Clinical Depression (Facts and Statistics): A Short Paper

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Abstract
Depression affects people of all ages, from all walks of life, in all countries. It causes phrenic anguish and impacts on people’s competency to carry out even the simplest everyday tasks, with sometimes devastating consequences for relationships with family and friends and the facility to earn a living. At worst, despondence can lead to suicide, now the second leading cause of death among 15–29-year-olds. Yet, dejection can be obviated and treated. A better understanding of what melancholy is, and how it can be obviated and treated, will avail reduce the stigma associated with the condition, and lead to more people seeking avail.

Keywords: Depression, mental anguish, devastating, suicide, stigma

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INTRODUCTION
Depression is the leading cause of ill health and incapacitation ecumenical. According to the latest estimates from WHO, more than 300 million people are now living with melancholy, an incrementation of more than 18% between 2005 and 2015. A lack of fortification for people with phrenic disorders, coupled with a trepidation of stigma obviates many from accessing the treatment they require to live salubrious, productive lives. Despondence can transpire at any age, but often commences in the teens or early 20s or 30s. Most chronic mood and solicitousness disorders in adults commence as high calibers of solicitousness in children [1]. In fact, high calibers of solicitousness as a child could designate a higher risk of dejection as an adult.

Dejection can co-occur with other earnest medical illnesses such as diabetes, cancer, heart disease, and Parkinson’s disease. Dejection can make these conditions worse and vice versa. Sometimes medications taken for these illnesses may cause side effects that contribute to despondence. When a person has dejection, it interferes with daily life and mundane functioning [2]. It can cause pain for both the person with dejection and those who care about him or her. Medicos call this condition “depressive disorder,” or “clinical despondence.” It is an authentic illness. It is not a designation of a person’s impuissance or a character imperfection. A person cannot “snap out of” clinical melancholy. Most people who experience dejection need treatment to get preponderant.

What is Depression?
Depression is an illness characterized by persistent sadness and a loss of interest in activities that customarily relish, accompanied by an inability to carry out daily activities, for at least a fortnight.

Signs and Symptoms
Sadness is only a small part of depression. Some people with depression may not feel sadness at all. Depression has many other symptoms, including physical ones. If patients have been experiencing any of the following signs and symptoms for at least 2 weeks, they are suffering from depression:

- Persistent sad, anxious, or “empty” mood
- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Loss of interest or pleasure in hobbies and activities
- Decreased energy, fatigue, being “slowed down”
- Difficulty concentrating, remembering, making decisions
- Difficulty sleeping, early-morning awakening, or oversleeping
- Appetite and/or weight changes
• Thoughts of death or suicide, suicide attempts
• Restlessness, irritability
• Persistent physical symptoms

Causes of Depression
The causes of depression are not fully understood and may not be due to a single source. Depression is likely to be due to a complex combination of factors that include:
• Genetics
• Biological—changes in neurotransmitter levels
• Environmental
• Psychological and social (psychosocial)

Some people are at higher risk of depression than others; risk factors include:
• Life events: These include bereavement, divorce, work issues, relationships with friends and family, financial problems, medical concerns, or acute stress.
• Personality: Those with less successful coping strategies or previous life trauma are more susceptible.
• Genetic factors: Having a first-degree relative with depression increases the risk.
• Childhood trauma.
• Some prescription drugs: These include corticosteroids, some beta-blockers, interferon, and other prescription drugs.
• Abuse of recreational drugs: Abuse of alcohol, amphetamines, and other drugs are strongly linked to depression.
• A past head injury.
• Having had one episode of major depression: This increases the risk of a subsequent one.
• Chronic pain syndromes: These and other chronic conditions, such as diabetes, chronic obstructive pulmonary disease, and cardiovascular disease make depression more likely.

Types of Depression
There are several types of depressive disorders.
• Major depression: Severe symptoms that interfere with the competency to work, slumber, study, victual, and relish life. An episode can occur only once in a person’s lifetime, but more often, a person has several episodes.
• Persistent depressive disorder: A depressed mood that lasts for at least 2 years. A person diagnosed with assiduous depressive disorder may have episodes of major despondence along with periods of less rigorous symptoms, but symptoms must last for 2 years.

