DEPRESSION : A HAZARDOUS STATE OF HUMAN LIFE

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Abstract

Day by day the prevalence of depression is increasing. Our youngsters are passing through a phase of transition where our society is getting changed due to modern technology. Apart from this there is excessive competition in every field of life. It is much of importance to understand this disorder so that it can be prevented to occur. All youngsters are our future citizens. I feel it is must on our part to understand this negative state of mental health so that further steps can be taken to prevent the onset of depression.

Key words: Depression; mental state; young people; comorbidity

Introduction

Depression is a feeling or state that is inner directed and usually accompanied by over controlled behavior. It is a complex state ranging from unhappiness to life threatening stupor. Depression is defined clinically as an emotional state with retardation of psychomotor and thought process, a apathetic emotional reaction, feeling of guilt, hopelessness or unworthiness. Depression is derived from latin word deprimere, meaning " to press down". It is a condition in which a person feels discouraged, sad, immotivated, or disinterested in life in general. These feelings are accompanied by persistent problems in other areas of life e.g. appetite changes (increase or decrease), changed sleep patterns, diminished ability to think. Depressive experience and disorders have long been a source of concern in western cultural traditions. Hippocrates (330-399) included melancholia within his tripartite classification of disorders (i.e. mania, melancholia, phrenitis). He considered its cause to be a function of excessive black bile. Melancholy was used extensively in Europe until the 17th century when the term depression was derived. Depression can refer to a mood state, a subjective feeling, a collection of clinical signs or disease entity. In certain circumstances, people subject to severe and prolonged stress, develop a mode of protective adaptation which might be regarded as existential rather than clinical depression. A genuine clinical depression is an intense and palpable state that has a debilitating effect on the individual.

The depressed person often appears lost, vulnerable, detached, and unable to find joy in any aspect of life. Thought about self are likely to be overwhelmingly negative. The person may feel incompetent, inferior or unsuccessful at work. The future may seem blank, and this may be one important reason of suicide. When these feelings last for more than two weeks it is likely a major depressive episode. Depressed individual becomes dull and lazy. He/she withdraws from society and prefers to live in a secluded environment. The individual has ideas in a negative direction. Such individuals always feel insecured, angry, looses interest in social life and sexual life. Their will power and self confidence is shattered and sometimes they are so frustrated that they suffer from insomnia that leads to headache. In depressive disorders sleep disturbances are very common. Typically sleep is lighter throughout the night. The process of dreaming is not altered but contents becomes gloomy or frightening. Young sleep longer than usual during their

depressive episodes. There is lack of enjoyment of food and can progress to almost total anorexia.

Review of Literature

There are different sets of symptoms of depression. These symptoms are emotional, cognitive, motivational and physical. A person need not have all of these to be diagnosed as depressed but the more symptoms he or she has, the more intense the individual is suffering from depression. He/she does not have any interest in hobbies, recreation or any activity. They have low self esteem, insomnia, lack of energy, feeling of worthlessness. They become unsocial. Sadness and rejection are the most silent emotional symptoms of depression. Tasks are postponed or avoided and this is accompanied by indecisiveness, self depreciation and lack of confidence. Many children and youth with depression will not necessarily be troublesome to parents and teachers, and because adults may not recognize any overt symptom, such a child or youth can easily fall through cracks. Depression is one of the most common disorders in young people with an estimated life time prevalence ranging 15% to 20% (Essau & Dobson,1999).After reviewing six community studies Angold & Costello (1993) concluded that the presence of depression in adolescent increased the probability of the presence of another disorder by at least 20 times. The most common comorbid disorder with depression is anxiety.

People may face life long struggles due to depression and in some cases it may even be lethal. It is often associated with a constellation of psychological, behavioral and physical symptoms as well (Cassano & Fava,2002). Depression is recurrent disorder and is accompanied by impairment in various life areas, not only during the worst depressive episode but also when the criteria for depression are no longer even met. Despite the impairment, a large proportion of depressed persons in the community do not receive professional help (Essau, Conradt & Peterman,2000; McGree, Feehan & Williams, 1995). For presenting depressive disorders in people, comorbid syndromes are rule rather than the exception, but their validity as clinical markers of etiologic difference within the group of conditions remain unclear (Angold et. al.,1999). Studies have found that 3-9% of teenagers meet criteria for depression at any one time, and at the end of adolescence as many as 20% of teenagers reported a lifetime prevalence of depression (Zuckerbrot and Jensen,2006).

Researchers believe that biological factors also play an important role in development of depression. It may be caused by low levels of some of the neurotransmitters in the body. Researches showed that people who use a depressive attributional style were more likely than others to become depressed when things go wrong in their lives (Anderson and others, 1987; Nolen-Hoeksema and others, 1986).

