Depression

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"I have absolutely no pleasure in the stimulants in which I sometimes so madly indulge. It has not been in the pursuit of pleasure that I have periled life and reputation and reason. It has been the desperate attempt to escape from torturing memories, from a sense of insupportable loneliness and a dread of some strange impending doom" (Meyers, 2000, p. 89).

Depression exists as a regular mental disorder presented in the form of loss of interest, depressed moods, and feelings of low self-worth, guilt, poor concentration and disturbed sleep. The most common symptoms of depression are manifested in the form of anxiety. The problems could become recurrent or chronic, leading to notable impairments in a person to become responsible. When it reaches its worst stage, depression might lead to suicide. Over one million succumb to depression annually. This translates to at least three hundred suicidal deaths per day (Stark, 2010). A single individual who commits suicide motivates twenty more to attempt suicide.

Depression is among the most prevalent form of diagnosed mental disorders. Institutions, such as the World Health Organization estimates that 500 million people experience worst forms of depression across the world (Trickett, 2007). Projections estimate that depression will become the leading cause of disability and a major contributor to global troubling diseases. People across the world experience varied symptoms of depression warranting treatment in the course of their lives. With the widespread prevalence of this disorder, it can be described as an old form of mental health problem, which strikes the poor and the rich not forgetting the old and the young. Depression has varied symptoms ranging from feeling gloomy, sad, and extremely guilty, hopeless, and deep thoughts of despair and suicidal (Kanner, 2012). Persistent depression produces physical and behavioral symptoms like insomnia, fatigue, chronic aches, excessive weight loss or gain, frequent crying and impotence. Thus, depression is a sophisticated and a multifaceted syndrome comprising of various dimensions.

People can suffer from multiple variations of depression. The most significant difference is depression among individuals who do not have or who have a history of maniac episodes. Depressive episodes draw symptoms like loss of interest, increased fatigability and depressed mood. Depending on the severity and number of symptoms, a depressive episode could be categorized as moderate, mild or severe (Wasserman, 2011). Individuals with mild depressive episodes will experience difficulties in continuing with social activities and ordinary work. However, such people will not cease from functioning completely. In the case of a severe depressive episode, it is unlikely that the individual will be able to proceed with domestic and social activities, but to a limited extent.

Bipolar effective depression entails both depressive and maniac episodes separated by normal mood periods. Maniac episodes entail increased energy and elevated mood leading to over-activity, decreased need of sleep and pressure of speech. Although

depression is among the key causes of disability for both females and males, the depression burden tends to be approximately fifty percent in females than the male counterparts (Winokur & Tsuang, 2009). Evidently, depression is the major cause of the burden of diseases in women in low, middle and high income countries. Studies conducted in third world nations indicate that maternal depression could be a risk indicator for poor growth among young children. This risk indicator might imply that maternal mental health within low income nations could have a significant effect on child development. The impacts of depression will not only affect this generation but will be also visible in the next generation.

Depression differs from grieving. However, a prolonged grieving period may develop into a depression episode although it is a rare occurrence. Depression is more prevalent in adults than in young children but also occurs in children. For instance, instead of instead of showing sadness, children tend to go bald or depict danger signs. They tend to be fussy in terms of food, demonstrate lack of interest in things they previously valued or become cranky (Wasserman, 2011). Scientists have found that different causes of depression depend on the victims. Besides, some individual genes tend to make them more prone to be depressed as individuals are more expected to experience depression if close family members has previously experienced depression.

"Depression moods lead, almost invariably, to accidents. But, when they occur, our mood changes again, since the accident shows we can draw the world in our wake, and that we still retain some degree of power even when our spirits are low. A series of accidents creates a positively light-hearted state, out of consideration for this strange power" (Baudrillard, 2003, p. 138).

There are numerous manifestations of depressive. Major depression is portrayed by a fusion of indications that meddle with an individual's capacity to work, eat, study and enjoy once pleasurable exercises. Major depression leads to disability and deters an individual from working regularly. Some individuals might experience just a single episode in their lifetime, yet more regularly, an individual may have numerous episodes.

Dysthymic manifestation of depression, or dysthymia, is marked by enduring manifestations that may not be extreme enough to incapacitate an individual. However, a person can avert typical functioning or feeling well. Individuals with dysthymia might likewise experience one or more episodes of major depressions throughout their lifetimes. Minor depressions are described by having manifestations for two weeks or more that do not meet full criteria for major depressions (Stark, 2010). Without medication, individuals with minor depressions are at high risk for experiencing major depressive disorders.

