

**A STUDY ON ROLE OF MANASIKA BHAVAS IN ETIOPATHOGENESIS OF VISHADA
W.S.R TO DEPRESSION IN WORKING PEOPLE****Dr. Harika Bangi^{1*} and Dr. A. S. Patil²**¹Final Year PG Scholar, Department of Roga Nidana Government Ayurveda Medical College and Hospital Bengaluru, Karnataka.²Professor and Head of Postgraduate Department of Roga Nidana, Government Ayurveda Medical College and Hospital Bengaluru, Karnataka.***Corresponding Author: Dr. Harika Bangi**

Final Year PG Scholar, Department of Roga Nidana Government Ayurveda Medical College and Hospital Bengaluru, Karnataka.

Article Received on 29/10/2024

Article Revised on 19/11/2024

Article Accepted on 09/12/2024

ABSTRACT

Vishada is a disease of antiquity. It is that state of manas where it is impacted by a lack of perseverance as a result of failure or disappointment. It is quoted that “Manasaha punah ishtasyalabhat alabhat cha anishtasya upajayate” as the cause of manasa vikara. This produces shokadi manasika bhavas in the person by vitiation of rajas and tamas which will ultimately lead to manasika vikara and vishada is one of the mano vikaras. Present Modern lifestyle has a significant impact on depression with more people participating in the workforce and increasing competition among them which is contributing to increased stress. **Aim:** To study the role of manasika bhavas in the etiopathogenesis of vishada. **Methodology:** This research utilized across sectional design, employing a survey strategy. Data collection was conducted using a specialized case proforma prepared which includes detailed history taking, physical signs and symptoms as mentioned in our classics. **Results:** The observational findings indicate that bhaya is the most prevalent manasika bhava and dukha manasika bhavas i.e., bhaya, krodha, shoka, dwesha, rajah, manasa, chinta experienced by the patients because of avara satwa and constant chronic stress because of all the nidanas mentioned had lead to impairment of dheer, dhriti and smriti leading to vitiation of manasika doshas affecting the manovaha srotas and formed vishada.

KEYWORDS: Manasa roga, Vishada, Depression, manasika bhavas.**INTRODUCTION**

Emotions are fundamental to human life, and each person's unique characteristics are shaped by their discriminating, creative, and intuitive mind. The human mind is a complex gift with the potential for both constructive and destructive behaviour, positivity and negativity, and activeness and dullness. The mind unconsciously balances these elements in people's lives, but this balance is being compromised by the increasing stress and pressures of modern life. When an individual's emotions, thoughts, or behaviours frequently cause disturbance or disruption to their life and the lives of those around them, it may indicate mental illness. Despite the fact that an estimated 1 in 5 people are believed to experience some form of mental illness, there still exists a stigma and discrimination associated with it. Many individuals are hesitant to acknowledge their problems and seek help or treatment. Unfortunately, untreated mental illness can lead to tragic outcomes such as suicide, which claims 873000 lives each year. The economic costs of these conditions are also substantial and continue to grow.^[1]

The concept of Manas and the Maanasika vyadhis have been very scientifically explained in various contexts of the Ayurvedic literature. One such manovyadhi - Vishaada. It is a Vata Nanatmaja Vikara.^[2] The somatic symptom which is resultant of the psychological condition of Vishada is described in the Indian epics of Mahabharata, Ramayana etc.

Vishada is defined in Sanskrit dictionaries as a condition of sadness or despair. The indications of Vishada closely resemble those of depression in contemporary psychiatry. Occasionally, everyone experiences feelings of sadness or gloominess. However, these emotions typically subside within a few days. When an individual suffers from a depressive disorder, it disrupts their everyday life, causing distress for the affected person and those around them.

The competitive nature of today's world has made people very ambitious and driven to work hard in order to achieve greater recognition and a more prestigious lifestyle. However, the fear of failure and the struggle to attain these goals have become the primary causes of the

mental health condition known as depression. According to the World Health Organization, depression is a common mental disorder characterized by feelings of sadness, loss of interest or pleasure, low self-worth, disrupted sleep or appetite, and a lack of energy and concentration.^[3] The competitive nature of today's world has made people very ambitious and driven to work hard to achieve greater recognition and a more prestigious lifestyle. However, the fear of failure and the struggle to attain these goals have become the primary causes of the mental health condition known as depression. Many people who have this condition belong to the *heena satva* category. They are more likely to develop a fear of loss and struggle to understand and analyze the reasons for their loss in certain situations.

It is quoted that "Manasaha punah ishtasyalabhat alabhat cha anishtasya upajayate" as the cause of manasa vikara.^[4] This produces shokadi manasika bhavas in the person by vitiation of rajas and tamas which will ultimately lead to manasika vikara and vishada is one of the mano vikaras.^[5] Present Modern lifestyle has a significant impact on depression with more people participating in the workforce and increasing competition among them which is contributing to increased stress. Hence this study, may help in upcoming clinical research for early identification of nidana, prevention of further

progression of the disease and planning effective management. Hence the was chosen for research which enables us to analyze and understand thoroughly, to assess the role of these manasika bhavas in the etiopathogenesis of vishada.

Objectives of study

- To study the role of *manasika* bhavas in etiopathogenesis *vishada*.
- To study *vishada* as per classics.

METHODOLOGY: A minimum of 80 subjects suffering from *Vishada* will be selected for the study, irrespective of their religion, social, economic and educational statuses. A special pro forma will be prepared which includes detailed history taking, physical signs and symptoms as mentioned in our classics. Patients will be clinically examined, analyzed and selected accordingly. The study will be done using a structured questionnaire.

RESULTS: The observed data were recorded in a well-designed case proforma. Total observed data and results are divided into two sections: demographic data and data related to disease.

LAKSHANAS OF VISHADA

Table No: 41 Distribution of Patients According to *Vishada lakshana*.

<i>Vishada Lakshana</i>	Frequency	Percentage
<i>Asiddhi</i>	64	80%
<i>Bhaya</i>	79	98.75%
<i>Avasaada</i>	56	70%
<i>Apravritti</i>	48	60%

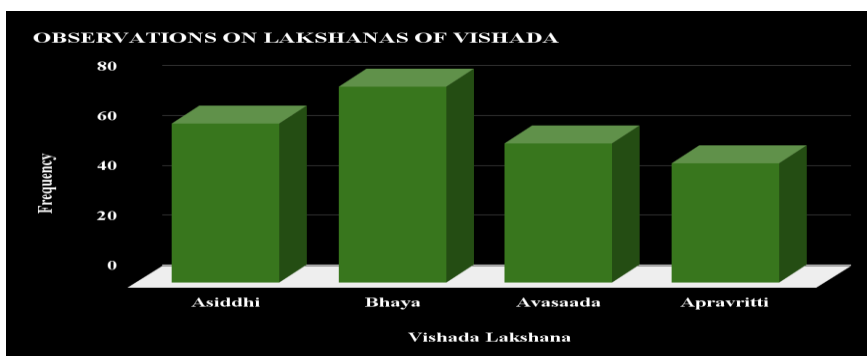


Fig No 01: Distribution of Patients According to *Vishada lakshana*.

Table No 42: Symptoms according to Hamilton's Depression Rating Scale.