There are different sub types of depression that may incorporate different interpersonal problem area. The symptoms of depression consist of a network of cognitive, affective and interpersonal elements. Thus within a group of depressed persons, one may suffer from social skills deficits leading to loneliness; another may experience particular difficulties allowing for intimacy; while a third person just as depressed, may feel completely unable to take an aggressive stand when necessary. The clinical spectrum of disease can range from simple sadness to a major depressive or bipolar disorder (Son and Krichner, 2000). A study of 9 to 17 yrs. old estimates that the prevalence of any depression is more than 6% in 6 months period with 4-9% having major depression (Shaffer et. al.,1996). The symptoms aches and pains also are relatively common in children and adolescent presenting with estimates in clinical population as high as 70%, (McCauly et. al., 1991). The current data is sparse but it seems that physical symptoms such as pains and aches may be an index of affective disorders in young people. The relation between somatic and depressive features deserves further enquiry in this younger population. Compared with adolescent, somatic symptoms are reported more frequently by younger depressed children but loss of weight, diurnal variation of mood and psychomotor retardation were less pronounced in youth than in adulthood, (Cooper & Goodyer, 1993; Kolvin et. al.,1991). In adolescence persistent sad mood especially with overt functional impairment may be an indicator of an evolving depressive disorder (Compas et. al., 1993). The symptoms of hopelessness is a significant predictor of completed suicide among already depressed adults (Brown et.al., 2000).

According to Freud's psychoanalytical theory, depression is result of overly demanding superego i.e. one who sets high standards to live up or from early loss of attachment figures. The cognitive style of depressive person is best described as pessimistic. Depressives not only expect that the worst will happen, they despair that life will never improve. The negative things, the depressed people say, represent direct manifestations of fundamental cognitive distortions or erroneous way of thinking about themselves. These pervasive and persistent negative thought

presumably play a central role in the onset of depression. There are various distortions, errors and biases that characterize the thinking of depressed people. These include tendencies to assign global, personal meaning to experience of failure, to over generalize conclusions about the self based on negative experience. Although originally trained in psychoanalytic mold, Beck has described a cognitive model for understanding personality and depression. (Beck, 1983; Beck at. el., 1979). Beck proposes that helplessness and hopelessness lie at the centers of depressed people. A social cognitive model for depression has been proposed that postulates that dysphoric mood and dysfunctional thinking are more apparent among individuals with a previous history of depression increasing the tendency to further episodes through biases in recall of negative thoughts about the self (Teasdale and Barnard, 1993). Many depressed individuals may be unable to perform well in academic because they do not have courage in what they are doing. They may feel that they are not reaching the standard of performance set for them.

Types of Depression

Many subgroups of depression have been proposed, both on clinical grounds and statistical manipulations of the data from the group of patients. According to International Foundation for Research and Education of Depression (2005) there are three main types of depression:

- Dysthymia.
- Bipolar Disorders.
- Major Depression.

In dysthymia, the person experiences only the repeated mild depressive spells, which last for a few hours or days or weeks or months. It is a chronic disorder with a duration of at least two years with two or more symptoms as appetite and sleep disturbance, low energy and self esteem, poor concentration and indecisiveness and feelings of hopelessness. These symptoms cause distress and impairment. Dysthymia is less common than major depression but in both conditions, impaired functioning can be very marked.

Bipolar disorder involve mood fluctuations. In this disorder the individual is sometimes elated and sometimes depressed. The depression or elation may last for a few days, weeks or months. During the period of depression some individuals become irritable and get angry easily. Family member may find it difficult to cope with their irritability and violence. Sometimes they become

a management problem for their families. Some tire easily. Depression causes lack of interest and lack of self confidence. Their speed in work comes down and they find difficult to make decision.

Major depression requires five or more characteristic depressive symptoms to be present during the some two-week period and to represent a change from previous functioning. At least one of these symptoms is either depressed mood or loss of interest or pleasure. The symptoms must cause clinically significant distress or impairment in social, occupational or other areas of functioning.

According to a study by Bland (1997) depression is the most common mental health disorder. It is a leading cause of disability worldwide, as measured by years of life lived with a severe impairment. Seasonal depression or seasonal affective disorders are also recurrent disorders that regularly emerges usually during September to November and also weaken at a specific time of year (usually March to May). Seasonal depression is estimated to strike one in seven of all depressed individuals or two to four percent of general population. The possible causal factors of seasonal depression though not proven, are fewer daylight hours, winter temperatures and barometric pressure.

Major Risk Factors

The most commonly identified broad risk factors include cognitive factors, family factors, financial factors, life events and genetic factors.

Cognitive factors

In line with cognitive theories of depression, negative or maladaptive belief system plays an important role in onset and maintenance of disorder. Depressed persons of both sexes show low perceived control and excessive pessimism. They also display depressive attributional styles e.g. they blame themselves for failures and attribute positive experience to external sources (Essau 2002; King, Naylor, Segal, Evan and Shaip, 1993).

Family Factors

The unhealthy relationships may be one of the cause of depression. The mechanism responsible for transmission of depression from parents to children is unclear. However dysfunctional parent-child interaction, marital conflict, emotional unavailability of parent and genetic factors

have been proposed (Essau & Marikangas, 1999; Gotlib & Sommerfield,1999). A high proportion of depressed adolescents report the presence of other disorder in their parents, including alcohol, drug & anxiety disorders.