Some forms of depression are slightly different, or they may develop under unique circumstances, they include the following:
• Psychotic depression, which occurs when a person has astringent despondence plus some form of psychosis, such as having perturbing mendacious credences or a break with authenticity (delusions), or aurally perceiving or visually perceiving upsetting things that others cannot aurally perceive.
• Postpartum depression, which is much more earnest than the “baby blues” that many women experience after giving birth, when hormonal and physical changes and the incipient responsibility of caring for a new born can be inundating. It is estimated that 10 to 15 percent of women experience postpartum despondence after giving birth.
• Seasonal affective disorder (SAD), which is characterized by the onset of melancholy during the hiemal months, when there is less natural sunlight. The despondence generally hoists during spring and summer. WOEFUL may be efficaciously treated with light therapy, but proximately a moiety of those with DOLEFUL do not get better with light therapy alone. Antidepressant medication and psychotherapy can reduce sad symptoms, either alone or in coalescence with light therapy.
• Bipolar disorder is different from despondence. The reason it is included in this list is because someone with bipolar disorder experiences episodes of extreme low moods (dejection). But a person with bipolar disorder additionally experiences extreme high moods (called “mania”).

Tests
• Depression is a mood disorder characterized by persistently low mood and a feeling of sadness and loss of interest. It is a persistent problem, not a
passing one, lasting on average 6 to 8 months.

**Diagnosis starts with a consultation from a mental health expert:**
- Diagnosis of dejection commences with a consultation with a medico or phrenic health specialist. It is consequential to seek the avail of a health professional to rule out different causes of dejection, ascertain a precise differential diagnosis, and secure safe and efficacious treatment.
- As for most visits to the medico, there may be a physical examination to check for physical causes and coexisting conditions. Questions will additionally be asked—"taking a history"—to establish the symptoms, their time course, and so on.

**What does not class as depression?**
- Depression is different from the fluctuations in mood that people experience as a part of normal life. Temporary emotional responses to the challenges of everyday life do not constitute depression.
- Likewise, even the feeling of grief resulting from the death of someone close is not itself depression if it does not persist. Depression can, however, be related to bereavement—when depression follows a loss, psychologists call it a "complicated bereavement."

**Depression Affects People in Different Ways**
Not everyone who is depressed experiences every symptom. Some people experience only a few symptoms. Some people have many. The severity and frequency of symptoms, and how long they last, will vary depending on the individual and his or her particular illness. Symptoms may also vary depending on the stage of the illness [3].

**Women**
Depression is more prevalent among women than among men. Biological, lifecycle, hormonal, and psychosocial factors that are unique to women may be linked to their higher despondence rate. For example, women are especially vulnerable susceptible to developing postpartum dejection after giving birth, when hormonal and physical changes and the incipient responsibility of caring for a newborn can be inundating.

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

**Children**
Before puberty, girls and boys are equally liable to develop depression. A child with despondence may pretend to be sick, reluctant to peregrinate to school, clinging to a parent, or worry that a parent may die. Because mundane demeanors vary from one childhood stage to another, it can be arduous to tell whether a child is just going through an ad interim “phase” or is suffering from despondence. Sometimes the parents become apprehensive about how the child’s demeanor has transmuted, or a pedagogia mentions that “if the child does not seem to be himself.” In such a case, if a visit to the child’s pediatrician rules out physical symptoms, the medico will probably suggest that the child be evaluated, preferably by a noetic health professional who specializes in the treatment of children. Most chronic mood disorders, such as despondence, commence as high calibers of solicitousness in children.

**Teens**
Children and teenagers usually rely on parents, teachers, or other caregivers to recognize their suffering and get them the treatment they need. Many teens do not know where to go for mental health treatment or believe that treatment won’t help. Others do not get help because they think depression symptoms may be just part of the typical stress of school or being a teen. Some teens worry what other people will think if they seek mental health care.
Depression often persists, recurs, and continues into adulthood, especially if left untreated. If a child or teenager is suspected to be suffering from depression, speak up right away.

Treatment
Depression is a treatable mental illness. Depression is among the most treatable of mental disorders. Between 80 percent and 90 percent of people with depression eventually respond well to treatment. Almost all patients gain some relief from their symptoms.

