ORIGINAL RESEARCH PAPER

Psychiatry

CLINICAL DEPRESSION AN - AYURVEDIC PERSPECTIVE

KEY WORDS: Depression, Kaphaja Unmada, Vishada

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ABSTRACT

Depressive disorders are characterized by persistent sadness and loss of interest or pleasure. It affects people of all ages, from all walks of life, in all countries. It is a leading cause of disability worldwide and is a major contributor to the overall global burden of disease. It affects person's daily life and he cannot live effectively. Even with advancement in medications, prevalence rate of depression is very high. In Ayurvedic perspective, alpa satwata (feeble minded) is a predisposing factor for the development of mano vikaras. Depression can be explained under the title of vishada and unmada. Vishada includes the symptoms of mild depression, but moderate to severe forms resembles with the symptoms of kaphaja unmada.

INTRODUCTION

State of wellbeing of mind is essential for maintaining health. In current social scenario prevalence of mental disorders are increasing. Depression is one among such disorder of public health importance in terms of its sufferings, dysfunction, morbidity and economic burden. According to WHO, depressive disorders are characterized by persistent sadness, loss of interest or pleasure, feeling of guilt or low self-worth, disturbed sleep or appetite, feeling of tiredness and poor concentration for at least 2 weeks[1]. It is the leading cause of disability worldwide, and is a major contributor to the overall global burden of disease[2]. At its worst, depression can lead to suicide. Although depression can affect any, the risk of becoming depressed is increased by poverty, unemplo yment, negative life events, physical illness and problems caused by alcohol and drug abuse.

EPIDEMIOLOGY

The globally estimated proportion of population affected with depression is 4.4 %. If current trends for demographic and epidemiological transition continue, the burden of depression will increase to 5.7% of total burden of disease and it would be the 2nd leading cause of DALY second to IHD. It is more common among females (5.1%) than males (3.6%). In India DALYs attributable to depression are projected to rise roughly 2.6 million by 2025[3].

RISK FACTORS FOR DEPRESSION

Depression is multifactorial and there can be no single identifiable cause. There are certain domains like biological, social, economic and environmental etc plays a key role in developing depression. These factors could be grouped under predisposing factors, precipitating factors and perpetuating factors. Depression can affect people at any age, from all backgrounds across the life – course.

1. **Demographic factors** – which includes age and sex. It is approximately two fold more common among women than men. Increased stress sensitivity and multiple social roles make the female gender vulnerable. Age of onset differs between depressive illness and shows much higher lifetime prevalence among people younger than 45 yrs[4]

2. **Social variables** – marital status and mood disorders are complexly related. Being single (divorced/separated/ widowed), negative life events and low socio economic status can be the risk factors for depression. Depression was more frequent in urban residents than in their rural counter parts due to stressful life events[5].

3. **Seasonal and dietary variables** – statistically spring and fall are the peak times for depression. While considering dietary factors, low serum folate levels and omega – 3- fatty acids increase the prevalence of depressive episode.

4. **Psychosocial factors** – social stressors, lack of social support and negative childhood events.

5. **Genetic factors**

6. **Physical illness** – chronic/severe physical illness (parkinson's disease, stroke) is associated with an increased risk of depression. Some chronic disorders of uncertain etiology, such as chronic fatigue syndrome and fibromyalgia, are strongly associated with depression and anxiety[6].

PATHOPHYSIOLOGY OF DEPRESSION[4]

Since antiquity biological factors have been implicated in the pathogenesis of depression. Subjective experience, signs and symptoms associated with depression have long suggested dysfunction of basic central nervous system processes. Several mechanisms with possible role in pathophysiology of depression were identified.

A. Monoamine system

Monoamine hypothesis of depression predicts that the underlying pathophysiologic basis of depression is depletion in the levels of serotonin, norepinephrine or dopamine in the central nervous system.