Financial factors

Financial pressure may be one of the important causal factor of depression. Accordingly to several studies it has been found that there is negative relationship between financial strain and depression. Especially lower income is associated with depression symptomatology (Blazer, Hughes and Fowler, 1989).

Life Events

Specific life events that significantly predicted depression included death of a parent before age of 15 years, pregnancy and health problems interfered with daily functioning specially in females (Reinherz et. al., 1993). Numerous studies have linked negative life events and chronic stressors with concurrent depression (Essau,2002; Lewinsohn, Clarke, Seeley & Rohde, 1994). In Breeman Adolescent Study (Essau, 2002) negative life events such as end of a romantic relationship were associated with the onset of depression, whereas chronic life conditions e.g. (daily hassles) were related to depression. Life events such as bereavement, loss of employment, loss of self esteem may precipitate a reactive depression.

Genetic Factors

Various studies suggest that genetic factors are some how involved. The process of neural transmission in brain is dysfunctional in some individuals. In some cases hormonal abnormalities are regularly associated with depression.

Self Esteem and Depression

One of the most basic responses to any object is evaluation and the most important thing in one's life is the self. Self esteem is seen to be an enduring, characteristic level of self evaluation. Deficiencies in self esteem have been blamed for problems as diverse as depression, unwanted pregnancies, illiteracy and child abuse (Branden 1994; Mecca, Smelser & Vasconcelles,1989).

Normal depression weakens different skills. It weakens performance because preoccupation with unhappy thoughts lowers a person's level of attention and reduces their capacity to focus

attention (Hertel, 1992; Yesavage et. al., 1989). Even normal ups and down affect academic performance because they affect how we feel physiologically (Cacioppo, Petty & Morris, 1985). In a study by Hokanson et. al., (1980) it was found that depressed student send strong messages of self de-evaluation, sadness and helplessness to their newly acquainted laboratory partners.

Suicide is one of acute emergencies resulting in deaths. It may occur for a number of reasons, including depression, shame, guilt, desperation, physical pain, financial difficulties etc. First the future seems gray to patients, then black. They wish they had never been born and that they could fall asleep and not wake up. Existence is bleak or agonizing and it seems logical to end it all. Recent research reiterates that suicide is a leading cause of death among adolescents and adults (Cicchetti and Toth, 1998).There is undoubtedly a strong relationship between depression and self destructive acts. Depressive disorders have high comorbidity rates with other serious mental disorders including substance abuse, anxiety and schizophrenia (Weissman et. al., 1996). Major depression has been reported as fourth leading cause of disease burden worldwide (Murray and Lopez, 1997). In the study by Ryan and Colleagues (1987) suicidal ideation was found associated with both negative cognitions and the conduct factor. Suicide ideation among youth may have a unique etiology because of developmental transitions that occur in young adulthood including changes in family relationship, more opportunities for drug use.

Suicide is perceived as s social problem in our society, and hence mental disorders are given equal status with social maladjustment, family relationship etc. The family generally perceived by society as a unit responsible for providing children with an environment that serves their physical and emotional needs. Majority of suicides in India are by those below the age of 30 years.

Psychiatrist held lack of tolerance and stress prompt the person to take extreme step. Different family processes have significant relationships with adolescent suicidal ideation. Family disorganization, conflicts, lack of control, cohesion and expressiveness have been observed as common factors in the family background of children develop suicidal behavior (Asarnow, 1992; Asarnow et. al., 1987; Campbell et. al., 1993).

Different culture and individual view the act of suicide in different ways similarly there are a number of different factors that can drive one to commit suicide. These factors are called triggers and reflect different segments of population that are at risk for suicidal tendencies. Suicide is

often commited out of despair, the cause is attributed to a mental disorder such as depression, schizophrenia or drug abuse etc. Stress factors such as financial difficulties also play a significant role.

The rapidly increasing number of mental patients has become an alarming issue. Mental health is a vitally important aspect of our life. It has long been segregated and neglected. Mental illness suddenly bulks very large indeed. All predictions are that the future will bring a dramatic increase in mental problems. It is the time to move mental health into the mainstream of health policy and practice.

Epilogue

The present article is an attempt to understand the problem of depression. It is a curable mental disease. The supervision of specialists like Counselors, Psychiatrists or Psychologist may be very effective in prevention and cure. As it is also clear that the depression is a major cause of suicide, the utmost care should be taken to prevent the onset of depression.

There are a number of characteristics of depression that make them particularly difficult to assess and treat. The heterogeneity among youngsters who have this disorder, the high degree of comorbidity with other problems in adjustment, combine to make this a complex undertaking. Effective prevention and treatment of this disorders in general education settings may require an emphasis on a social curriculum in which student learn about and become aware of each others strengths and weakness and learn how to help others. It is high time when schools, colleges and parents altogether have to think that in what best way they can nurture our young people.

As a final note this article clearly place paramount importance on prevention efforts so that this negative state of mental health can be prevented or treated before this develop into a serious and life threatening problem. This exciting area for research has far reaching implication not only for the prevention & treatment of serious disorder but also for the healthy functioning of society.

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