Major depressive disorder symptoms

Major depressive disorder MDD, clinical depression – in contrast to the usual depression, which refers to almost any bad or depressed, melancholy mood, major depressive disorder is a complex of symptoms. Moreover, MDD may not be accompanied by low mood, depression or grief – the so-called depression without depression, or masked depression. If the symptoms described below lasted more than two weeks and begin to interfere with normal life, work or school, social functioning, it is reason to suspect MDD or depressive symptoms (associated with bipolar affective disorder).

According to sociological research, not less than 16% of the population experienced conditions that fall under the diagnostic criteria of ICD-10 for BDR at least once in their lifetime. However, less than half the people who experience these effects, treated or treated for medical and / or psychological help, and received an official diagnosis.

“ Great” depression – is the fundamental reason of temporary disability in the U. S. and other countries and is likely to become the second leading cause of temporary disability in the world by 2020, according to World Health Organization.

Women BDR observed almost twice as often, although this imbalance in recent years reduced. With an increased frequency of “ major depression” occurs in homosexuals of both sexes (more than twice as likely than the average population) and those with gender identity disorders – transgender and transsexual. Major depressive disorder is also more prevalent among the population of major towns and cities compared with a population of small cities, towns and villages, most often among people in developed countries

than underdeveloped and developing countries. Probably, this difference is largely due to improved diagnosis, higher levels of medical and health care and greater awareness of the population of developed countries and especially the major cities that is depression, and as a consequence, more frequent calls to physicians. But overcrowding and congestion of large cities, the faster pace of life, higher social demands and more stress, and poor environmental situation, apparently, also play a role in the greater prevalence of MDD in developed countries and in major cities, according to Major Depressive Disorder (2005).

Major depressive disorder with an increased frequency occurs among people prone to stress – such as the unemployed, those with poor socio-economic status (lower income, not having their own homes), people working in a heavy, dull, monotonous, unloved or uninteresting work on work related to the increased amount of stress and nervous and mental overload (like executives). Often (but not always) MDD develops after trauma – such as job loss, bankruptcy, serious illness or death of a close loved one, divorce, moving to a new place with the loss of all previous social ties, etc. But often it develops and by itself, for no apparent reason, or from minor, seemingly stress.

Large role in the development of MDD in adolescents and adults are the conditions under which grew and developed in this man as a child. It was shown that persons who were abused in childhood, adolescence or early adulthood (physical abuse: twitching, spanking, slapping, beating, sexual abuse, rape – or (and) mental abuse: abuse, carping from the parent (s) obvious or veiled verbal or behavioral provocation by the parent (s) or other

adult (adults) with respect to the child or young person to make him a sense of guilt, shame, inferiority, worthlessness), in adulthood there is pre-programmed to stress and depressive reaction constant expectation of something bad; elevated compared to normal “ background” levels of the stress hormone cortisol, and there is a sharp rise in cortisol levels during even minor stress than normal, and than in people exposed to stress and ill-treated as adults and formed. In these people, the incidence of “ major depression” is more than 3 times the average rate in the general population. And vice versa – in patients with MDD increased the percentage of persons subjected to any form of violence, humiliation or abuse in childhood, adolescence or early adulthood.

With an increased frequency of “ major depression” occurs in persons whose relatives (especially coming) suffered or suffer from mood disorders such as MDD, bipolar disorder, schizoaffective disorder, and some other mental illness. This indicates the important role of hereditary predisposition in the development of major depression and the possible existence of common mechanisms for the development of a number of disorders having in its composition affective component, according to Major Depressive Disorder (2011).

