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Depression: A Definition

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Abstract - The most prevalent affective illness is depression, which may vary in severity from a very mild state bordering on normalcy to a severe disease accompanied by delusions and hallucinations. Depression is a substantial contributor to disability and early mortality on a global scale. Depression symptoms occur when our negative responses to life's circumstances become too frequent and powerful over time. Numerous circumstances in life arise, and we react to them with both good and negative emotions including enthusiasm, frustration, fear, happiness, rage, and sorrow. In practically all age groups and professions, depression is common. The most sad people in the world come from India. A WHO-sponsored survey found that although over 36% of Indians reported having MDE, just 9% of respondents in India reported having had a prolonged episode of depression throughout their lives.

Keywords - Depression, disability, World Health Organization, disorders.

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INTRODUCTION

The Organization (WHO) defines psychological health is the state of wellness marked by self-awareness, the ability to manage everyday pressures, the capacity for productive work, and the capacity to contribute to one's community. This concept of mental health includes happy emotions and functional abilities as important components of mental well-being in addition to the absence of mental disease. It is challenging to reconcile the idea that well-being is a crucial aspect of mental health with the many difficult life circumstances in which well-being might be unhealthy. For example, most people would regard as mentally unhealthy a person who is in a state of wellness while killing multiple people during a war action and would respect as healthy a person who is feeling desperate after losing their job in an environment with few employment opportunities. People with poor mental health are often depressed, irate, and unhappy, yet these emotions are natural parts of living a complete life. Despite this, mental state is often thought of as having a positive impact, characterised by contentment and a feeling of control over one's surroundings.[1]

Many academics use the term "mental health," which encompasses both of the WHO definition's essential elements: happy feelings and productive work. Keyes (2014) distinguishes between emotional well-being, cognitive well-being, & social well-being as the three pillars of mental health. Mental well-being includes personality characteristics, responsibility managerial skills, good relationships & communication skills, and a satisfied and happy life. Social well-being refers to the positive functioning & productive social functioning, including such social contribution, social inclusion, social actualization, and that social coherence. Emotional well-being includes cheeriness, positivity, interest in life, as well as satisfaction.[2-3]

A dynamic condition of inner stability known as mental health allows people to apply their skills in accordance with society's core principles. Essential elements of mental health that, to varying degrees, contribute to the state of stability include: the development of necessary skills; the capacity to identify with others and recognise, express, & modulate one's own emotions; adaptability and the capacity to deal with adverse situations in life and fulfil social roles; and the harmonious interaction of the body and mind.[4]

Factors Affecting Mental Well-Being

To understand mental health, it is important to look at variables such as one's capacity to regulate their thoughts and emotions as well as how they connect with others, their ability to communicate with others as well as their ability to work and live in a certain setting. Among these characteristics, poverty and poor educational attainment are the most important. It's not only physical aspects that make you more susceptible to disease. The influence of one's genes cannot be underestimated. As with physical health, the state of one's mind is influenced by a variety of social, psychological, or biological elements that interact. Several studies have identified a link between mental illness and poverty.[5] In all civilizations,

regardless of their degree of development, poverty and mental illness are linked. Hopelessness, instability, fast social change, and the dangers of violence & disease all contribute to the mental health problems of the poor. An American Indian tribe recently opened a casino as a natural experiment to reduce poverty, and the results show that socioeconomic factors, such as poverty, have a significant role in behavioural problems in children. Such reactions decreased in frequency after the establishment of a casino. Parental supervision of a children found to be the mediating factor in this study. Families and children's mental health are directly linked to economic conditions. Problems with mental, social, and behavioural health are often intertwined, and this may have a compounding influence on a person's behaviour and overall well-being. In times of high unemployment, poor income, insufficient education, stressful work environments, gender discrimination, unhealthy lifestyles, and human rights violations, health issues including heart disease, depression, anxiety, and stress are more common and more difficult to deal with.[6-8]

