A Review on managing depressive symptoms

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Abstract - **This article gives a review of recent literature, current and ongoing research in the field of prevention and managing depressive symptoms. Major depression is a mood disorder characterized by a sense of inadequacy, despondency, decreased activity, pessimism, anhedonia and sadness where these symptoms severely disorganized and adversely affect the person's life, sometimes to such an extent that suicide is attempted. It highlights the efforts employed in targeting fenceless and susceptible individuals at higher risk of causing depressive symptoms. Prevention efforts should target both the specific and non-specific risk factors of depression, increase protective factors, use a developmental approach, and target selective and/or indicated samples. Overall, it come into view that there is a reason for hope regarding the role of intercession in preventing depressive symptoms in high-risk groups. It is also important to keep in mind that the diagnosis is often unclear to patients, especially the elderly, tend to present with only complaints of physical symptom of depression**

keywords - **Depression, Prevention, Susceptible, protective, approach, elderly, symptoms**

Introduction

Depression is more than just feeling sad or currently happen through a rough patch. It's a serious mental health condition that requires understanding of patient mental condition and proper medical care. Left untreated, depression can be devastating for the people who have it and for their families. Fortunately, with early detection, diagnosis and a treatment plan consisting of medication, psychotherapy and good lifestyle choices, many people do get better and managing their depressive symptoms [10].

What is depression?

Depression and anxiety disorders are not the same, but people with depression or depressive symptoms also having or receive nervousness, irritability, and problems in sleeping and concentrating and other symptoms similar to an anxiety disorder. It is not uncommon for someone with an anxiety disorder to suffer from depressive symptoms and vice versa. Depression is a significant contributor to the global burden of disease and affects people in all communities across the world. The demand for curbing depression and other mental health conditions is on the enhance globally [3].

Nearly one-half of those diagnosed with their depressive symptoms are also diagnosed with an anxiety disorder. Depression is common problem in the population and is repeatedly encountered in the under writing environment. It is state of low mood and mope that can affect a person's thoughts, feelings, behaviour and sense of behalf. It is a very serious and incapacitates psychiatric condition that occasionally leads to suicidal or premature death due to unattended physical and mental problems. The annual prevalence of major depressive symptoms is 6.6% and the lifetime prevalence of depression is 16.2% are affected by depression [1].

Worldwide, 804,000 people committed suicide in 2012, making depression one of the leading reason of death in young adults (15-29 years) second to road traffic accidents. Persons with major depression have a 40% greater chance of dying prematurely and lead to suicide than the general population [2]. Today, depression is estimated to affect 350 million people. The world mental health survey in 17 countries found that on average about 1 in 20 people reported having an episode of depression in the previous year. Depressive disorders often start at a young age; they reduce people's functioning often are coming back. For these reasons, depression is the leading cause of disability worldwide in terms of total years lost due to disability [14].

Managing depressive symptoms

Depression is a disorder that can be diagnosed and treated in primary care. As outlined in the WHO mhGAP intervention guide, preferable treatment options consist of basic psychosocial help combined with antidepressant medication or psychotherapy, such as cognitive behaviour therapy, interpersonal psychotherapy or problem solving treatment. The intervention consisted of case management and psychosocial interventions led by a trained lay health counsellor, as well as supervision by a mental health specialist and medication from primary care physician.

The trial cast that patients in the mediation group were more likely to have recovered at 6 months than patients in the control groups, and therefore that an intervention by a trained lay counsellor can lead to the betterment in recovery from depression. Where data is accessible, this is globally fewer than 50%, but fewer than 30% for most regions and even less than 10% in some countries [26].