There are numerous methodologies to psychotherapy incorporating talk therapy, cognitive-behavioral and interpersonal treatment. These psychotherapy treatments help people recuperate from depression. Psychotherapy helps individuals distinguish the elements that lead to their depression and deal viably with the behavioral, psychological, situational and interpersonal contributors. Mental health and skilled health experts like authorized psychologists must help depressed individuals in order to pinpoint the life issues contributing to their depression. This helps such people understand aspects of these

problems they might improve or solve. An authorized therapist can help depressed patients recognize future options and set sensible objectives that empower them to improve their emotional and mental well-being. Psychotherapy likewise can support people who have been depressed in the past with distinguishing how they have effectively managed comparable feelings (Knittel, 2013).

One way of exposing depression alarm is by observing changes in sleep patterns. Although the most common alarm is insomnia (lack of adequate sleep), sometimes people experience an increase in need of sleep and feel an excessive loss of energy. Lack of sleep causes alarms that signals possible depression. They include loss of energy, extreme tiredness and difficulty in making decisions or concentrating. Other ways of exposing depression alarms include irritability, feeling of hopelessness, weight loss or weight gain. If depression is treated at an early stage, it helps individuals control all these alarms (Wasserman, 2011).

Depression puts a negative turn on everything, incorporating the way people see themselves, the scenarios they experience, and their desires for the future. Such people cannot break out of this skeptical personality outline by "simply thinking positively. Wishful thinking or happy thoughts will not cut it. Rather, the strategy is to displace negative contemplations with more equalized thoughts.

Individuals must think outside themselves. This requires them to avoid being too hard on themselves. Instead, individuals are advised to think about minimally harsh statements that serve as realistic descriptions. Depressed victims must permit themselves to be less than perfect. Numerous depressed individuals are perfectionists, expecting them to remember inconceivably exclusive requirements and after that beating themselves up after failing to meet them. They must fight this root of self-imposed distress through challenging their negative approaches of thinking.

Socializing with positive individuals. One must recognize how individuals who regularly look on the shining side manage challenges, even minor ones, such as not having the ability to locate a parking space. At that point, individuals must think about how they might respond in the same scenario. They need to imagine, attempt to embrace their persistence and optimism in the face of depression.

With its yellow pears
And wild roses everywhere
The shore hangs into the lake,
O gracious swans,
And drunk with kisses
You dip your heads
In the sobering holy water.

Ah, where will I find
Flowers, come winter,
And where the sunshine
And shade of the earth ?

Walls stand cold
And speechless, in the wind
The weathervanes creak. ” (Downes, Francesch, Henze, Henze, & Kölner Rundfunk-Sinfonie-Orchester, 2011, p. 124)

Depression is one of the major public health issues. According to joint studies conducted by the World Health Organization and Harvard School of Public Health, depression is among the leading causes of disability among the youth worldwide. In the US, the lifetime prevalence of this problem is estimated to be 20% of the youth (Lines, 2006). Depression is spread across the world among patients with chronic disabling medical diseases. Although the prevalence point of major depression among the youth in the US is 8%, this figure is increasing day by day. Antidepressants-based treatment in primary care facilities has increased dramatically in the recent years. Although antidepressants-based interventions save many lives, it is associated with threats of side effects in frail patients. It also enhances the threat of drug interactions with treatment prescribed for non-psychiatric diseases. This is obvious because major depression is a viable risk factor leading to disease morbidity among because depressed youths have doubled the death risk of those with no depression.

In addition, medications are costly and handling side effects, and drug interactions heighten the expenses further. Psychotherapy also helps depressed young children. Depression observed within primary medical care is situation-specific because of the changes in life caused by physical illness like day-to-day issues at work and home. Therefore, psychotherapeutic strategies focusing on helping the youth adjust to varying real life situations are effective in depressed youth visiting a primary care environment (Schneider & Levenson, 2008). Obviously, psychological strategies like cognitive behavioral therapy have shown to be effective in managing depression in medical youth. Often, they are achieved through addressing maladaptive thoughts and beliefs associated with medical illness initiating and maintaining depression.

Depression refers to a disorder that could be dependably diagnosed and treated under primary care. As portrayed in outcomes for individuals with anxiety and depression disorders. The intervention comprises of psychological and case management led by trained counselors. This is conducted under the supervision of mental health specialists and medication primary care physicians. Researchers discovered that patients in the group intervention are likely to recover in six months than patients in the control team. In this case, interventions by trained counselors can accelerate a change in recuperation from depression. Even with the known viability of medicine for depression, the dominant part of individuals in need do not appropriate it. Where information is accessible, this is universally less than 50%, but fewer than 30% in most areas and even less than 10% in some third world nations (Joiner, 2010). Obstacles to adequate care incorporate the absence of resources, absence of qualified personnel, and the social stigma connected with mental disorders.

Getting the required support is essential in eliminating depression. It might be troublesome to uphold point of view and maintain the exertion needed to battle depression, yet the precise nature of depression makes it challenging to seek help. On the

other hand, loneliness and isolation exacerbate depression, so sustaining social activities and close relationships are vital.