Sl no	Symptoms	Grade 0	Grade 1	Grade 2	Grade 3	Grade 4
1	Depressed mood	0	45	28	4	1
2	Feeling of guilt	4	37	31	8	0
3	Suicidal tendency	6	55	15	2	2
4	Insomnia early	20	53	7	-	-
5	Insomnia middle	15	53	12	-	-
6	Insomnia late	34	37	9	-	-
7	Work and activities	5	21	49	3	2
8	Psychomotor retardation	63	14	1	2	0

9	Agitation	58	20	2	-	-
10	Anxiety psychic	5	40	31	3	1
11	Anxiety somatic	10	55	9	4	2
12	Somatic- GIT symptoms	16	61	3	-	-
13	Somatic-General Symptoms	20	56	4	-	-
14	Genital Symptoms	56	20	4	-	-
15	Hypochondriasis	9	32	36	3	0
16	Loss Of Weight	49	39	2	-	-
17	According To Insight	20	50	10	-	-
18	Diurnal variations	57	17	6	-	-
19	Depersonalisation and derealisation	20	50	10	0	0
20	Paranoid symptoms	14	51	14	1	0
21	Obsessive-compulsive symptoms	24	51	5	0	-
22	Helplessness	2	47	30	1	-
23	Hopelessness	1	31	43	4	1
24	Worthlessness	1	33	43	3	0

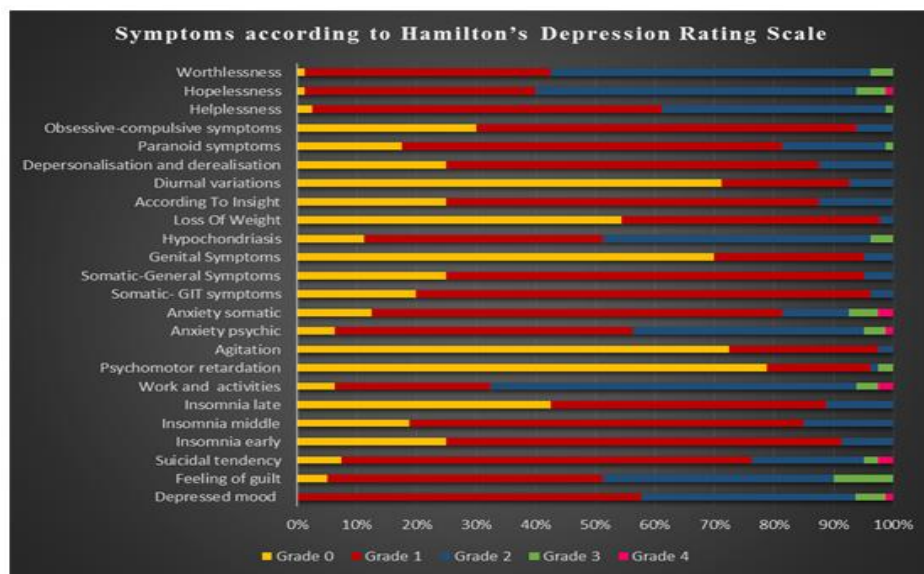


Fig No 02: Symptoms according to Hamilton's Depression Rating Scale.

Table No 43: Total Score of Hamilton's Depression Rating Scale.

Severity	Frequency	Percentage
None/Minimal	1	1%
Mild depression	7	9%
Moderate depression	45	56%
Severe	27	34%
Total	80	100%

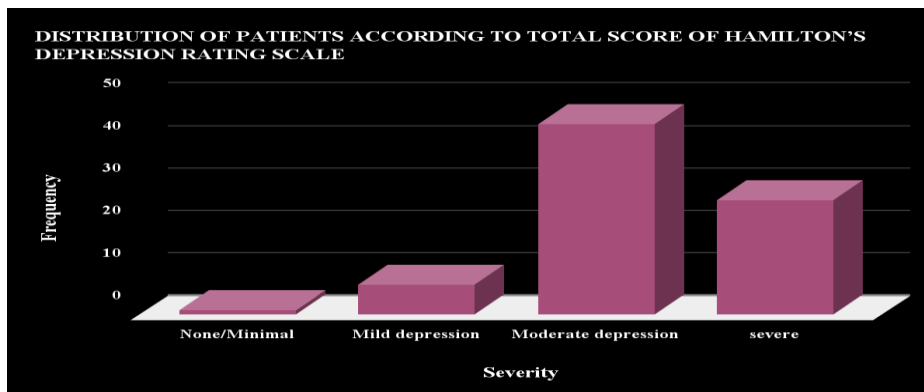
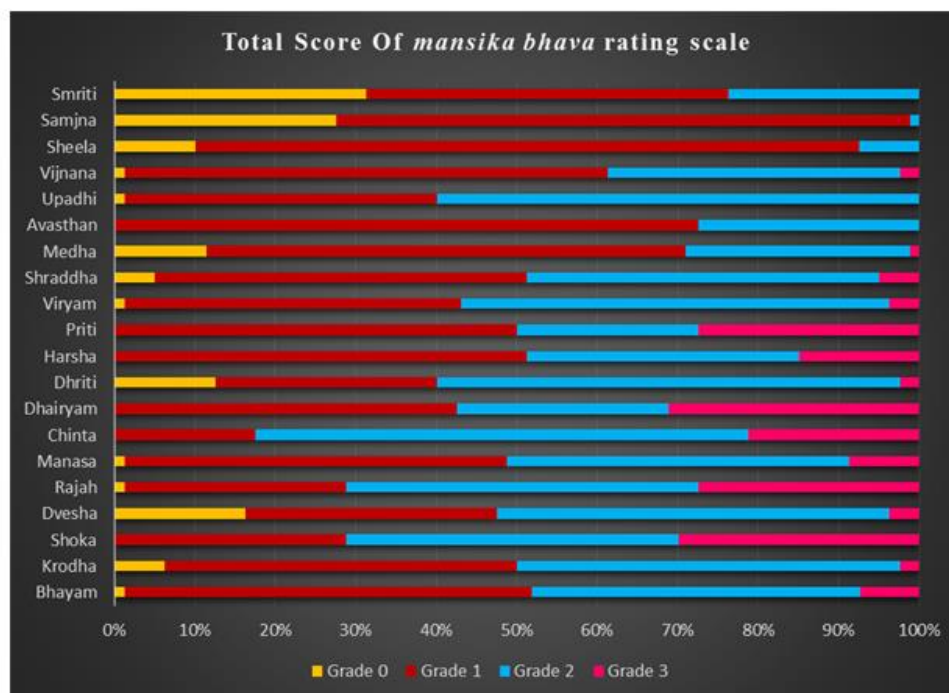


Fig No 03: Distribution of Patients according To Total Score of Hamilton's Depression Rating Scale.

OBSERVATIONS ON MANASIKA BHAVA SCALE

Table No 44: Total Score Of *mansika bhava* rating scale.

Sl no	Manasika Bhava	Grade 0	Grade 1	Grade 2	Grade 3
1	Bhayam	1	41	33	6
2	Krodha	5	35	38	2
3	Shoka	0	23	33	24
4	Dvesha	13	25	39	3
5	Rajah	1	22	35	22
6	Manasa	1	38	34	7
7	Chinta	0	14	49	17
8	Dhairyam	0	34	21	25
9	Dhriti	10	22	46	2
10	Harsha	0	41	27	12
11	Priti	0	40	18	22
12	Viryam	1	33	42	3
13	Shraddha	4	37	35	4
14	Medha	9	47	22	1
15	Avasthan	0	58	22	0
16	Upadhi	1	31	48	0
17	Vijnana	1	48	29	2
18	Sheela	8	66	6	0
19	Samjna	22	57	1	0
20	Smriti	25	36	19	0

Fig No 04: Total Score of *mansika bhava* rating scale.

DISCUSSION

Discussion on Demographic Data

Age: The age limit of the patients in the study was 18 to 70 years. Out of 80 patients, 31% were of the age group 18-30 years. 25% were from the age group 31 to 40 years. 19% were in the age group 41-50 years and 15% were from the age group 51 to 60 years. 10% were in the age group 61-70 years. Depression can affect at any age, but incidence seems to be higher after the age of twenty which is the beginning of self-realization of individual,

familial and social responsibilities. In view of the age prevalence, the maximum numbers of the patients were found in their 3rd and 4th decade of life which is most vulnerable to depression due to various stressors like job crisis and economic problems etc.

Gender: there was a near-equal distribution of gender in the study. 39 males (48%) and 41 females (52%) were registered. The burden of depression is 50% higher for females than males (WHO, 2008). It is more common in

females than males.^[6] Females are more at a twofold risk of the problem as neuroticism is more prevalent in females.^[7]

Socioeconomic status: depression is not immune to any class of people. 56% were of middle economic class, 30% of lower class and 14% of upper class. The lack of income due to the higher demands may be the reason. The middle class is the strata in the struggling and developing stage, which is expecting more to earn, more to work and less for leisure. This stage is more prone to stress. The time, awareness, and attention towards personal physical, mental, emotional and spiritual health are less to this community.