Risk factors for depression

Before any discussion on risk factors for depression or depressive symptoms, it is necessary to make it clear that there is a remarkable confusion over what compose a risk factor and how they conduct. Factor to be set up as problem cause, prospective studies must be done where the risk factors are measured this proof to be difficult, and even when this is established; more evidence is needed to prove it as a casual risk factor. The matter is even more complex due to the multi –dimensional view of

depression where these risk factors are not isolated and not passive. There are some risk factors, which are setting factors like race, culture, age, gender and socioeconomic status, etc. In general, there are biological, cognitive and social factors that increase the risk of depression. One of the major objectives of mental health and prevent mental disorders. To achieve this, it is necessary to provide technical support to help countries in selecting, formulating and fulfil evidence-based and cost effective best practices [2].

World Health Organisation (WHO) produced a pervasive mental action plan. The global target is that by 2020, 80% of countries will have at least two functioning national multi-sectoral mental health advancement and prevention programs. If treatment of depression was effective and available to patients, the prevalence of depression should decrease. However, it has been shown that the impact is not changing and is not becoming an "epidemic".

1. Biological factors

About a third of depression cases are linked to genetic factors and the rest to non-genetic or environmental factors. However, evidence of the role of specific genes or specific gene environment associations is not yet established. Even though early life trauma increases the chance of developing depression, not all individuals develop depression; and those who produce it, may do so due to the presence of genetic factors.

2. Psychological factors

Exposure to negative parental effects such a critical and condemning parental style during early childhood may give rise to negative feelings about oneself. The long-term consequences of separation or early loss of the maternal attachment bond are many, and include depressive condition.

3. Social factors

Distressing social relationship such as familial, marital and parental relationships have been related with the onset of depression. Domestic and intimate partner violence among women, which is prevalent in India. Of recent importance is the impact of modernization, urbanization, migration and globalization of family and social support system, leading to social separation.

4. Culture factors

Culture plays a significant role, such as religion, caste, beliefs, attitudes and symptom thresholds, which vary across different parts of India. People with depression often have features related to various sociocultural contexts and may not fit into the classical definition of depression as per set up diagnostic categories.

4. Economic factors

People who experienced acute (sudden economic crisis) or chronic (poor income households) economic adversities are more fenceless to producing depression. Individuals living in conflict zones or at times of natural disasters are also likely to involvement to a greater extent.