Afore a diagnosis or treatment, a health professional should conduct an exhaustive diagnostic evaluation, including an interview and possibly a physical examination. In some cases, a blood test might be done to ascertain the despondence is not due to a medical condition like a thyroid quandary. The evaluation is to identify categorical symptoms, medical and family history, cultural factors and environmental factors to arrive at a diagnosis and plan a course of action. There are three components to the management of depression:
- **Support**, ranging from discussing practical solutions and contributing stresses, to educating family members.
- **Psychotherapy**, also known as talking therapies, such as cognitive behavioural therapy (CBT).
- **Drug treatment**, specifically antidepressants.

Psychotherapy
- Psychological or talking therapies for depression include CBT, interpersonal psychotherapy, and problem-solving treatment. In mild cases of depression, psychotherapies are the first option for treatment; in moderate and severe cases, they may be used alongside other treatment.
- CBT and interpersonal therapy are the two main types of psychotherapy used in depression. CBT may be delivered in individual sessions with a therapist, face-to-face, in groups, or over the telephone. Some recent studies suggest that CBT may be delivered effectively through a computer.
- Interpersonal therapy helps patients to identify emotional problems that affect relationships and communication, and how these, in turn, affect mood and can be changed.

Antidepressant Medications

Medication
Brain chemistry may contribute to an individual’s depression and may factor into their treatment. For this reason, antidepressants might be prescribed to help modify one’s brain chemistry. These medications are not sedatives, “uppers” or tranquilizers. They are not habit-forming. Generally, antidepressant medications have no stimulating effect on people not experiencing depression.

Antidepressants may produce some improvement within the first or two weeks of use. Full benefits may not be seen for two to three months. If a patient feels little or no improvement after several weeks, his or her psychiatrist can alter the dose of the medication or add or substitute another antidepressant. In some situations, other psychotropic medications may be helpful. It is important to let a doctor know if a medication does not work or if the patient experience side effects.

Antidepressants are drugs available on prescription from a doctor. Drugs come into use for moderate to severe depression, but are not recommended for children, and will be prescribed only with caution for adolescents.

Psychiatrists usually recommend that patients continue to take medication for six or more months after symptoms have improved. Longer-term maintenance treatment may be suggested to decrease the risk of future episodes for certain people at high risk.

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A number of classes of medication are available in the treatment of depression:
- Selective serotonin reuptake inhibitors (SSRIs)
- Monoamine oxidase inhibitors (MAOIs)
- Tricyclic antidepressants
- Atypical antidepressants
- Selective serotonin and norepinephrine reuptake inhibitors (SNRI)
Each class of antidepressant acts on a different neurotransmitter. The drugs should be continued as prescribed by the doctor, even after symptoms have improved, to prevent relapse.

A warning from the Food and Drug Administration (FDA) says that "antidepressant medications may increase suicidal thoughts or actions in some children, teenagers, and young adults within the first few months of treatment." Any concerns should always be raised with a doctor including any intention to stop taking antidepressants. The patients of all ages taking antidepressants should be watched closely, especially during the first few weeks of treatment.

**Common side effects of antidepressants are:**
- Nausea and vomiting
- Weight gain
- Diarrhoea
- Sleepiness
- Sexual problems

Other more serious but much less common side effects listed by the FDA for antidepressant medicines can include seizures, heart problems, and an imbalance of salt in the blood, liver damage, suicidal thoughts, or serotonin syndrome (a life-threatening reaction where body makes too much serotonin). Serotonin syndrome can cause shivering, diarrhea, fever, seizures, and stiff or rigid muscles.

**How Should Antidepressants Be Taken?**
People taking antidepressants need to follow their doctor’s directions. The medication should be taken in the right dose for the right amount of time. Once a person is taking antidepressants, it is important not to stop taking them without the help of a doctor. Sometimes people taking antidepressants feel better and stop taking the medication too soon, and the depression may return. When it is time to stop the medication, the doctor will help the person slowly and safely decrease the dose. It’s important to give the body time to adjust to the change. People do not get addicted, or "hooked,” on the medications, but stopping them abruptly can cause withdrawal symptoms. If a medication does not work, it may be helpful to be open to trying another one.

**Self-help and Coping**
There are a number of things people can do to help reduce the symptoms of depression. For many people, regular exercise helps create positive feeling and improve mood. Getting enough quality sleep on a regular basis, eating a healthy diet and avoiding alcohol (a depressant) can also help reduce symptoms of depression.

