramson et al. 1989; Hamilton, 1982; Kendler et al. 1992)

One of the greatest risk factors for depression is simply being female. Women are at least twice as likely to experience all types of depressed states than are men. Past researchers have tried to understand this difference in cultural terms. In American culture it has been thought to be more ecceptable in general for women than for men to seek help for emotional problems. Women are more likely to consult physicians or mental health experts and to take psychological view of their problems than they are to see them only in terms of physical symptoms. However, these explanations of more women seeking treatment for depression do not explain the higher overall rate for depression because the same difference in rate of depressive disorder for women and men has been consistently found in community surveys such as the ECA study described earlier, where people are contacted on a randomized basis and not because they have sought help. One explanation that has been suggested by researchers interested in social support and its effect on health is that while women in general receive more social support than do men.

OBJECTIVES

(1) To ascertain the impact of anxiety on depression.
(2) To assess the impact of mental health on depression.

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HYPOTHESES

(i) Respondents having high- low anxiety would significant differ on the dimension of depression.

(ii) Respondents having low mental health would have higher depression than those who have higher mental health.

METHOD

(a) Sample :

For this study 300 (100 general case and 100 backward caste) Male graduate youths were selected through incidental-cum-purposive sampling technique from the colleges of L.S. & R.D.S, Muz. The respondents were matched on socio-economic status. The mean age of respondents was 18.55 & SD was 4.72.

(b) Research Tools

The following tests and scales were used in this study.

(i) Hindi version of Beck's Depression Inventory adopted by Mirza (1983).

(ii) Sinha's Anxiety Scale (2001).

(iii) Singh and Gupta's Mental Health Battery (2000).

(iv) Personal-Data sheet was used to know the background variables like caste, residence and socio-economic status etc.

PROCEDURE

The data were collected in a class room situation. The respondents were contacted on their leisure hour. First of all personal data sheet was applied, then Beck's depression inventory, Sinha' anxiety scale and mental health battery were administered one by one. The respondents were thanked for their participation.

RESULTS & DISCUSSION

Data have been analysed keeping in mind the objectives of the study and the hypotheses formulated. The depression scores were analysed by means of t-test. The findings have been presented in the respective tables below.

TABLE -1

Mean, SD and t-value of depression scores as a function of anxiety

Gender	N	Mean	SD	t	df	p
High	150	32.22	6.16	4.56	298	<.01
Low	150	27.61	5.12			

It is evident from table 1 that respondents having higher anxiety have greater depression than those who have low anxiety. The difference between the groups statistically significant (t=4.56, df=298, p<.01). The hypothesis has been sustained.

TABLE – 2

Mean, SD and t-value of depression scores as function of mental health

Gender	N	Mean	SD	t	df	p
High	150	28.39	6.82	3.49	298	<.05
Low	150	32.25	5.73			

It is apparent from table 2 that mental health plays a significant role on the causation of depression. The respondent who have higher mental health have lower depression than those who have low mental health. The difference between the group is statistically significant (t=3.49, df=298, p<.01). The hypothesis has been retained.

The findings of the study have been corroborated by the findings of Abramson et I. 1989' Beck, 1976; Davison & Neale, 1996; Hamilton, 1982; Kendler et al. 992; Klein et I. 1976; Srason & Sarason, 1996). Depression has been studied from several perspectives. Psycho-analytic view emphasises on the unconscoious confilicts associated with grief and loss, cognitive theories focus on the depressed persons self-defeating thought processes, learning theorists contend with the curtailment of activity associated with depression; and physiological theorists concentrate on what the central nervous system is doing at the neural-chemical level. (Schwartz, 1979; Seligman, 1973; Tsuang & Faraone, 1990; Weissman et al. 1984).

In the era of globalization, like-realization and modernization, college youths are highly disturb, perturb and stressed. Un-employment and poverty have damage the psyche of youths. There is a wider gap between have and have not. All these lead to frustration, Aggression and suicidal tendence among college youths.

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