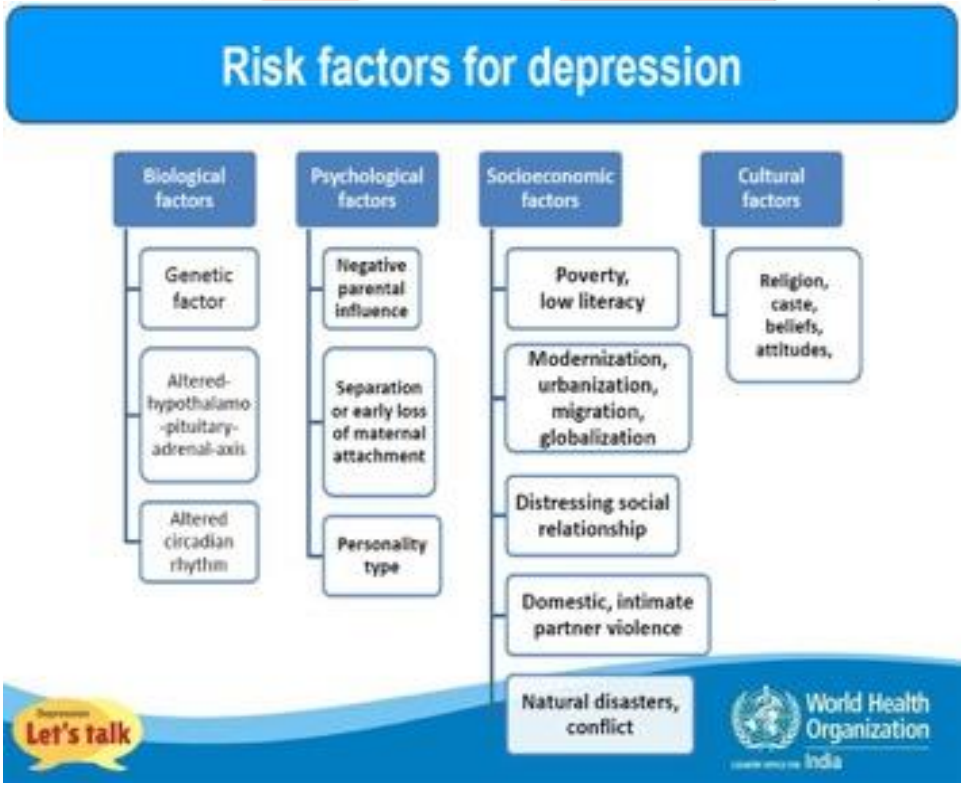

Fig. 1 Risk factors for depression

Symptoms

Just like with any mental illness, people with depression experience symptoms differently. But for most people, depression changes how they intend day-to-day. Common symptoms of depression include:

- Changes in sleep

- Changes in appetite
- Lack of concentration
- Loss of energy
- Lack of interest
- Low self compliment
- Hopelessness
- Changes in movement
- Physical aches and pains

Types of depression

1. Major depression
It involves at least five of the symptoms listed below for a two-week period. Such an episode is disabling and will interfere with the ability to work, study, eat, and sleep. Major depressive episodes may occur once or twice in a lifetime, or they may recur frequently. They may also take place spontaneously, during or after the death of a loved one, a romantic breakup, a medical illness, or other life event. Some people with major depression may feel that life is not worth living and some will attempt to end their lives.

2. Persistent depressive disorder, or PDD
It is a form of depression that usually continues for at least two years. Although it is less severe than major depression, it involves the same symptoms; sad mood combined with low energy, poor appetite or overeating, and insomnia or oversleeping. It can show up stress, irritability, and mild anhedonia, which is the inability to derive pleasure from most activities.

3. Bipolar disorder
Once called manic depression, is characterized by moods that shift from severe highs (mania) or mild highs (hypomania) to severe lows (depression). The mood episodes associated with the disorder persist from days to week or longer and may be dramatic. Severe changes in behaviour go along with mood changes.

Causes
Depression does not have a single cause**,** it is associated with a life crisis, physical illness or other risk.

- Trauma – When people experience trauma at an early age, it can cause long term changes in how their brains respond to fear and stress. These brain changes may explain why people who have a history of childhood trauma are more likely to experience depression.
- Genetics – Mood disorders and risk of suicide tend to run in families, but genetic inheritance is only one factor.
- Life circumstances – Marital status, financial standing and where a person lives have an effect on whether a person develops depression, but it can be a case of "the chicken or the egg".
- Brain structure – Imaging studies have shown that the frontal lobe of the brain becomes less active when a person is depressed. Depressed is also associated with changes in how the pituitary gland and hypothalamus respond to hormone stimulation.
- Other medical condition – People who have a history of sleep disturbances, medical illness, chronic pain, anxiety and attention deficit hyperactivity disorder (ADHD) are more likely to develop depression.
- Drug and alcohol abuse – Approximately 30% of people with substance abuse problems also have depression.

Treatments
Many people with a depressive illness never seek treatment. But most, even those with the most severe depression, can get better with some form of treatment.

- **Medication –** It including antidepressant, mood stabilizers and antipsychotic medications.
- **Psychotherapy –** It including cognitive behavioural therapy, family focused therapy and interpersonal therapy.
- **Brain stimulation therapies –** It including electroconvulsive therapy (ECT) or repetitive transcranial magnetic stimulation.
- **Exercise**
- **Alternative therapies –** It including acupuncture, medication and nutrition**.**
- **Self-management and education**
- **Mind/body/spirit approaches**

Fig. 2 Integration and collective impact

Medications

Symptoms of depressive disorders respond to different classes of medications. Selective serotonin reuptake inhibitor (SSRI) and serotonin norepinephrine reuptake inhibitor (SNRI) medications are the treatment of choice. SSRIs and SNRIs have fewer side effects than many of the medications prescribed in the past. These medications must be taken for at least two to four weeks to experience their full effect, and it may take several weeks to adjust the medications to correct the dosage.