Discussion Based On Family History

Family atmosphere: 59% had a conflicted family with family problems. The rest 41% was harmonious. Family directly affects the wellness of the mind. Lack of problem-solving and Stressful life events may be a reason for *vishada*. Those with a parent or sibling who has had major depression maybe 1.5 to 3 times more likely to develop the condition than those who do not.^[10]

Family problems: 71% of subjects had family problems. Relationship difficulties such as poor social adjustment, particular tensions in family and marital relationships, lower levels of social support, dependant personality difficulties and interpersonal difficulties were significantly found in the patients of *vishada*.^[11]

Psychiatric abnormality in the family: only 7% of the subjects had psychiatric abnormalities in the family. It may create a sense of alienation in social circles and make it difficult to fit the societal norms.

Drug addiction in the family: 36% of subjects had drug addicts in the family. This is a stressor and may be a reason for the disease. The well-being of an entire family can be compromised by the needs of a single individual, as they require ongoing care that can deplete resources and strain family dynamics. This situation has the potential to negatively impact the mental and emotional health of all family members and may set a detrimental precedent for others.

Family breakup: 23.75% of the subjects had broken family. This may be the reason for their ailment. Children of divorced parents, or those who have experienced family separation due to various circumstances, often encounter challenges in developing robust interpersonal connections and may face difficulties in forming healthy adult relationships. Prolonged exposure to familial discord and isolation can create an environment where family members feel compelled to navigate their daily lives with extreme caution, thereby fostering an atmosphere of heightened anxiety and fear.

Death of immediate family member: the death of a family member in 32.5% of the subjects may be the influencing factor for their disease. Grief can significantly influence depression. When a person experiences a significant loss, such as the death of a loved one or the end of a relationship, they may go through a grieving process. This process can involve intense feelings of sadness, longing, and emptiness. If these feelings persist and begin to interfere with the person's ability to function in their daily life, it can lead to a depressive episode. Grief and depression can share similar symptoms, such as feelings of intense sadness, loss of interest in activities, changes in appetite or sleep patterns, and difficulty concentrating.

Other family problems: among 80 subjects 13 had different family problems like displacement in childhood (16.25%), children-related problems (32%) and isolated family (40%). In an Indian society family issues are not expressed or resolved adequately. This may lead to depression due to a lack of emotional expression and introjections inward. Nuclear family, living alone, Life events, financial problems, death in the family and breakups are precipitating factors for depression in young adults.^[12]

It is also possible that workers with long working hours cannot maintain a balance between work and family life, often leading to time poverty and exclusion from family events. Consequently, work-family conflicts come into being, which in turn results in higher stress and depression.^[13] Previous studies have revealed that longer working hours are associated with work-family conflict, which contributes to less family interaction, more conflict in marriage, and less participation in housework.^[14]

Discussion Based on Childhood History: Among the 80 enrolled patients, 42.5% had the habit of **playing alone** in childhood, 22.5% had **particular fear** and 47.5% had symptoms during **physical stress**.

Many patients in the present study had a complicated history of development and behaviour in childhood. Many of them were not blessed with the love, care and affection of the parents due to parental conflicts and/or familial disruption, rather some of them had harassment from parents due to the ill psychological health of the parents. Prospective data from several cohort studies have also demonstrated a link between childhood adversity and depressive symptoms in adulthood. Early childhood adversity confers risk that persists beyond childhood. Research data shows that family disruption and low socioeconomic status in early childhood increase the long-term risk for major depression. Chronic adversity has been linked to disturbances in the hypothalamic-pituitary-adrenal (HPA) axis in children with depression; HPA abnormalities in major depression may also become more pronounced in adulthood.^[15]

Thus, reducing childhood disadvantages may be one avenue for the prevention of depression.

They often experienced inconsistent discipline and a lack of independence in childhood. A study reveals that persistent shyness and shyness in late childhood were associated with the development of anxiety disorders in adolescence.^[16] Lower emotional strength and introversion are premorbid risk factors of depression. Dysthymia in children evolves into major depressive disorder.^[17]

Discussion Based On Educational History: Among 80 patients taken for the study, 18% were uneducated, 9% completed Primary education, 31% completed their Secondary education, 25% of patients were graduated and 9% were postgraduates. Out of 68 educated patients, 67.5% went to school with self-interest and 32.5% went to school by force. 60% of patients had a cordial school atmosphere where as remaining 40% had a very hostile environment. 66.2% of patients have a good relationship with their classmates at school while the remaining 33.8% have bad relationships. 35% of patients had good performance in school and 30% had an average performance. But 25% did excellent in school and college performance whereas 10% did very poorly.

Educational status is a prime milestone formative of excellence and the standards of any living population. In the present study, most of the patients had good educational status. Researches indicate that highly educated people show higher scores of happiness than those with low education. Maybe due to high education, they learn the adaptation quickly so depressive illness is more prevalent among low educated and illiterate. But present study seems limited to establishing such a relationship between education and depression. There was a positive relation found between education and the severity of depression may be because with increasing education expectations of a job etc. increases from others and of course from the self and if not fulfilled may drag the patient with the greater severity of the symptoms. The positive relation between education and the severity of depression was established in the present study. One reason may be that educated people have more awareness of the symptoms of depression and they take it as a mental health problem and use the mental health services. So maybe the prevalence of depression is higher in low-educated people but because of a lack of awareness about mental health services and of course lack of knowledge of the severity of the disease (if it is untreated), the cases reported are few as compared to highly educated people.

Discussion Based On Occupation

Occupation: In the present study, a variety of work types are studied, as it was not limited to a specific working group. Among the 80 subjects, there were farmers (10%), teachers (8.75%), tailors (5%), doctors (3.75%), IT Professionals (6.25%), drivers (7.5%),

business (8.75) and many others. With respect to job satisfaction history, many patients were not satisfied with the work they were doing. Moreover, they had feelings of competition Work plays a great role in life as nearly one-third of adult life is spent at the workplace, indulged in work. Workplace stressors and fear of failure can contribute to the disease.

Among 80 patients who had an occupation, 67 subjects (83.7%) had **workplace stress**. Out of 80 subjects who were employed, the maximum number of patients worked 42.5% worked 41 to 49 hours, followed by 27.5% who worked less than 40 hours, and 2.5% people worked more than 60 + hours. Out of 80 subjects who were employed, 72.5% of people worked 6 days, 7.5% of people worked 6 days, 20% of people worked less than 6 days. Out of 80 subjects who were employed, 88.75% worked the day shift, 12.5% worked the night shift.

In service and business professionals, the key holders are their bosses and customers whom they have to satisfy for their bread and butter, which play the role of stressors in patient's life. Work satisfaction directly relates to psychological and spiritual health, which has an impact on mental health. The content of work shows a positive influence on the overall performance of the individual. In the present study, the data is indicative of the negative influence of the psycho-physical nature of work. Many studies have shown that stress at the workplace and discontent towards work lead to increasing stress and ultimately result in mental health disturbance. Hypercortisolaemia due to chronic stress results in neuronal damage resulting in depression.^[8]

Discussion Based On Marital History

Marital status: The majority of subjects in the study were married. 21% were unmarried and the rest 79% were married. Both groups have their own causes for the occurrence of *vishada*. Marriage is the social system made for the fulfilment of the third principal object of life i.e. "*kama*" by the union of two opposite sexes. Though matrimonial status is neither an etiological factor nor a risk factor for depression still marriage is one of the positive stressors enlisted. It can affect in both positive and negative ways overall human beings. Positively, this provides physical and mental satisfaction and support throughout the adversities which is most important in coping with stress but a surplus amount of stress and increased familial responsibilities beyond capacity affect negatively a disturbed relationships and may drag both individuals towards depression. Married people require significant adaptation to other family members in sharing life moments which may drain psychological energy.