The prospect of contacting even close relatives and companions appears overwhelming. An individual might feel humiliated, excessively exhausted to talk, or guilty for ignoring the relationship. Individuals ought to remind themselves that this is the depression talking. Friends and family think about these individuals and need to offer assistance.

Turn to trusted loved ones and members of the family. These people must share what they are experiencing with the individuals they adore and trust. The victims might have withdrawn from their most loved relationships, yet they can pass through this challenging time.

Psychologists suggest that depressed individuals must try to engage in social exercises regardless of the fact that they do not feel like it. When people are depressed, they consider it easy to be in self-withdrawal, but being around them is useful in eradicating depression.

If a person has depression, he/she presumably have a list. Furthermore, the person is likely to relate to the heavy weight of guilt and gnawing. The guilt may create self-mistrust or self-harm in some cases. Guilt is a recipe for insecurity, uncertainty and even poor choices. It masks a person's choice and discussion where they second-guess their opinions. Guilt is not something that essentially breaks down with numerous quick fixes. However, an individual can gradually chip away his/her guilt. The tips below might help get rid of guilt medicines (Joiner, 2010).

Moving the body: psychological specialists encourage someone to engage in physical activities, which result in lower cortisol levels, increased flow of endorphin, and stirred common senses. It likewise assists individuals with depression feel better and thinks clearly.

Shifting thoughts: Feelings of guilt that medicine can set depressed individuals into a cycle of negative thoughts. The thoughts may intensify into deep and hopeless thought-frames. That is the reason addressing negative thoughts is key. Studies proposed reforming negative thoughts into positive contemplations or utilizing positive imagery. This includes using statements such as “I am able to do this".

Recall guilty thoughts are not realities: psychologists find it helpful for depressed individuals to remind themselves that their guilt is only a voice. This requires such people to differentiate the guilt and themselves.

Some studies illustrate that brain activity or structure differs during the depression and depression is attributed to brain chemical disruptions. In addition, some evidence shows that hormonal imbalances contribute to depression. Experiencing stressful life occurrences triggers depression in people who could be vulnerable to become depressed (Knishinsky, 2008). Some medications or medical conditions cause depression or signs that appear as depression like hypothyroidism looks like depression in some individuals.

Psychologists and therapists collaborate with depressed people to repair their mental and psychological damage. They help sort out reality from what the brain feeds individuals for a period leading to depression. Some people tend to feel that approaching a therapist or psychologist entails pouring everything from what happened during childhood. Today, we have modern psychologists who are professionals in brain chemistry and are experts at repairing thoughts damage and reconstructing confidence. The combination of therapy and medication is effective. In most cases, both therapy and medication are used in severe depression for successful treatment. With such a combination, the victim could expect normal sleep patterns accompanied by a slowed mind speed. Depression does not only affect the depressed person; it also spreads to the family members. If a spouse is depressed, she/he constantly talks about the history of the relationship or the marriage (Trickett, 2007).

This process allows the garbage truck to run across their minds, remembering every bad thing that has been done, said, or not done. The depressed partner dumps a series of accusations on the spouse that is not depressed and such accusations are beyond the point of correction. The non-depressed partner suddenly learns that their spouse never likes anything that happened. The non-depressed partner starts to experience a series of thoughts running across his/her mind. Such things may have happened before they got married, but were not mentioned (Kanner, 2012). The partner who is not depressed is now awakened with complaints and accusations hour after hour. He/she is triggered to feel responsible for everything happening to the depressed spouse. This happens as the depressed partner continues to list misunderstandings and mistakes, which have occurred in the course of their entire marriage. While they might have discussed them at one point, the non-depressed partner receives all blame for past events.

If someone is depressed, he/she feels helpless, exhausted, and hopeless. It will be challenging for such a person to initiate any action to help himself. However, as an individual begins to recognize the depression and takes treatment, the person will feel better. The following are some ways through which a depressed person can expose the alarm of depression:

I. A person should not wait too long before getting evaluation and treatment. Research evidences that prolonged waits leads to massive impairment along the road. Individuals must attempt and see an expert as soon as she or he can
II. Try to exercise or be active- this could be going to movies, playing games or events that were once enjoyable
III. A person should develop a tendency of setting realistic goals
IV. Large tasks must be broken into smaller tasks, priorities must be set, and a person should do what he or she can
V. If someone is suffering from depression, he or she should try to spend time with other people. This could include confiding in a trusted relative or friend. Such people should not isolate themselves and can accept help from other people
VI. These people should expect their mood and feelings to improve slowly and not immediately. They should not expect to snap suddenly from their depression. In the

course of treatment, appetite and sleep will start to normalize before the depressed moods can lift (Knishinsky, 2008).