B. Other neurotransmitter disturbances

i. Acetyl choline – reciprocal relation with monoamine system
ii. GABA – inhibitory effect on monoamine pathway

C. Alterations of hormonal regulation

i. Hypothalamic pituitary adrenal axis (HPA axis)- elevated HPA activity is a hallmark of mammalian stress response. It is evident in 20-40% of depressed outpatients and 40-60% of depressed inpatients.
ii. Thyroid axis activity [7]– 5-10% of people evaluated for depression have hypothyroidism

D. Alterations of sleep neurophysiology

In depression, premature loss of sleep and nocturnal arousal is found. The disturbed sleep could be due to an increased cholinergic or decreased serotonergic/noradrenergic drive

E. Immunological disturbances

Includes decreased lymphocyte proliferation in response to mitogens and other forms of impaired cellular immunity. There is increasing evidence that depression is a pro-

inflammatory condition, which may partly explain the increased incidence of comorbid disorders such as obesity, diabetes and atherosclerosis.

SIGNS AND SYMPTOMS

The most important feature is sadness of mood/loss of interest in activities. Sadness of mood results in feeling of hopeless, helpless and worthless[8]. Other features are difficulty in thinking, difficulty in concentration, indecisiveness, poor memory, lack of initiative and energy. Suicidal ideations are more frequent in depressed individuals. Some patients may present with psychotic symptoms such as delusions (delusions of guilt/poverty, nihilistic delusions) and hallucinations. Depending on the number and severity of symptoms, a depressive episode can be categorized as mild, moderate and severe. Hamilton Rating Scale for Depression can be used to score and assess the severity of depression.

AYURVEDIC PERSPECTIVE

Ayurveda the science of life defines health as the equilibrium between body, soul and mind[9]. A person is said to be healthy, when his body and mind are properly functioning. Disorders of body and mind are interconnected and any kind of physical illness imparts its effect on mana. Derangement in mental functioning also results in various kinds of mental disorders. In classics of Ayurveda, psychiatric disorders are described under the title of unmada and apasmara.

Symptoms of depressive illness cannot be found exclusively under a single heading in Ayurvedic texts. Many of the symptoms are scattered under different titles. When the features of depressive illness are compared with ayurvedic terminologies, many of the symptoms will resemble with kaphaja unmada, adhija unmada, vishada, avasada and tantra.

Depression and Tantra

Tantra is a condition characterised by hridaya vyakuleebhava (sadness of mood), gourava in vak-cheshta-indriya (poor speech, activities & functions of sense organs) manobudhi aprasada (reduced clarity of mind). These syptoms directly point to the features of depressive illness.

Depression and Avasada

Avasada can relate with the fluctuation of mind with adverse situations (anavasthita chitta). It is a classic symptom in depressive patients.

Depression and Vishada

Vishada is one of the vatika nanatmaja vikara. Lack of vishada bhava is one among cardinal features of satwa sara and avara or heena satwa is prone to vishada. Acharya Dalhana comments that vishada is lack of interest in daily activities due to fear or loss. Depressive illness directly cannot be correlated with vishada as such. It may be depression in milder form but major depression is different from vishada.

Depression and Adhija unmada

Adhija unmada results from the disturbance of mental equilibrium precipitated by psychological trauma such a natural calamities, death of loved ones, attempt to robbery, loss of money etc. This condition presents features similar to depression, as deenata (miserable facies), akasmath rodana (crying without reason), sokaklishta mana (mind suffering from grief) jagarooka(insomnia).

Depression and Kaphaja unmada

In moderate to severe forms of depression, clinical manifestations cover the whole domains of unmada. Among the classification, kaphaja unmada shows striking similarities with depression. The features described in kaphaja unmada like alpahara (decreased appetite), alpavakyata(reduced rate of speech), soucha vidwesha[10](lack of personal hygiene), rahapreethi(desire for loneliness), alpamati(reduced attention and concentration), alpacheshta (psychomotor retardation), nidra (increased sleep) etc has close similarities with diagnostic criteria for depression(ICD 10 criteria)