1. Selective serotonin reuptake inhibitors (SSRIs)

Doctors often start by prescribing an SSRI. SSRIs relieve symptoms by blocking the reabsorption, or reuptake, of serotonin by certain nerve cells in the brain. This leaves more serotonin available, which improves mood. SSRIs (citalopram, fluoxetine, paroxetine and sertraline) generally produce fewer side effects when compared with tricyclic antidepressants. However, common side effects include insomnia or sleepiness, sexual dysfunction and weight gain.

2. Serotonin and norepinephrine reuptake inhibitors (SNRIs)

The serotonin-norepinephrine reuptake inhibitor, or SNRI, class (venlafaxine and duloxetine) is notable for a dual mechanism of action increasing the levels of the neurotransmitters serotonin and norepinephrine by inhibiting their reabsorption into cells in the brain. As with other medications, side effects may occur, including stomach upset, insomnia, headache, sexual dysfunction and minor increase in blood pressure.

3. Norepinephrine and dopamine reuptake inhibitors (NDRIs)

In this category is Bupropion, one of the few antidepressants not frequently associated with sexual side effects.

4. Atypical antidepressants

These medications include trazodone and mirtazapine, which are sedating and usually taken in the evening. Tricyclic antidepressants (amitriptyline, imipramine and nortriptyline) tend to cause more severe side effects than do newer antidepressants.

5. Monoamine oxidase inhibitors (MAOIs)

MAOIs (tranylcypromine and phenelzin) may be prescribed when other medications haven't worked, but they can serious side effects. Using MAOIs requires a strict diet because of dangerous (or even deadly) interactions with foods (certain cheeses, pickles, draft beer and other aged foods) and some medications including, birth control pills, decongestants, and certain herbal supplements. A selegiline skin patch at low dose does not cause food interactions. None of these medications can be combined with SSRIs.

6. Other medications

Other medications may be added to an antidepressant to enhance antidepressant effects. Your doctor may recommend combining two antidepressants or medications such as mood stabilizers or antipsychotics. Anti-anxiety and stimulant medications might also be added for short term use.

Conclusion

Depression is a mental disorder that is comprehensive in the world and affects us all. Efficacious and cost-effective treatments are available to the better health and the lives of the millions of people around the world suffering from depression. On an

individual, community and national level, it is time to educate ourselves about depression and help those who are suffering from this mental disorder. Pending such research, clinicians should consider both current active pharmacological and psychological treatments and benefits of protective plans and approaches to overcome barriers to accessing treatment for depressive disorders. There is also a need to study the course of depressive disorders present in the world so as to determine the need and duration of continuation treatment. Studies should also evaluate the cost-effective models of treatment which can be easily used in the primary care setting to successfully treat depression.

Future scope

The evidence is convincing that depression can be prevented. The task is to translate this knowledge into an actual action that will change the life of many people and will eventually save life and money. More studies are needed to answer the questions related to other less studied protective measures like food, nutritional supplements and exercise.