Relationship with spouse: out of 63 married subjects, 49 (61.25%) had an unsatisfactory relationship with spouse. On critical analysis, the marital life of the married patients was found disturbed in the present study due to various reasons like extra marital affairs of a spouse, conflicts in interpersonal relationships, lack of

understanding, no love, care and affection from the spouse or other family members, no support from spouse, the spouse being non-accommodative, irritable, suspicious and angry in nature. There were so many problems in their marital life and it was completely disharmonized which may be the core reason for the present finding. Sharing and solving problems together makes stress reduction. Issues in married life and imbalance in relationships is a major factors for depression.

Age of marriage: out of 63, 18 were married at a very early age (22.5%) 11.25% were late marriages and the rest 45% were married at a normal age. The social, familial and personal responsibilities which get at a very young age and stress due to loneliness may be the reason for disease respectively. Economic burden, interpersonal relationship difficulties, and partner violence can result in depression.^[9]

Discussion Based on Menstrual History: The age of **menarche** of 41 females registered for the study was distributed as 47.5% at 13 years, 39% at the age of 14 and 19.5% at 15 years. **Menopause** was attained by 10 of the subjects. Out of 31 females who have not attained menopause, 58.1% were on a regular **menstrual cycle**. Early maturing has increased the risk of depressive symptoms in adolescence.¹⁸ Out of 31 menstruating females 7 experienced **Premenstrual syndromes** in their cycles.

Discussion on Ahara vrittanta

Dietary Habits: Data obtained about the Diet of the patients shows the highest incidence of is seen in patients habituated to a Mixed diet (71.2%) and vegetarian (28.8%). This may be mainly due to the studied population within a particular territory. While mentioning about the *Nidanas* of Mental disorders like *Unmaada*, *Apasmara*, and *Attatwabhinivesha*, *Acharya Charaka* has given due emphasis on dietetic causes. *Rajasika* and *Tamasika* food may act as a predisposing factor in the manifestation of a psychiatric disorder.^[19,20] This type of food is contraindicated in psychiatric illness. *Bhagavad Geeta* quotes the relation between *Ahaara* and *Sattva*, *Rajas* and *Tamas* in mind. The flashy food is related to increased *Rajas* and *Tamas*, which stem at the causation of stress in psyche.^[21] A Vegetarian diet increases *Sattva*-the good quality in mind which helps to cope up with stress.^[22] *Bhagwad Gita* opines that *Rajasika Ahara* is dominant in *Rajo guna* which is responsible for disappointment, desire, jealousy, anxiety, etc.^[23] So based on the present findings it can be assumed that there may be some association between *Rajasika* food and *vishada*.

Ahara Abhyasa: 65% were involved in *Vishamashana*, 72.5% in *Anashana* and also 55% were involved in *adhyashana*. Ayurveda extensively explores the influence of diet on both the body and mind by establishing specific guidelines for dietary practices. It

emphasizes that the health of the body and mind, as well as the onset of diseases, is directly linked to the quality and quantity of food consumed.^[24] Another quotation highlights the importance of a calm mind during meals, noting that even a well-balanced and high-quality diet can go undigested if one's mind is troubled by anxiety, grief, fear, or anger. Thus, having peace of mind is essential for proper digestion.^[25] the present data shows the negative impact of improper diet and dietary habits to worsen the pathology of depression.

Ahara matra: 55% of the people were having *madhyama matra ahara* followed by *heena* which was 27.5%.

Ahara rasa: Among 80 patients taken for the study, 80% indulged in *sarva rasa* and 57.5% predominance of *katu*, 47.5% had *lavana rasa*. 72.5% have *madhura rasa*. *Katu*, *Amla*, *Lavana rasa pradhana ahara* are said as *Rajo guna pradhana*. *Rajoguna* increases *Krodha*. Our observations in this regard signify these facts. The food habit-wise distribution it shows that the maximum no of patients was following *Rajasika* and *Tamasika* types of food habits. According to the *Bhagavad Gita*, taking putrified food, food prepared before more than 2-3 hrs of consumption increases *Tamoguna*. Taking food with *Katu*, *Amla* and *Lavana Rasa* provokes *Rajoguna*. These types of *Ahara*, provoking *Tamoguna* and *Rajoguna* indulge *Satva* in ruin.

Ahara guna: Among 80 patients taken for the study, a maximum which is 77.5% had *guru ahara*, 72.5% *sheeta ahara*, 57.5% *snigdha ahara* followed by 55 % with *ushna* and 47.5% with *ruksha ahara* and also 30% having *teekshna ahara*.

Discussion on Viharaja Vrittanta

Ratrijagarana: In this study, 77.5% were doing *ratrijagarana*. *Ratrijagarana* causes *vata* and *pitta vrididhi* as the *kala* is *vata pitta pradhana*.

Divaswapna: In this study, 37.5% were doing *divaswapna*. Either sleeping for more than the general given time, or day sleep causes *kapha dosha prakopa*. Sleep is essential for good health and is considered as one of the three pillars of life. *Nidra* depends upon the natural retirement of the mind and sense organs owing to fatigue. Improper sleep is a cause as well as an effect of stress pushing a person into a vicious cycle.^[28] As per the quotation "*Ratrau Jagaranam Ruksham*", inadequate sleep can vitiate *Vata-pitta dosha* and *kapha* at a physical level and a mental level, it can disproportionate *Rajas*, *Tamas* and *Satva* quality.^[29] Various studies support the finding that improper sleep can adversely affect the physical as well as psychological functioning of the body. *Manas* during sleep get a free state from *Indriyas* and *Arthas*. A good sleep with morning freshness stable the state of mind, and it can work fully. But what is the observed deficit here. This type of mental fatigue remains prone to *Prajnaparadha*.^[30,31]

Ativyayama: In this study, 56.25% were doing *ativyayama*. This leads to *vata prakopa* and intern affect *manasika doshas* too leading to their imbalance that contributes to *vishada*.

Other viharas: (50%) like long-standing, excess long-distance travelling, continuous sedentary work, exposure to excess heat, the cold, wind, and work stress were also present which acted as a precipitating factor in the causation of the disease.

Discussion on Vyasana: Among 80 patients, 95% had a habit of taking tea, 75% were taking coffee, 27.5% had a habit of smoking, 37.5% had a habit of consuming Madya, 22.5% had a habit of tobacco chewing, 52.5% had a habit of consuming aerated drinks. All sorts of above-mentioned addictions vitiate *Pitta dosha* which can lead to a decrease in the *Snigdha guna* which further leads to the *Vruddhi* of *Vata* and *Kapha* simultaneously. These have a direct impact on *Annavaha* and *Raktavaha*. This observation signifies the aetiology of the disease. *Annavaha srotas* can get vitiated with *Chinta* and *Pitta* and *Raktavaha srotas* with *Krodha*.

Discussion on *vishada lakshana*

Asiddhi: (unable to get the desired object): Among 80 patients, 80% of patients had experienced *asiddhi*. Attainment of undesired objects and not being desired one are the causes of manifestation of *Manas Roga* as described in *Charak samhita*.^[32] Working people, especially in the present world with this economy is filled with competitiveness where everyone is not able to reach their goals and dreams because of various reasons like work stress, family issues, financial issues, marital issues etc and are forced to work in jobs that they may not desire personally, such patients experience this *lakshana*

Bhaya: (fear from known and unknown objects): Among 80 patients, 90% of patients had experienced *bhaya*. Acharya Charaka explains that aggravated *Vata* gives rise to *bhaya*.^[33] He also states that *bhaya* plays a significant role in causing sleep disturbances.^[34] Its intensity is examined by "*Vishada*".^[35] This is a specific emotion by which so many diseases are caused. Fear is caused due to injuries from physical and social environments, when one is threatened by some social foe or by some physical threat from the environment, one may attempt to flee from it with accompanying feelings of fear.^[36]

Avasaada: Among 80 patients, 70% of patients had experienced *avasaada*. It can be said that *Avasada* is a state of mind in which *Tama* remains dominant and *Raja* gets tranquillized. In this condition, the mind becomes static; hence the process of getting knowledge gets hampered. This state of dullness may be recognized as "*Moodha Chittabhoomi*" in which the person doesn't do any activity.