For each individual, elements such as personal experiences, social interactions, societal structures & resources, and cultural beliefs all have a role in determining their level of mental health. Families and schools and workplaces are all locations where it is shaped by ordinary life events. The health of a population or community is directly related to the health of its members' mental well-being. Environmental and social situations such as the slums of Mumbai impact local experiences as well as the psychological health of communities, according to ethnographic research conducted there.[9] In today's globalised society, mental health and associated challenges are becoming more significant. As a result, the public health tradition's foundational conceptions of health and sickness as multi-factoral in origin are often ignored when it comes to mental health problems and mental illness." Two dimensions are involved in the consequences. A community's mental health needs aren't being fully met because of a lack of awareness. Second, governments' attempts to decrease the economic and social cost of mental illness tend to rely primarily on the care of those who are afflicted with the condition.[10]

Mental disease is widespread and prevalent. In terms of years of life lost due to disability, mental and behavioural disorders accounted for 11% of all diseases in 1990. By 2020, this data is expected to rise by 15%. Other expenses to society are caused by mental health issues. Mental health issues, such as depression, were the fourth greatest cause of burden of disease in 1990 and thus are anticipated to become the second main cause by 2020. However, the majority of governments and communities have failed to address the issue of mental disease and mental health. Mental health resources in nations are significantly outstripped by the burden produced by mental health disorders, as shown by the most current WHO statistics.[11]

MENTAL HEALTH STUDIES

current trendsMore than 150 nation profiles on mental health resources were released on January 21st, 2019. A national picture of mental health policies, plans, regulations, and resources based on WHO Member States' data is offered by the profiles based on historical evidence. The types of facilities offering treatment are also shown. The WHO's Mental Health Atlas project publishes the profiles, which are revised every three years. The 66th World Health Assembly accepted the WHO's comprehensive mental health plan of action 2013-2020 in May of that year.[12]

As the head of the World Health Organization, Dr. Margaret Chan hailed the organization's new Comprehensive Mental Action Plan for 2013-2020 as a monumental success. An worldwide emphasis on a long-neglected issue is anchored in human rights ideals. This plan of action aims to bring about a beneficial shift in society. For centuries, societal stigma and prejudice have pushed individuals into social isolation, and this report urges them to improve their views and behaviours. It also advocates for an increase in services to encourage better resource use. The following are the plan's four primary goals.[13]

1. Strengthen and improve the effectiveness of national mental health leadership governance.
2. Provide mental health services that are comprehensive, integrated, and flexible. As an additional option, social services might be provided in the context of local communities.
3. Develop and implement mental health promotion and preventive methods.
4. Develop mental health information systems, evidence, or research.

One or two specific targets are associated with each of the four goals, allowing member states to take collective action and attain global goals that can be measured. The Mental Health Map project has created and is collecting data on a set of key indicators related to these goals and other events on a regular basis.[14]

India's Mental Health System

In a research done by NCHM and published by WHO, 6.5 percent of the Indian population suffer from different kinds of serious mental disease, with no noticeable ruralurban disparities. Psychiatrists, psychologists, and other mental health professionals are in high demand, yet there are just not enough of them. At its lowest point, it was believed to be 'one in 100,000 persons' in

2014. In India, the rate of suicide is 10.9 per 100,000 persons. The bulk of those who take their own lives are under the age of 44.[15]

'Depression is an emotional condition characterised by severe sorrow and anxiety, the belief that one is unloved and unworthy of love, withdrawal from social interactions, loss of sleep, food, and sexual desire'.[16]

"Depression is a mood illness defined by extreme melancholy that lasts for more than a few weeks, according to the Academic Dictionary of Psychology." Norepinephrine and serotonin—natural compounds that enable brain cells to connect with one another—are both linked to depression. Complete Dictionary of Education defines depression as "a state of mind marked by thoughts of hopelessness and a sense of doom," along with other unpleasant emotions.[17]

DEPRESSION TYPES

There are a number of different varieties of depression. When comparing them, look for common characteristics, symptoms that last a long time, and how severe they are. Major depressive disorder & dysthymic disorder are the most frequent. Depression may be classified in many ways, as outlined by the National Institute of Mental Health (NIMH) in 2001.[18]

(i) **Depression and psychosis:** When a person suffers from severe depression and psychosis, such as hallucinations and delusions, it is known as bipolar disorder.

(ii) postpartum depression: A new mother might be diagnosed with postnatal depression if she has a serious depressive episode within a month after giving birth. An estimated 10 to 15 percent of new mothers suffer from postpartum depression.