Near the so-called adherents of psychoanalytic theory in his time completely deny the importance of genetic predisposition, genetic and biochemical factors in the development of MDD. Supporters of the psychoanalytic theory of the origin of depression gave major importance to children’s and adolescent psychological traumas, imprinting, pre-programmed to stress. At the same time a number of so-called biological psychiatrists completely deny

the importance of children’s psychological traumas for the emergence and development of “ major depression” in the adult individual. The main significance of the biological theory of depression was given to genetic disorders and biochemical defects, as well as current or recently impacted stress as a provoking factor. In fact, as it turned out, the truth lies in the middle: the development of any depression in varying proportions involved and hereditary-genetic factors that create a predisposition to depression, lowered resistance to stress, and imprinting in childhood and the current chronic or acute stress has recently impacted as a provocateur of depression. Wrong to deny or underestimate the value of any of these factors and reduce the complex, multifactorial pathogenetic mechanism that leads to depression, to the effects of only one factor, according to Major Depressive Disorder (2011).

The fact is that the exact same symptoms as in the “ major depression” can be observed in various mental and somatic diseases and conditions. But with these diseases and conditions depression is secondary to underlying disease. This state is called the depressive syndrome or a depressive symptom and not an illness. Many people believe that depression is an illness – which has spread and gained so much social significance only in our time and was not known before. But it is not: “ major depression” is known by doctors since ancient times, from ancient times. Another famous ancient Greek physician Hippocrates described in detail under the title “ Melancholy” state, much like our current definition of BDR, and even the recommended treatment – within the capabilities of ancient medicine, of course.

Treatment of depression by Hippocrates consisted in the appointment of tincture of opium, warm cleansing enemas (Hippocrates drew attention to the fact that severe depression is often accompanied by constipation, and attached great importance to), psychological support (recommended patient “ cheer up and cheer”), a long warm bath, massage, and drinking mineral water from a well-known sources of Crete (as it turned out later, already in the times of Paracelsus, this water contained a large amount of bromide ions, magnesium and lithium – that is really able to help with depression).

Hippocrates also drew attention to the dependence of the state of many depressed patients on the weather and time of year, the seasonal periodicity of depression in many patients, to improve the condition of some patients after a sleepless night. That is, he was close to the discovery of the therapeutic effect of sleep deprivation and sunlight, although they have not made this discovery, according to Major Depressive Disorder (2005).

The importance of professional help. According to Major Depression (2010), a man who himself had not experienced clinical depression or not experienced it close enough, it is easy to understand its seriousness, he often sees it as just a “ bad mood”. But the great depression – is a syndrome of symptoms combined, representing a much more than just sadness or low mood. A number of biological measurements, including measuring the level of neurotransmitters in the brain, showed that depression is present in significant changes in the biochemistry of the brain and an overall reduction in brain activity. One consequence of the lack of understanding lies in the fact that depressed patients are often criticized for failing and unwillingness to help themselves. Without treatment, depression tends to progressive

deterioration, intermittent episodes of temporary stabilization. As well, without treatment, depression usually develops from six months to two years before moving into the chronic form, lasting many years (if not before the end of life) and difficult to treat, according to Major Depression (2010).

In a state of clinical depression, it can hurt a person socially (losing relationships with others), professional (losing a job), financially and even physically (up to suicide). Treatment can significantly reduce the likelihood of such damage, including reducing the risk of suicide, which otherwise could be tragic, but very common outcome. Therefore, treatment of MDD is very productive, and sometimes vital.

Critically important in treating clinical depression is a combination of pharmacotherapy (treatment necessary medication – an antidepressant) and psychotherapeutic work properly – namely: study of mental states and personal reactions to these conditions. Such a study can be carried out by the attending physician, therapist or specially trained psychologist. The essence of this work is to attract patients to their own healing and prevention of resistance, the resistance (which may occur in addition to consciousness of the patient) of treatment.

There can be many causes of MDD, and usually lead to an acute state several reasons for the complex. Iron deficiency causes depression simultaneously with anemia, but anemia disappears after taking the iron faster than a bad mood. People who consume large amounts of caffeine (three or four cups of coffee a day or more) usually receive a lot of points in a test designed to detect symptoms of depression.

Many people with depression turn to sweets as a comfort, but medical studies have shown that consumption of sugar increases depression, fatigue and gloom.

If you eat foods high in animal fats, especially fats, there is in meat, then can be enhanced manifestations of depression. Sometimes different circumstances lead people to the major depression and only professional help can be the way out.