Apravritti: (non-indulgence in work): Among 80 patients, 60% of patients had experienced *appravritti*. The clinical picture of depressive syndrome is so varied that it cannot be described fully in a short space. Although severe depression is readily recognized it can be difficult to distinguish the milder forms of depression from the emotional changes that are reported in everyday life. Unlike most medical disorders, depression is not associated with any characteristic laboratory changes or microscopic tissue abnormalities that can be used to confirm a suspected diagnosis.

Discussion on Symptoms according to the Hamilton depression rating scale

Depressed Mood: 58% had graded 1 symptoms as they stated their feelings only on questioning. 36% had grade 2 symptoms of depressed mood as they spontaneously reported it verbally. 5% had severe symptoms as emotions were known from facial expression, postures etc. 2 had mild symptoms as they reported only on questioning.

It is the cardinal symptom of the disease and is the first mark of diagnosis. It is always present in a mild or severe form. In its mildest form, the patient experiences a flattening of affect and as the depression increases, the patient is more miserable. He becomes preoccupied with gloomy thoughts and tends to look on the dark side of things. Some patients conceal this mood change from other people, at least for short periods. The patient may try to hide his low mood during clinical interview, making it more difficult for the clinician to detect depression.

Feeling of guilt: Feeling of guilt was absent in 4 subjects. Mild feelings were present in 46% of patients in the form of self-blaming. 39% had grade 2 symptoms and 10% had severe guilt with grade 3. The underlying guilt is a feeling of inadequacy. Guilt is a consequence of worthlessness in depression.

Suicidal Tendency: 7% of subjects did not have any suicidal ideations. 70% feel life is not worth living. 2% had thought of possible death. 2 were presented with suicidal ideations and one had attempted suicide. Suicidal thoughts are commonly present in depressive patients and they vary from mild to severe in intensity. The lowering of melatonin levels in depression results in suicidal tendencies.^[37] high risk of suicidal attempts were noted in depressed subjects below 30 years, single men, married women, students, and highly educated.^[38] Long working hours could probably result in worse health behaviours and have been associated with an increased risk of alcohol use and suicide.^[39,40]

Insomnia Early: 25% had no difficulty in falling asleep and another 66% complained of occasional difficulty in falling asleep. 9% had nightly difficulty in falling asleep which marked severe. Sleep disturbance in depressive disorder is of several kinds, the most characteristic of

which is early morning (Insomnia delayed) awakening. However, insomnia initial and middle also occurs. It is this combination of early morning awakening with depressive thinking that is important in diagnosis.

Insomnia Middle: 19% of the patients had no difficulty while 66% complained of disturbed sleep and restlessness during the night. 15% patients had waking during the night and getting out of bed.

Insomnia Late: 43% did not have the complaint of waking up in the early hours. 46% had mild complaints as they woke up but could get back to sleep 12% of subjects were unable to sleep again and get out of bed. Lesser time of sleep, longer sleep latency and frequent awakening are complained by depression patients of mild and moderate in nature.^[41]

In some depressed patients, hypersomnia rather than early morning awakening may occur, but they still report that the sleep was not refreshing.

Work and Activities: 94% of patients reported hindered work and activities. 61% had thought of incapacity, fatigue or weakness. 3% had actual incapacity in work, activities and hobbies. 4% of subjects had a decrease in actual time spent in activities and a decrease in productivity. Loss of interest and an inability to enjoy are frequent, though not always complained of spontaneously. The patient showed no enthusiasm for daily activities and hobbies, that he would normally enjoy otherwise. Work and activities are reduced along with depressed mood.^[42]

Psychomotor Retardation: Psychomotor retardation was absent in 79% of subjects. 18% had mild grade 1 symptoms. Rest 3% had obvious retardation during the interview. It is frequent. The retorted patient walks and acts slowly. There is a slowness or difficulty in thinking, accompanied by a poverty of ideas, which leads to a lack of concentration and indecisiveness. The serotonin and melatonin levels determine the psychomotor activity and its decrease will result in the symptom.^[36]

Agitation: In 72% the symptom was absent. 25% had grade 1 and 3% had moderate grades. 2 patients had severe agitation as they could not sit and stand still. It is a state of restlessness which is experienced by the patients as an inability to relax. The patient is restless and anxious when it is mild and seems to be plucking his fingers and making restless movements of his legs. When agitation is severe, he cannot sit for any length of time but paces up and down.

Anxiety Psychological: 75 out of 80 subjects reported the symptoms. 50% had subjective tension and irritability. 39% were worrying about minor matters. 4% presented with an apprehensive attitude in speech or face. Subjects with depression will often be anxious due to fear and sudden autonomous excitation due to worries

and apprehension. Patients feel these, unable to relax, with difficulty in concentration and lack of affection.

Anxiety Somatic: Anxiety symptoms pertaining to somatic as dry mouth, indigestion, cramps, belching, palpitation, tremors, headache, and short breaths were mild in 69%. 11% had moderate grade of symptoms while 5% had severe symptoms. The symptom was absent for 12% of subjects. Patients with depression are always subjected to autonomous excitation resulting in palpitation, tremors, perspiration, dryness of mouth etc.

Somatic- GIT Symptoms: 16 subjects did not present with the symptoms. 76% had in mild grade loss of appetite but could eat without compulsion. 3 had difficulty in eating even after compulsion. The serotonin which is mostly secreted in the GIT is directly related to mood disorders.

Somatic-General Symptoms: Out of 80 subjects 20 did not present with the symptom. 70% presented with the heaviness of limbs, back, and head, muscle aches and loss of energy. Lack of energy and easy fatigability are common in patients with depression. Somatic symptoms are a more common manifestation in India.^[43]

Genital Symptoms: Genital symptoms are loss of libido or menstrual disturbance. It was absent in 70% of subjects and present in mild severity in 25% of them whereas 5% had severe grade 2 symptoms. Those who presented with the symptom complained of loss of libido and sexual performance, menstrual disturbances etc.

Hypochondriasis: Hypochondriasis was absent in 11% of subjects. Bodily self-absorption was present in 40% and 45% of subjects had a preoccupation with health. 4% had frequent complaints and requests for help.

Loss of Weight: Weight loss was absent in 49% of subjects. 36% with mild weight loss and two had definite weight loss because of the disease.

Insight: 25% of the patients acknowledge being depressed and ill. 62% acknowledge illness but attribute causes to bad weather, food etc. 13% denied they had any illness.

Diurnal Variations: 57% did not have diurnal variations in the symptoms. 6% of patients had severe variations that increased mostly at late night and a few in the early morning. A diurnal variation of symptoms has long been recognized as a typical symptom of depression and is often present in endogenous depression as an early morning worsening of mood. The decrease in melatonin in depressed patients can contribute to the variation in the day and evening.^[34]

Depersonalisation and Derealisation: 62% of subjects had mild severity of the symptom. Whereas 25% had no

Depersonalisation and derealisation symptoms. Nihilistic delusions were less in the Indian population.^[44]

Paranoid Symptoms: Paranoid symptoms were absent in 14 subjects. 65% had some suspicions, 1 had ideas of reference and none had delusive ideas. Negative self-esteem can result in paranoid symptoms.

Obsessive-Compulsive Symptoms: A large number of patients had mild obsessive-compulsive symptoms i.e., 64% and at least 6% had moderate grade 2 symptoms. OC symptoms are less reported by Indian subjects with depression.^[44]

Helplessness: Grade 1 patients had 59% of helplessness symptoms majorly followed by 38% with grade 2 and least in grade 3.

Hopelessness: The majority 54% of patients had grade 2 hopelessness symptoms while 39% had grade 1. Only 5% of patients had grade 4 severity symptoms.

Worthlessness: 54% of patients had grade 2 worthlessness symptoms followed by 41% with grade 1. Only 4% of patients had grade 3 symptoms.