(iii) Seasonal affective disorder (SAD): During the winter, when there is less natural light, it is characterised by the start of a depressed disease. Spring and summer are prime times for the depression to lift. Some SAD sufferers may react well to light treatment alone, while roughly half of individuals with SAD are not. SAD symptoms may be alleviated by psychotherapy or antidepressant medication alone or in conjunction with light treatment.

Depressive disorders, such as major depression, are included in the DSM-IV-TR as fundamental symptoms in the majority of mental illnesses, adapted from the DSM-IV-TR, lists the many forms of mood disorders.[19]

TREATMENT OF DEPRESSION IN GENERAL

In general, antidepressant drugs and psychotherapy are required for the best result in severe depressive disorders, especially those that are recurring. A person has a 50% risk of experiencing another severe depressive episode if they have already had one. There is a 75% to 80% risk that a person will have a third severe depressive episode if they have already had two. A fourth season is almost certain if the individual has already had three. A first bout of depression could need gradual withdrawal from medication. However, most physicians would keep a patient on a maintenance dose of the medicine for years, if not permanently, following a second or third incident.[20]

An antidepressant is selected by the doctor after considering the patient's age, other medical problems, and adverse effects of the prescription. The milder side effects of SSRIs, compared to other antidepressant classes, make them a popular first choice among doctors. By beginning at low dosages & gradually increasing the levels, it is possible to reduce the side effects of SSRI drugs even more. After six to eight weeks on an SSRI at maximum dosage, physicians usually move their patients to a different SSRI or the other family of antidepressants. A different class of antidepressants will be prescribed to individuals who have not responded well to full dosages of one and two SSRIs or who have not tolerated those drugs well. atients with severe melancholy who have failed to respond to other treatments may benefit from antidepressants that work on both serotonin in the brain, such as duloxetine mirtazapine venlafaxine and desvenlafaxine It's possible to try bupropion (Zyban), which has an effect on the dopamine system . Antidepressants of several kinds are sometimes prescribed in combination by physicians. New antidepressant varieties are also continually being developed, and now one of them may be the best for a certain patient's needs.[21]

ADOLESCENTS' RISK OF DEPRESSION

Adolescents are all too acquainted with the signs of depression. The prevalence of mental problems in children is estimated to be 2.5 percent by various sources in India. 35.6%, 33.7%, and 10.54%, respectively. This vast range in prevalence rates seems to be the result of the many research methods that have been used. Depressive symptoms were present in 30-40% of the adolescents, while substantial levels of depression were present in 5-6% and depressive disorders were present in 2-3% of the youths. More and more people are becoming depressed and suicidal, as well as suffering from co-occurring disorders such as anxiety and bipolar disorder, which are all linked to higher rates of depression. Adolescents with depression are 15 percent more likely to be female than male, and the prevalence rises with age. In a rural location near Pune, Ganguli (2003) studied the development, beliefs, emotions, aspirations, and relationships with parents and teachers of 230 adolescents. A total of 57 male & 61 female

students took part in the research, and the findings revealed that both genders experienced mood swings. The researchers went on to discover that female students had higher levels of despair than male peoples. Being lonely is the most prevalent cause of depression, according to a new study. Adolescent depression in Kerala was investigated by Nair, Paul, and John (2004). According to the findings, 22.4% of high school females and 12.8% of high school guys were depressed. School dropout females experienced more severe depression than school-going girls, according to the research. Adolescents who suffer from depression for three years are more likely to develop adult depression and mental health issues later in life.[22]

Medical students had a greater frequency of depression (12.9 percent) than the general population, according to Dahlin, Joneborg, and Runeson (2005), who also found that women were more sad than men (16.1 percent).

There were 0.5% depressive disorders, 1.0% anxiety disorders, 0.4% behavioural disorders, and 0.2% ADHD among teenagers according to Pillai et al. (2008). According to Mohanraj and Subbaiah's (2010) research on urban teenagers in southern India, the incidence of depressive symptoms was found to be high. The research included 509 boys or 455 girls in grades 10lh, 1llh, and 12lil. The data was collected using the Beck Depression Inventorv. The study's findings revealed that 39.2% of participants were depressed-free, 37.1% had mild depression, 19.4% had moderate depression, and 4.3% had severe depression.. There were no significant differences between the sexes when it came to depression, however girls were more likely than boys to experience mild to severe depression . 79.2% of South Indian teenagers were found to be depressed, with 41.2% experiencing moderate depression, followed by mild depression, according to a recent research (26.6 percent). Depression was shown to be more common and more severe among those who were older, too.[23]