Depression is a real illness and help is available. With proper diagnosis and treatment, the vast majority of people with depression will overcome it. If a person experiencing symptoms of depression, a first step is to visit his/her family physician or psychiatrist. Talk about the concerns and request a thorough evaluation. This is a start to addressing mental health needs.

**Beyond Treatment: Things To Do**
If any patient is suffering from depression, then he/she may feel exhausted, helpless, and hopeless. It may be extremely difficult to take any action to help. But as he/she begin to recognize he/she depression and begin treatment, he/she will start to feel better. Here are other tips that may help he/she or a loved one during treatment:
- Try to be active and exercise. Go to a movie, a ballgame, or another event or activity that he/she once enjoyed.
- Set realistic goals for he/she.
- Break up large tasks into small ones, set some priorities, and do what he/she can as he/she can.
- Try to spend time with other people and confide in a trusted friend or relative. Try not to isolate and let others help himself/herself.
- Expect his/her mood to improve gradually, not immediately. Do not expect to suddenly “snap out of” his/her depression. Often during treatment for depression, sleep and appetite will begin to improve before depressed mood lifts.
- Postpone important decisions, such as getting married or divorced or changing jobs, until he/she may feel better. Discuss...
decisions with others who know well and have a more objective view of situation.

- Remember that positive thinking will replace negative thoughts as depression responds to treatment.
- Continue to educate about depression.

FACTS AND STATISTICS ON CLINICAL DEPRESSION

Depression is a prevalent phrenic illness occurring in children, teenagers and adults. According to melancholy facts, it's estimated the lifetime prevalence of depressive disorder in the United States is 20% in women and 12% in men. It's not known why the despondence statistics vary by gender, but a possible answer is women are more open to discussing their emotional health and are diagnosed more frequently. Another little known despondence fact: despondence symptoms become more astringent with age.

According to depression statistics, 70–80% of people with major depressive disorder (MDD) experience consequential reduction in symptoms when treated. Nevertheless, many people perpetuate to live with dejection and do not seek treatment. Facts about untreated melancholy include:

- 40% of people will continue to meet the diagnostic criteria in one year if not treated.
- People with untreated depression die, on average, 25 years sooner.
- Children born to depressed mothers show increased irritability, less attentiveness, fewer facial expressions and lower birth weights.

Rates of depression and apprehensiveness among teenagers have incremented by 70 per cent in the past 25 years. This is the most astronomically immense population-predicated study from India to report on prevalence of dejection and shows that among urban south Indians, the prevalence of melancholy was 15.1%. Age, female gender and lower socio-economic status are some of the factors associated with dejection in this population. Data from multiple studies point that noetic health-cognate quandary is a solemn issue. The National Noetic Health Survey 2015–16 conducted by National Institute of Noetic Health and Neuro-Sciences (NIMHANS), reported phrenic morbidity of 10.6% among those who are aged 18 and above. The rate was marginally lower, 7.5%, among the youth (18–29 years). A World Health Organization report relinquished in 2017 estimated that more than 56 million individuals in the country face depressive disorders currently. A recent study published in the Asian Journal of Psychiatry predicated on a survey of more than 700 arbitrarily culled students found that virtually a moiety of them (53%) were suffering from either moderate or astringent form of dejection [4, 5].

CONCLUSION

Depression can affect anyone, whatever age, sex, or social status. Depression increases the risk of other non-communicable diseases, such as diabetes and cardiovascular disease. In addition, diseases such as diabetes and cardiovascular disease increase the risk of depression.

- Depression is a common mental disorder that affects people of all ages, from all walks of life, in all countries.
- The risk of becoming depressed is increased by poverty, unemployment, life events such as the death of a loved one or a relationship break-up, physical illness and problems caused by alcohol and drug use.
- Depression causes mental anguish and can impact on people’s ability to carry out even the simplest everyday tasks, with sometimes devastating consequences for relationships with family and friends.
- Untreated depression can prevent people from working and participating in family and community life.
- At worst, depression can lead to suicide.
- Depression can be effectively prevented and treated. Treatment usually involves either a talking therapy or antidepressant medication or a combination of these.
- Overcoming the stigma often associated with depression will lead to more people getting help.
- Talking with people a person trust can be a first step towards recovery from depression.
REFERENCES

The most common mental health disorders can be prevented and treated, at relatively low cost.

Cite this Article