The total score of Hamilton's depression rating scale: Out of 80 patients, 56% of patients had Moderate depression 34% had severe depression and 9% patients had mild depression.

Various *manasika bhavas* observations seen in this study

Bhaya: The majority of bhaya patients were fearful only at reasonable cause in grade 1 with 51% and 41% fearful even in reasonable cause respectively followed by grade 3 of 7% who were always and only 1% in grade 1 who had no fear. Most of the subjects were scared of their future and had fear of failure from the demands of a job, making workers more vulnerable to worsening mental health. *Bhaya* can cause various hormonal and neural imbalances. This can vitiate *Vata* and *Pitta doshas* and aggravate the symptoms.

Krodha: A significant number of patients of *krodha* belonged to grade 1 (44%) with rare violent thoughts and grade 2 with 47% who had violent thoughts often whereas only 6% in grade 0 never had any violent thoughts and 3% had Frequent thoughts and functions of violence and sadistic in grade 3. *Krodha* causes Vitiating of *Pitta*, *Pitta* is mindful of all Sorts of Metabolic changes within the body, *Sadhaka Pitta* is found in *Hridaya* which covers the *Manas* from *Rajo Guna*. When a person takes *Hita Ahara* and *Mita Ahara* in appropriate time and the individual gets afflicted by *Manasika Bhavas* like *Krodha* the ingested food will not experience total absorption.

Shoka: *Shoka* patients are present in grade 2 (41%) majorly with Inferiority complexes and greed often

followed by grade 1 (29%) who Feel inferiority and sorrow at occasion and grade 3 (30%) who Weeps and feel inferior very frequently. His face colour changes and continuous lacrimation occurs. Aggravated *Vata* causes *Shoka*.^[45] The degree of *Shoka* can be measured based on the intensity of "*Dainya*".^[46] A man of weak mind "*Hina Sattva*" can pass into a stupor "*Murchha*" or even die due to the acuteness of *Shoka* persisting for a long time.^[47]

Dvesha: Most of the Patients of *dvesha* belong to grade 2 (49%) with thoughts and acts of revenge often followed by 31% in grade 1 with thoughts of revenge only a few events and 16% in grade 0 with No revenging tendency at all while only 4% belonged to grade 3 who Always thoughts and acts of revenge. It causes vitiation of *rajo* and *tamo guna* and leads *mano karma vikriti*.

Rajah: Major part of *rajah* patients belong to grade 2 with 44% who felt Loss of affection occasionally followed by 27% in both grade 1 with gradually decreased affection and grade 3 who had a total loss of affection and least by grade 0 with 2% with Normal affection. This causes attachment issues and conflicts in personal and professional relationships. In a *avara satwa purusha*, this causes feelings of *dukha* and becomes the cause of vitiation of *manasika doshas* that further lead to *mano vibhrama* and cause *vishada*.

Manasa: Out of 80 subjects, grade 1 with 48% had predominant patients who were Getting deviated very rarely, with 42% in grade 2 who had Deviation often and knowledge perception impaired whereas 9% belonged to grade 3 who had Deviation and perception frequently disturbed. Inappropriate mental perceptions, even in the presence of all other senses along with their respective objects indicate *mano avyabhicharnena*. Absence or altered perception indicates dissociation of mind with senses. This impairs *dhee*, *dhriti*, *smriti* and afflicts the *manasika doshas*, *rajas* and *tamas*.

Chinta: In 80 subjects registered in the study, 61% of patients had grade 2 *chinta* who had anticipation of the worst frequently 21% in grade 3 who had Excessive worry with irritation and at least 18% of grade 1 who anticipated the worst occasionally. *Chinta* causes vitiation of *Vata* and *vishada* is a *vataja nanatamja vikara*. *Chinta* is *dukha manasika bhava* that causes vitiation of *manasika doshas* and leads to *vishada*.

Dhairyam: 42% of patients had grade 1 of *dhairyam* who were fearful only at reasonable at any cause followed by 32% in grade 3 who were always fearful and depressed emotions and 26% in grade 2 who felt Fearful occasionally. In *vishada*, the capacity of *dhairya* is reduced and having *avara satwa* makes it even more difficult to overcome difficulties in life making them experience *dukha* that causes *vishada*.

Dhriti: The majority 57% had grade 2 *dhriti* who were Greedy but not strongly willing and 28% of patients

belonged to grade 1 who were Greedy and willing for a few objects followed by 12% in grade 0 who were Not greedy for anything and least grade 4 with 3% who felt Greedy for all objects. When it is impaired the mind inclined towards sensual desires cannot be prevented from doing harmful things due to *Dhrittibhramha*.

Harsha: 51% of patients were grade 1 *Harsha* who were Cheerful and initiative with good circumstances 34% in grade 2 who were Cheerful and active in that, only on occasion and at least 15% in grade 3 who had No feeling of cheerfulness. It is a characteristic of *rajasika prakruti* where *vata* is the predominant *dosha*. When *vata dosha* is affected, it vitiates the remaining *doshas* too affecting the happy emotions of the person with *avara satwa* that causes the symptoms.

Priti: Among 80 registered subjects of the study 50% of patients experienced grade 1 of *priti* who were pleased occasionally accompanied by 28% in grade 3 with No feeling of happiness at all and 22% in grade 2 who would express a happy mood often. In a *vishada* patient, the patient is not happy nor pleased because of constant stress and is *dukhita*. So they find it difficult to express joy and a happy mood.

Viryam: 3% of patients had grade 2 of *viryam* with delayed and decreased working capacity and 42% had grade 1 works with less interest accompanied by only 4% in grade 3 who was not able to start any work. *Apravrutti* is the *lakshana* of *vishada* where patient finds it difficult to initiate or carry out any task as they are filled with constant fear of failure. Hence this *mansika bhava* is affected.

Shraddha: The majority of patients had grade 1 (46%) who were Occasionally good in attitude and interest and grade 2 (44%) of *shraddha* with Impaired attitude and interest and least by 1% with Always very good in attitude and interest in grade 0 and 1% in grade 3 with Total loss of attitude and interest. Patients of *vishada* experience constant *bhaya* and apprehension of failure, hence are very pessimistic. Because of impaired *manokarma*, they lack purposiveness in their actions and impaired interest and attitude towards their tasks and goals.

Medha: 60% of patients had grade 1 *medha* who Grasped the event but is confused and 28% had of grade 2 who were Delayed in grasping the events with confusion followed by 11% in grade 0 who Always grasped the events at an instance. This vitiates *dhee*, *dhriti*, *smriti* of *manas* leading to imbalances in *rajas* and *tamas* that afflict the functions of *manas*.

Avasthan: 72% of patients belonged to grade 1 of *avasthan* and were Often stable in knowledge perception while 28% belonged to grade 2 who Rarely felt confident and stable in perception. *Avasthan* is understood by the absence of doubts and confusion. When it is affected, the

person is not confident and stable in their activities. This causes *mano karma vibhrama* and leads to *vishada*.

Updahi: Major 60% of patients belonged to grade 2 of *upadhi* who had Impacts that could only be solved by perseverance effort and counselling by others following by 39% in grade 1 who even had Prolonged, disturbing impact but able to solve by self-efforts and least 1% by grade 0 who had Normally short impact that can be solved by the person himself. When *manas* becomes vitiated by *rajasika* and *tamasika gunas*, it affects its functions and becomes cause of *manasika vikaras*.

Vijnana: most patients, i.e, 60% of patients had Gradually hampered performance in functioning were in grade 1 followed by 36% in grade 2 as they had Impaired motivation towards functioning often and only 3% had Loss of pace and motivation in functioning in grade 3 whereas only 1% belonged to grade 0 because they had Normal functioning in routine. *Vijnana* is assessed by skills that can be seen in one's occupation. When it is hampered by vitiation of *rajo* and *tamo guna*, it causes *mano vibhrama*.