The rate of mental was examined by Black, Roberts, and Li-Leng (2012) in a study of south Australian teenagers (aged 13 to 18 years). More than one in five teenagers tested positive for depression, and more than one in ten adolescents reported feeling down most of the time, according to the findings of the research. In addition, women were shown to be more depressed than men. Study by Sidhu and Singh (2012) examined the prevalence of melancholy in late adolescent years. The research used a random sample of 1000 peoples. In order to gather data, we employed Beck Depression Inventory. There were 30 percent girls and 36 percent men in late childhood showing indicators of slight depression, according to the findings of the research. A serious depressive illness was found in 2% of women and 1.2% of men in the study. The Beck Depression Inventory was used in a research in Karnataka to determine the prevalence of depression among a sample of medical students. According to the findings, men were found to be more depressed than women. A total of 29.8 percent of the population was considered normal, 27.8 percent mildly depressed, 29.3 percent moderately depressed, 7.5 percent seriously depressed, and 6.7 percent very badly depressed, according to BDI cut-off scores.[24]

The incidence of depression among teenagers in West Bengal was reported to be 45.3%, with the majority of cases being of the mild, moderate, or severe kind. In a sample of Delhi residents, 84% of individuals who inject drugs showed signs of despair, anxiety, and suicide thoughts, and 54% had mild to severe depression. Self-blame and a sense of worthlessness were also shown to be the most frequent symptoms of depression.

DEPRESSION FROM A SOCIAL AND ECONOMIC PERSPECTIVE

There are several levels of depression. Some theories emphasise biological predisposition; others focus on psychological elements; and yet others believe that social influences have a role in the development of depression. The biopsychosocial approach, which takes into account a person's biological make-up, psychological disorders, and sociocultural context, has largely supplanted the once-dominant single explanation. The biopsychosocial model, the foundation of marriage counseling, is a close ally to the systems model. Depressed people's lives are taken into consideration by this method. Depression may affect anybody in a family because of the interplay between internal experiences and environmental systems.[25]

Depression is a major source of illness burden in both developed and developing countries. As of 1 2015, depression accounted for 7.5 percent of worldwide YLDs and 2.0 percentage points of global DALYs in non-fatal health losses. Nearly one-third of all DALYs caused by mental and drug use disorders are attributable to depressive disorders, according to the Global Health Estimates 2015. By 2030, it is predicted to be the 2nd biggest source of disease burden worldwide and the third most common cause of burden of disease in low- and middle-income countries (LMICs) respectively.

CONCLUSION

According to a WHO-sponsored research, Indians are the world's most sad population, with about 36% suffering from the cluster of depressive symptoms. People in more affluent countries, such as the Netherlands, France, and the United States, were shown to be less content and more sad than their counterparts in less prosperous countries. The Netherlands ranked in second

place with an average of 33.6 per cent of MDE cases, followed by France and the United States with 32.3 and 30.9 per cent, respectively. Around 9% of Indians have had a prolonged period of depression at some point in their lives, while 36% have been diagnosed with major depressive episode.

Suicide is the most common outcome, and it claims the lives of 850,000 people each year. Psychotherapists, psychiatrists, psychologists, therapists, counsellors, and appropriately qualified psychiatric nurses may provide psychotherapy to individuals, groups, or families. There may be a need for a mix of medicine and counselling for more severe or long-term forms of the depression.[26]

