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Pespective

The Causes of Violence in Depression and Suicide

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DESCRIPTION

One in six people in the US, or over 17.6 million people each year, suffer from depression, a potentially fatal mood condition. Type 2 diabetes and cardiovascular disease are more prone to occur in depressed persons. Unipolar depression is anticipated to overtake secondary illness states as the second biggest cause of disability globally and the primary cause in high-income countries, including the United States, within the next 20 years. Although the morbidity of depression is hard to measure, its mortality is quantifiable in the form of completed suicide, the tenth most common cause of reported death in the United States.

In the United States alone, the yearly cost of depression is currently estimated to be $30-44 billion. Depression has a significant negative impact on the sufferer's quality of life and interferes with their ability to function, but it also has an impact on those who care about them, sometimes causing the breakdown of family ties or workplace interactions. Therefore, it is impossible to overstate the human cost of suffering.

Up to two thirds of depressed individuals do not seek treatment because they are unaware that they have a medical condition that may be managed. Only 20% of people with major depression who receive any treatment at all do so in accordance with the American Psychiatric Association's current practice recommendations. Only 50% of people with serious depression receive any treatment at all (APA). More concerningly, in a sizable Canadian study, 24% of patients who had attempted suicide and 48% of patients who had suicidal thoughts reported not obtaining assistance or even realizing they needed it.

The public's persistent ignorance about depression and some medical professionals' flagrant misperceptions of the illness as a personal flaw that can be "willed" or "wished away" cause sufferers to endure painful stigmatization and discourage many people who are affected by the illness from seeking a diagnosis. Multiple factors contribute to depression's causes. People with the illness frequently have a familial history of suicide as well as a history of depression.

Other factors, such as alcohol/substance misuse (particularly of opiates and cocaine), impulsivity, and specific familial characteristics, may significantly raise the risk for suicide in addition to depression. A history of mental illness or drug misuse, suicide in the immediate family, any form of familial violence, and separation or divorce is a few of these.

The availability of a handgun in the home, incarceration, and exposure to the suicidal behavior of family members, peers, famous people, or even widely recognized fictitious characters are additional risk factors. It is also known that starting psychotherapy treatment for depression can momentarily raise the prevalence of suicidal ideation and energizing motivation, which, regrettably, can enhance the risk of successful suicide attempts. Healthcare professionals experience depression at a similar rate to the general population, but a higher likelihood of successful suicide. Depressed healthcare professionals should therefore be seen as having a higher risk of attempting or actually committing suicide, especially if they also have burnout or a substance use disease.

Physiologic factors in depression

Changes in the receptor-neurotransmitter interactions in the limbic system, as well as the prefrontal cortex, hippocampus, and amygdala, are hypothesized to contribute to depression. Though dopamine and norepinephrine have also been linked to depression, serotonin and norepinephrine are regarded to be the main neurotransmitters involved.

Neurotransmitters are typically transferred from one neuron to another; after that, they are either reabsorbed into the neuron, where they are either actively withdrawn by a reuptake pump or stored until needed, or they are oxidized by Monoamine Oxidase (MAO), which is found in the mitochondria. Neurotransmitters may be affected by environmental circumstances, such as concurrent illnesses or substance addiction, and/or have an independent impact on depression. It is likely that gene-environment interactions, as well as endocrine, immunologic, and metabolic mediators, play a role in the onset of depression in addition to localizable brain chemistry alterations.

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Studies have shown a significant association between migraine with aura and depression, which may be at least partially explained by hereditary factors. Additionally, there is a symbiotic relationship between depression and fat.

Although it differs from depression clinically, bipolar disorder includes a significant depressive component. Current genetic research is equivocal, however there may be a chromosome II or X abnormality.

Antidepressants and suicide

The US Food and Drug Administration (FDA) released a public health advisory in October 2003 in response to reports of suicidality in children receiving antidepressant therapy for major depressive disorder. The findings of an FDA review published in September 2004 revealed that there was a real risk of emerging suicidality among children and adolescents taking Selective Serotonin-Reuptake Inhibitors (SSRIs). The Psychopharmacologic Drugs Advisory Committee and the Pediatric Advisory Committee of the FDA recommended the following:

- All antidepressants should carry a "black-box" warning label stating that they raise the risk of suicide thoughts and actions (suicidality).
- Every prescription should come with a patient information leaflet (Medication Guide) for the patient and their caregiver.
- Antidepressant medicine labels should reflect the findings of controlled paediatric depression trials.