Sheela: 82% of patients had Impaired conduct only at occasions were in grade 1 while only 10% were in grade 0 with Very good conduct at all instances and 8% had Impaired conduct recurrently in grade 2. There were no patients in grade 3 with Total abnormal conduct It hampers their ability to follow regular life as they have lost the function of *swasyanigrahana* to control the mind and cause *mano vibhrama*. This vitiates the *manasika doshas* and forms *vishada*.

Samjna: 73% of patients who were attentive occasionally belonged in grade 1 and 28% in grade 0 were completely attentive on all occasions where whereas grade 2 had only 1% who were Attentive rarely and no patients in grade 3 with absolutely no attentiveness. When *samjna* is impaired, it affects their attention and concentration power during daily activities, it causes difficulty in performing many tasks and having meaningful relationships and this leads to impairment of *dhee*, *dhriti*, *smriti* and which is also a sign of *mano vibhrama* leading *vishada*.

Smriti: 31% of patients belong in grade 0 because they are Very good at recalling and remembering, 45% of patients belong in grade 1 as they Recalled and remembered with difficulty and 24% patients Delayed recall and remembered things with difficulty in grade 2 while grade 3 had 0% because none of patients had delayed recall and remembered with confusion. When *Rajasa* and *Moha* overshadow a person's mind, their actions reach a point where they cannot access the memories related to *Tatwagyana* (true knowledge). This state is referred to as *Smritibramsas*.

Thus, from the above discussion, it is found that the *Manasika bhavas* do have a significant role in causing

vishada. These *manasika bhavas* create desires (*trishna*) that form *moha*, *iccha*, *dwesha*, *karma*. So when a person experiences *dukha manasika bhavas* by *trividha nidana* i.e., *Parinama*, *Pragyapradha*, and *Asatmendriyartha Samyoga* respectively and *Hinayoga*, *Atiyoga* and *Mithyayoga* of these factors cause *vishada*. Among these *Pragyapradha* is very important, it is the main causative factor of all the *manasika vikaras*.

Vishada which is one among *manasika vikaras* can be caused because of *Sadvritta Apalana* (not following good conduct), *Vegavidharana*, *Purvajanmakrit*, *Prakriti Viparyaya*, *Kaama*, *krodha & lobha*, *Himsa*, *rathi*, *kaama* or *ishtasyalabhat* and *Anihtasya Labhat* or by *Dhana kaantaadi naashayet* which we can see throughout the history of mankind in all ages.

When a *Heenasatva Purusha* indulges in all *nidanas* they lead to impairment of *Dhee* (intellect), *Dhriti* (patience or controlling power) and *Smriti* (memory). *Dhee* i.e. intellect normally views things as they are and discriminates between right from wrong. So when the person views *Ahita* (harmful) as *Hita* (useful) and vice versa, this is indicative of impairment of *Dhee* (intellect). *Dhriti* is the ability to adhere to good or to avoid bad and to withstand difficulties with strong willpower. When it becomes impaired, *manas* indulges in worldly enjoyments that cannot be restrained from harmful objects as it cannot separate good from bad. *Smriti* is the process by which the objects are directly perceived, heard and experienced earlier and are remembered. It keeps everything memorable. When *Smriti* is impaired, the person becomes devoid of *Tattvagyaana* (true knowledge) due to being overcome by *Rajasa* and *Tamasa*.

This leads vitiation of *Manodosha* and *sharirika doshas* and takes *sthanasamshraya* in *hridaya* which is *sthana* of *manas*. It causes *manovahasroto dushti* and causes *manokarma vikrut*i and results in *Vishada*.

Limitations: The study was limited by small sample which was not enough for providing statistically significant data analysis, even though the study fulfilled the objectives mentioned.

CONCLUSION

The insights derived from this comprehensive scientific discourse are presented below.

- *Vishada* is a constant feeling of *bhaya* that originates from apprehension of failure making them incompetent to accomplish or perform a desired work and resulting into incapability of mind and body to function properly.
- The current study revealed that the age group experiencing *vishada* were majorly of *madhyama vaya*.
- In the present study of working people, the majority of patients had *avara satwa* experiencing chronic stress which was identified as the primary *nidana* for

vishada, as majority of them also had work stress, and worked long hours, 6 days a week, and where many of them had worked day shift whereas small minority worked night shift.

- The present study revealed that, many of them had family problems and conflicts, disharmony in marital relationship, and had difficult childhoods because of various reasons, and belonged to mainly middle class with financial problems and that affected their personal relationships which contributed to their psychological disturbances affecting their mental health. This was observed to be also a cause of stress.
- In this current study on *vishada*, *bhaya* is seen as most prevalent *lakshana* among the patients followed by *asiddhi*, *avasaada*, and *apravritti*.
- It was observed that their fulfilment derived from professional occupation was intrinsically linked to their psychological and spiritual well-being, thereby exerting a profound influence on their mental health.
- In the present study, *dukha manasika bhavas* i.e., *bhaya*, *krodha*, *shoka*, *dwesha*, *rajah*, *manasa*, *chinta* experienced by the patients because of *avara satwa* and constant chronic stress because of all the *nidanas* mentioned had lead to impairment of *dhee*, *dhriti* and *smriti* leading to vitiation of *manasika doshas* affecting the *manovaha srotas* and formed *vishada*.
- The *Manasika bhava pareeksha* scale used to assess the *manasika bhavas* affected found that negative emotions *bhaya*, *krodha*, *shoka*, *dwesha*, *rajah*, *manasa*, *chinta* were increased more, especially *bhaya* and positive emotions *dhairya*, *dhriti*, *harsha*, *priti*, *viryam*, *shraddha*, *medha*, *avasthan*, *upadhi*, *vijnana*, *sheela*, *samjna*, *smriti* were decreased.
- By the study, it is concluded that there is a definite association of *dukha manasika bhavas* and people of *avara satwa* having chronic stress irrespective of time duration as a significant determinant for occurrence of *vishada*
- *Vishada* is correlated with depression in the present study by its *lakshanas* and its impact on the mind and body and are categorised under mild, moderate and severe depression.

REFERENCES

1. Mental health. Supplement for mental health, January 10, 2017; Available from: <http://wangtastic.blogspot.in>
2. Agnivesa, Charaka, Chakrapanidatta. Sharma RK, Das B. Charaka Samhita with ayurveda dipika commentary. Reprint edi. Varanasi: Chaukhambha Orientalia, 2009; 365.
3. World health organization; health topics; depression; cited on, January 2017; Available from: <http://www.who.int/topics/depression/en/>.
4. Acharya Agnivesha, Vaidya Yadavji Trikamji Acharya (ed). Charaka Samhita, revised by Acharya Charaka, redacted by Acharya Dridhabhala with Ayurvedadipika commentary by Sri Chakrapanidatta, reprint edition of, 2021; sutra sthana, chapter 11, shloka 45, page 76.