REFERENCES

1. Castillo-Quan J, Barrera-Buenfil D, Pérez-Osorio J, et al. Depresión y diabetes: de la epidemiología a la neurobiología. Revista de Neurología. 2010;51(6):347–359.
2. Diagnostic and statistical manual of mental disorders. 5th ed. USA: American Psychiatric Association; 2014. 991 p.
3. Jiménez G, Miguel-Tobal J. El Cuestionario Tridimensional para la Depresión (CTD): Un nuevo instrumento para medir la tristeza/depresión. Ansiedad y Estrés. 2003;9(1):17–34.
4. Jiménez G. La depresión desde una perspectiva tridimensional: Elaboración de un instrumento de medida. Universidad Complutense de Madrid, Spain; 2002.
5. Rivas-Acuña V, García H, Cruz A, et al. Prevalencia de ansiedad y depresión en las personas con Diabetes Mellitus Tipo
6. Salud en Tabasco. 2011;17(1–2):30–35. 2. Reyes G. Psicoterapia psicodramática: Una forma de diagnóstico y tratamiento para la depresión. Revista Brasileira de Psicodrama. 2013;21(2):53–64.
7. Schiffer, R.B. (2007), Psychiatric Disorders in Medical Practice, in: Goldman, L. and Ausiello, D. (eds), Goldman: Cecil Medicine, 23rd ed, Saunders Elsevier, Philadelphia.
8. Schinka J, Busch R, Robichaux-Keene N. 2004. A meta-analysis of the association between the serotonin transporter gene polymorphism (5-HTTLPR) and trait anxiety. Mol. Psychiatry 9:197–202
9. Segal ZV, Shaw BF, Vella DD, Katz R. 1992. Cognitive and life stress predictors of relapse in remitted unipolar depressed patients: test of the congruency hypothesis. J. Abnorm. Psychol. 101:26–36
10. Segrin C. 2001. Social skills and negative life events: testing the deficit stress generation hypothesis. Curr. Psychol. Dev. Learn. Personal. Soc. 20:19–35
11. Sen S, Villafuerte S, Nesse R, Stoltenberg SF, Hopcian J, et al. 2004. Serotonin transporter and GABA(A) alpha 6 receptor variants are associated with neuroticism. Biol. Psychiatry 55:244–49
12. Serrano C, Claudia Ivette, Zamora K, et al. Comorbilidad entre depresión y Diabetes Mellitus. Medicina Interna de México. 2012;28(4):325–328.
13. Shrout PE, Link BG, Dohrenwend BP, Skodol AE, Stueve A, Mirotznik J. 1989. Characterizing life events as risk factors for depression: the role of fateful loss events. J. Abnorm. Psychol. 98:460–67
14. Simons AD, Angell KL, Monroe SM, Thase ME. 1993. Cognition and life stress in depression: cognitive factors and the definition, rating, and generation of negative life events. J. Abnorm. Psychol. 102:584–91
15. Strickland PL, Deakin JFW, Percival C, Dixon J, Gater RA, Goldberg DP. 2002. Bio-social origins of depression in the community: interactions between social adversity, cortisol and serotonin neurotransmission. Br. J. Psychiatry 180:168–73
16. Swindle RW, Cronkite RC, Moos RH. 1989. Life stressors, social resources, coping, and the 4-year course of unipolar depression. J. Abnorm. Psychol. 98:468–77
17. Tennant C. 2002. Life events, stress and depression: a review of the findings. Aust. NZ J. Psychiatry 36:173–82
18. Thase M, Jindal R, Howland R. 2002. Biological aspects of depression. See Gotlib & Hammen 2002, pp. 192–218
19. Toro-Tobar R, Grajales-Giraldo F, Sarmiento-López J. Riesgo suicida según la tríada cognitiva negativa, ideación, desesperanza y depresión. Aquichan. 2016;16(4):473–486.
20. Vallejo J. Introducción a la psicopatología y psiquiatría. 8th ed. Madrid, Spain: Elsevier Masson; 2015. 712 p.
21. van Os J, Jones PB. 1999. Early risk factors and adult person-environment relationships in affective disorder. Psychol. Med. 29:1055– 67
22. Weiss EL, Longhurst JG, Mazure CM. 1999. Childhood sexual abuse as a risk factor for depression in women: psychosocial and neurobiological correlates. Am. J. Psychiatry 156:816–28
23. Whiffen VE, Clark SE. 1997. Does victimization account for sex differences in depressive symptoms? Br. J. Clin. Psychol. 36:185–93
24. Young EA, Lopez JF, Murphy-Weinberg V, Watson SJ, Akil H. 2000. Hormonal evidence for altered responsiveness to social stress in major depression. Neuropsychopharmacology 23:411–18
25. Zimmerman M, Coryell W, Pfohl B. 1986. Validity of familial subtypes of primary unipolar depression: clinical, demographic,

and psychosocial correlates. Arch. Gen. Psychiatry 43:1090–96
26. Zuroff DC, Mongrain M, Santor DA. 2004. Conceptualizing and measuring personality vulnerability to depression: comment on Coyne and Whiffen 1995. Psychol. Bull. 130:489–511

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