SAMPRAPTHI OF UNMADA

Depression or any other psychiatric illness in Ayurveda is multifactorial. If significant exogenous factors generated in a predisposed individual, disease will manifest. Hence depression takes origin at the subtle level of mind right from birth itself, and its growth depends upon various positive and negative factors at physical, personal, familial, social, psychological as well as spiritual planes. An alpasatwa vyakthi[11]/ bheeru (feeble minded) if continuously habituated to etiological factors like; exogenous stress factors afflicting mind, disrespect to god,vyadhi vega (perturbation due to severity of disease), viruddha bhojana (antagonistic food) and dushta bhojana (polluted food) will lead to vitiation of kapha pradhana tridosha and manasa dosa (rajas and tamas). Then vitiation occurs in hridaya (heart) which in turn causes vitiation of monovaha srotas and ultimately leading to the manifestation of kaphaja unmada

In early stages of depression, full core symptoms may not manifest. It will not interfere with daily activities, work or studies. Patient may feel distress, but cannot identify as a psychiatric disorder and often consult with general physician for his lassitude. So in early phase, this disorder never shows any relation with insanity (unmada). Later on, the classic features of loss of interest, feeling of worthless, reduced concentration etc evolves and progressively disease will hamper the life style. Here evolves the insanity or so called unmada with the impairment of budhi (intellect), samjna (consciousness), smrithi (memory), bhakthi (desire), seela (manner), cheshta (behaviour) and achara (conduct). In severe forms of depression it becomes associated with psychotic symptoms such as delusions, hallucinations and grossly inappropriate behaviour. It will resemble the features of unmada with more specificity towards kaphaja variant. Then symptoms like rahapreethi, alpavakyata, soucha vidwesha are noticed.

CONCLUSION

Depression is ranked as the single largest contributor to non-fatal health loss in world wide. It is a chronic, pervasive and disabling illness, which can result from a combination of various biological and psychosocial factors. In unmada vitiation of sareerika and manasa doshas leads to the derangement in metal functions. Though mild depression causes impairment of quality of life of the subject, the full core symptoms of unmada will not develop. But, if severity and chronicity increases, affliction of all domains may be manifested and symptoms of unmada will be more prominent. So it is better to correlate mild depression with vishada and moderate to severe varieties to kaphaja unmada.

REFERENCES

1. WHO- MSD- MER- 2017.2-eng.pdf
2. www.who.int/campaigns/world-health-day/2017/toolkit.pdf
3. Depression in India Let S talk 5- April 2017 Rev.cdr
4. Benjamin James Sadock (2015). Comprehensive Textbook of Psychiatry. (9 ed.). New Delhi:Wolters Kluwer. Page no: 1638
5. Benjamin James Sadock (2015). Synopsis of Psychiatry. (11 ed.). New Delhi: Wolters Kluwer. Page no: 349- 351
6. Kasper & Fauci (2015). Harrison's Principles of Internal Medicine. (15 ed.). Newyork : McGraw Hill. Page no: 2714
7. M.G Gelder, Juan. J. Lopez (2000). New Oxford Textbook of Psychiatry. (1 ed.). Italy: Oxford University Press. Page no : 715
8. Niraj Ahuja (2011). A Short textbook of Psychiatry. (7 ed.). Haryana: Jaypee Brothers. Page no: 71
9. Dalhana, Nibandha Sangraha commentary on Susruta samhita, edited by Vaidya Yadavji Trikamji Acharya, Varanasi Choukhambha Prakashan, 2011, page no:75
10. Sharma R.K. Dash Bhagwan Charaka Samhita Nidana Sthana (7/7)Chaukhambha Sanskrit Series Office:Varanasi Reprint 2007: page no:92
11. Vagbhata. Ashtanga Hrdayam Utharasthana. Chaukhambha Sanskrit Sansthan:Varanasi Reprint 2018: page no: 797
12. Grover, S. Dutt, Avasthi, A. (2010). An Overview on Indian research in depression. Indian journal of psychiatry, 52 (Suppl 1), S178-S188. Doi: 10.4103/0019-5545.69231