5. Acharya Agnivesha, Vaidya Yadavji Trikamji Acharya (ed). Charaka Samhita, revised by Acharya Charaka, redacted by Acharya Dridhabhala with Ayurvedadipika commentary by Sri Chakrapanidatta, reprint edition of 2021, vimana sthana, chapter 6, shloka 5, page 254.
6. Blehar MD, Oren DA. Gender differences in depression. *Medscape Women's Health*, 1997; 2: 3. Revised from: Women's increased vulnerability to mood disorders: Integrating psychobiology and epidemiology. *Depression*, 1995; 3: 3-12. from <http://www.nimh.com/depression> accessed on 8/9/2007.
7. A. Fanous et al. neuroticism, major depression and gender. *Psychological medicine*; Cambridge university press; May 2004; 32(4): 719-28.
8. Eleni Palazidou. The neurobiology of depression. *British Medical Bulletin*. Oxford journals, 2012.
9. Nandi DN, Banerjee G, Boral GC, Ganguli H, Ajmany S, Ghosh A, Sarkar S. Socio-economic status and prevalence of mental disorders in certain rural communities in India. *Acta Psych Scand*, 1979; 59: 276-93.
10. http://www.allaboutdepression.com/dia_03.html.
11. *Worry and its psychological disorders theory, assessment and treatment*, edited by Davey G C.L & Wells A, Wiley series in clinical psychology, 2006; 389.
12. Chatterjee RN, Mukherjee SP, Nandi DN. Life events and depression. *Indian J Psychiatry*, 1981; 23: 333-7.
13. Grant-Vallone, E.J.; Donaldson, S.I. Consequences of work-family conflict on employee well-being over time. *Work Stress*, 2001, 15: 214–226.
14. Hill, E.J.; Hawkins, A.J.; Ferris, M.; Weitzman, M. Finding an Extra Day a Week: The Positive Influence of Perceived Job Flexibility on Work and Family Life Balance. *Fam. Relat*, 2001, 50: 49–58.
15. *Biol Psychiatry* 1997; 42: 669–679, *Biol Psychiatry*, 1996; 39: 267–277.
16. Davis K L, Charney D, Coyle J T, and Nemeroff C, *Neuro psychopharmacology: The fifth Generation of progress*, Chapter 61: Genetic and other vulnerability factors for anxiety and stress disorders, American college of Neuropsychopharmacology, 2002: 872.
17. Kovacs M et al. childhood - onset dysthymic disorder. Clinical features and prospective natural outcome. *Arch Gen Psychiatry*, 1994; 51: 365-374.
18. Sequeira M, Lewis S, Bonilla C, Smith G, Joinson C. Association of timing of menarche with depressive symptoms and depression in adolescence: Mendelian randomisation study. *The British Journal of Psychiatry*, 2016; 210(1): 39-46.
19. Acharya Agnivesha, Vaidya Yadavji Trikamji Acharya (ed). Charaka Samhita, revised by Acharya Charaka, redacted by Acharya Dridhabhala with Ayurvedadipika commentary by Sri Chakrapanidatta, reprint edition of, 2021; Chikitsa sthana, chapter 9/4, 467.
20. Acharya Agnivesha, Vaidya Yadavji Trikamji Acharya (ed). Charaka Samhita, revised by Acharya Charaka, redacted by Acharya Dridhabhala with Ayurvedadipika commentary by Sri Chakrapanidatta, reprint edition of, 2021; Chikitsa sthana, chapter 10/4, 474-5.
21. *Bhagavadgita As it is (Marathi)*, by A.C. Bhaktivedanta Swami Prabhupada, eight edition, Bhakti Vedanta Book Trust, Jahu, Mumbai – 400 049, 2001; *Shraddha traya vibhaga yoga*, 17/8-10, 552-553
22. http://en.wikipedia.org/wiki/Sattvic_diet 18/3/2011
23. *Bhagavadgita As it is (Marathi)*, by A.C. Bhaktivedanta Swami Prabhupada, eight edition, Bhakti Vedanta Book Trust, Jahu, Mumbai – 400 049, 2001; Chapter, pg.
24. Acharya Agnivesha, Vaidya Yadavji Trikamji Acharya (ed). Charaka Samhita, revised by Acharya Charaka, redacted by Acharya Dridhabhala with Ayurvedadipika commentary by Sri Chakrapanidatta, reprint edition of, 2021; sutra sthana, chapter 28/45, 180.
25. Acharya Agnivesha, Vaidya Yadavji Trikamji Acharya (ed). Charaka Samhita, revised by Acharya Charaka, redacted by Acharya Dridhabhala with Ayurvedadipika commentary by Sri Chakrapanidatta, reprint edition of, 2021; Vimana sthana, chapter 2/9, 238.
26. Cann PA, Read NW, Cammack J, Childs H, Holden S, Kashman R, et al. Psychological stress and the passage of a standard meal through the stomach and small intestine in man. *Gut*; 1983; 24: 236-40.
27. <http://www.gutsense.org/constipation/stress.html>.
28. Acharya Agnivesha, Vaidya Yadavji Trikamji Acharya (ed). Charaka Samhita, revised by Acharya Charaka, redacted by Acharya Dridhabhala with Ayurvedadipika commentary by Sri Chakrapanidatta, reprint edition of, 2021; sutra sthana, chapter 21/35, 118.
29. Acharya Agnivesha, Vaidya Yadavji Trikamji Acharya (ed). Charaka Samhita, revised by Acharya Charaka, redacted by Acharya Dridhabhala with Ayurvedadipika commentary by Sri Chakrapanidatta, reprint edition of, 2021; sutra sthana, chapter 21/50, 119.
30. http://www2.wqrwick.ac.uk/newsandevents/pressreleases/researchers_say_lack/18/03/2011.
31. http://en.wikipedia.org/wiki/sleep#cite_note-26 18/03/2011.
32. Acharya JT. *Susrutasamhita of Susruta with Nibandhasangraha Commentary of Dalhanacharya*. Varanasi: Choukambha Sanskrit samsthan. 2013 Sutra sthana chapter 1:33.
33. Acharya Agnivesha, Vaidya Yadavji Trikamji Acharya (ed). Charaka Samhita, revised by Acharya Charaka, redacted by Acharya Dridhabhala with Ayurvedadipika commentary by Sri Chakrapanidatta, reprint edition of, 2021; sutra sthana, chapter 12-8.

34. Acharya Agnivesha, Vaidya Yadavji Trikamji Acharya (ed). Charaka Samhita, revised by Acharya Charaka, redacted by Acharya Dridhabhala with Ayurvedadipika commentary by Sri Chakrapanidatta, reprint edition of, 2021; sutra sthana, chapter 21-55.
35. Acharya Agnivesha, Vaidya Yadavji Trikamji Acharya (ed). Charaka Samhita, revised by Acharya Charaka, redacted by Acharya Dridhabhala with Ayurvedadipika commentary by Sri Chakrapanidatta, reprint edition of, 2021, vimana sthana, chapter 4-8.
36. Ahuja Niraj: A Short Text Book of Psychiatry, Jay Pee Brothers, Medical Publisher (P) Ltd. New Delhi, 2006; 134.
37. Venkoba Rao A, Devi SP, Srinivasan V. Urinary melatonin in depression. Indian J Psychiatry, 1983; 25: 167-72.
38. Painuly N, Sharan P, Mattoo SK. Antecedents, concomitants and consequences of anger attacks in depression. Psychiatry Res; 2007; 53: 39-45.
39. Yoon, J.H.; Jung, P.K.; Roh, J.; Seok, H.; Won, J.U. Relationship between Long Working Hours and Suicidal Thoughts: Nationwide Data from the 4th and 5th Korean National Health and Nutrition Examination Survey. PLoS ONE, 2015; 10: e0129142.
40. Kleppa, E.; Sanne, B.; Tell, G.S. Working overtime is associated with anxiety and depression: The Hordaland Health Study. J. Occup. Environ. Med; 2008; 50: 658-666.
41. Gupta R, Dahiya S, and Bhatia MS. Effect of depression on sleep: Qualitative or quantitative? Indian J Psychiatry, 2009; 51: 117-21.
42. Teja S, Narang RL, Aggarwal AK. Depression across cultures. British J Psychiatry, 1971; 119: 253-60.
43. Chaturvedi SK, Upadhyaya M. Double Depression and Somatization. Am J Psychiatry, 1989; 46: 1354-5.
44. Rao KN, Begum S. A phenomenological study of delusions in depression. Indian J Psychiatry, 1993; 35: 40-2.
45. Acharya Agnivesha, Vaidya Yadavji Trikamji Acharya (ed). Charaka Samhita, revised by Acharya Charaka, redacted by Acharya Dridhabhala with Ayurvedadipika commentary by Sri Chakrapanidatta, reprint edition of, 2021, vimana sthana, chapter chapter 4/8.
46. Acharya Agnivesha, Vaidya Yadavji Trikamji Acharya (ed). Charaka Samhita, revised by Acharya Charaka, redacted by Acharya Dridhabhala with Ayurvedadipika commentary by Sri Chakrapanidatta, reprint edition of 2021, vimana sthana, chapter 4/8.
47. Dvivedi, K.D. Vedic Mano Vogyana (Psychology in Vedas), Vishvabharathi Anusandhaan Parishad. Bhadohi, 1998; 161.