References

1. Zaved khan, Depression- A review, Research journal of recent sciences, vol-1, issue 4, p.p 79-87, 2012.
2. Al Qahtani A, prevention of depression: A review literature, journal of depression and anxiety, vol-6, issue 4, p.p 1-6, 2017.
3.Kessler R.C., McGonagle K.A., Zhao S., et al., Lifetime and 12-month prevalence of DSM-IIIR psychiatric disorders in the United States, p.p 8-19, 2003.
4. Robins L., Regier D., Psychiatric Disorders in America, New York: Free Press, 2004.
5. Md. Nasir Uddin Mina, Depression among elderly people: A literature review, p.p 5-47, 2017.
6. Organization, Geneva, Preventing Suicide, A global imperative. World Health Organization, Geneva.
7. Dilsaver SC, An estimate of the minimum economic burden of bipolar I and II disorders in the USA. J Affect Disord 129:p.p 79-83, 2011.
8. Chisholm D, Sweeny K, Sheehan P, Rasmussen B, Smit F, Scaling-up treatment of depression and anxiety: A global return on investment analysis. Lancet Psychiatry 3: 415-24, 2016.
9. Miller CJ, Abraham KM, Bajor LA, Lai Z, Kim HM, Quality of life among patients with bipolar disorder in primary care versus community mental health settings. J Affect Disord 146: p.p 100-105, 2013.
10.National alliance on mental illness, Depression ,march 2015, (http://www.nami.org/Learn-More/Mental-Health-Conditions/Depression).
11. Depression and other common mental disorders: global health estimates. Geneva: World Health Organization; 2017 (http://apps.who.int/iris/handle/10665/254610, accessed 25 March 2017).
12. Saxena S, Krug EG, Chestnov O, World Health Organization, editors. Preventing suicide: a global imperative. Geneva: World Health Organization; 2014.
13. GHDx – GBD Results Tool [website]. Seattle: Institute for Health Metrics and Evaluation; 2017 (http://ghdx.healthdata.org/gbd-results-tool, accessed 25 March 2017).
14. WHO. Health statistics and information systems – Estimates for 2000–2015 [website]. Geneva: World Health Organization; 2017.(http://www.who.int/healthinfo/global_burden_disease/estimates/en/, accessed 25 March 2017).
15. National Mental Health Survey of India, 2015–16. Prevalence, Pattern and Outcomes. [website]. Bengaluru: National Institute of Mental Health and Neuro Sciences;2016. (http://www.nimhans.ac.in/, accessed 25 March 2017).
16. Katon W. The epidemiology of depression in medical care, *Int J Psychiatry Med*, 17, p.p 93-112,2006.
17. Judd L.L., The clinical course of unipolar major depressive disorders Arch Gen Psychiatry, 54, p.p 989-99,2008.
18. Greenberg P.E., Stiglin L.E., Finkelstein S.N. and Berndt E.R., The economic burden of depression in 1990, *J Clan Psychiatry*, 54 , p.p 405-418, 2009.
19. Blair-West G.W., Mellsop G.W. and Eyeson-Annan M.L., Down-rating lifetime suicide risk in major depression, *Acta Psychiatr Scand*, 95, p.p 259-263, 2010.
20. Harris E.C., Barraclough B., Suicide as an outcome for mental disorders, *A meta-analysis Br J Psychiatry*, 170, p.p 205-228, 2001.
21.Nock MK Recent and needed advances in the understanding, prediction, and prevention of suicidal behaviour: Editorial. Depression & Anxiety 3: p.p 460-463, 2016.
22. Stockings EA, Degenhardt L, Dobbins T, Lee YY, Erskine HE, Preventing depression and anxiety in young people: A review of the joint efficacy of universal, selective and indicated prevention. Psychol Med 46: p.p 11-16, 2015.
23. Brugha TS, Smith J, Austin J, Bankart J, Patterson M, can community midwives prevent antenatal depression? an external pilot study to test the feasibility of a cluster randomized controlled universal prevention trial. Psychol Med 46: p.p 345-412, 2015.
24. Jørstad HT, Minneboo M, Helmes HJM, Fagel ND, Peters JG,Effects of a nurse-coordinated prevention program on health-related quality of life and depression in patients with an acute coronary syndrome: Results from the RESPONSE randomized controlled trial. BMC Cardiovasc Disord 16: 144, 2016.
25. Zwaanswijk M, Kösters MP, Children's and parents' evaluations of 'Friends for life', an indicated school-based prevention program for children with symptoms of anxiety and depression. Behaviour Change 32: p.p 243-254, 2015.
26. Marina Marcus, Depression, a global public health concern, WHO department on mental public health and substance abuse, p.p 6-8, 2012.