VII. A person can postpone important decisions like being divorced or married until he or she feels better. This requires discussing the decision with trusted people who have an objective view of the situation at hand (Trickett, 2007).

There are various approaches by which depressed people can avoid depressive thoughts. They include the use of medication and counseling or even both combined. Decades of studies demonstrate that depressed people respond differently to treatment although most individuals respond to treatment appropriately. Studies suggest that depressed people can eradicate depressive thoughts through counseling. Similarly, people should continue educating themselves about depression as this will also eradicate depressive thoughts (Wasserman, 2011). Other ways to eradicate depressive thoughts include:

I. A depressed person ought to remember that positive thinking replaces negative thoughts as the depression responds to treatment

II. Things cannot turn around overnight, but people suffering from depression will find themselves more able to enjoy their lives

Depression can be effectively treated through psychotherapy. When someone is depressed, he or she must have someone to listen to his/her feelings, give support, and help understand the situation. Although family, lovers, or friends might serve such functions, having a more objective and a well-trained mental health expert is the best person to offer such help. Supportive talk therapy must be lengthy. The quickest way of relieving major depression is through antidepressant medication. It can also be helpful in treating severe depression related to suicidal thoughts and major disruption of normal functioning. By relieving symptoms, it allows individuals to continue with their normal lives (Murray, 2009). Most people with patients suffering from major depression tend to respond positively to medication with up to two or three months. Some patients may show some improvement when they use antidepressants. Major depression is categorized as the most treatable medical condition.

In addition, the medication is effective in dysthymia. Although improvements could be less dramatic compared to major depression, it leads to a reasonable improvement in a patient's life. The most effective treatment for both dysthymia and major depression is combining talk therapy and medication. Various studies demonstrate that both medication and psychotherapy are extremely effective in treating depression. Recent research findings coupled with clinical evidence suggest that a combination of both approaches is the most effective in depression treatment (Trickett, 2007).

If someone is experiencing a major depression, he/she may wish to discuss it with a professional. The person ought to figure out a doctor or a counselor. Psychological help is available at licensed mental health institutions, licensed hospital outpatients or from licensed psychologists in most communities. The person could visit community mental health institutions providing services at low cost. Depression can be treated, and

unnecessary suffering alleviated (Knishinsky, 2008). When a person is experiencing the following circumstances, he or she must consult a mental health expert:

I. Persistent and severe symptoms that impair normal daily functioning
II. Overwhelming stress such that suicide appears to be the viable option
III. The problems of pain outweigh the pleasures

Licensed mental health experts will help identify and sources, causes of depression, and recommend ways of managing depression.

Thoughts of being guilty are not fact; therefore, it is helpful for people to remind themselves that their guilt is a mere voice. This requires that people must erect a distance between themselves and the guilt. Such people should try humor. Researchers in this field find that humor brightens heaviness (Murray, 2009). For example, people can laugh when they remember about guilt as a symptom of depression. For most depressed people, guilt is a stubborn and real symptom. It has a tendency of exacerbating moods and manipulating facts. However, although guilt tends to be overwhelming and persistent, it can be minimized and managed.

The so-called 'psychotically depressed' person who tries to kill herself doesn't do so out of quote 'hopelessness' or any abstract conviction that life's assets and debits do not square. And surely not because death seems suddenly appealing. The person in whom its invisible agony reaches a certain unendurable level will kill herself the same way a trapped person will eventually jump from the window of a burning high-rise. Make no mistake about people who leap from burning windows. Their terror of falling from a great height is still just as great as it would be for you or me standing speculatively at the same window just checking out the view; i.e. the fear of falling remains a constant. The variable here is the other terror, the fire's flames: when the flames get close enough, falling to death becomes the slightly less terrible of two terrors. It's not desiring the fall; it's terror of the flames. And yet nobody down on the sidewalk, looking up and yelling 'Don't!' and 'Hang on!', can understand the jump. Not really. You'd have to have personally been trapped and felt flames to really understand a terror way beyond falling." (Wallace, 1996, p. 187)

"Psalms 40:1-3- I waited patiently for the LORD; he inclined to me and heard my cry. He drew me up from the pit of destruction, out of the miry bog, and set my feet upon a rock, making my steps secure. He put a new song in my mouth, a song of praise to our God. Many will see and fear, and put their trust in the LORD"(Wenham, 2012, p. 70).

Some study looks at depression from the religious perspective and discusses the relationship between depression, religious involvement and its relationship to psychological changes affecting the process of medical illness. It offers randomized strategies of overcoming religious and physical barriers to psychotherapy by using CBT (cognitive behavior therapy), which integrates spiritual resources into psychotherapy. It presents the technical challenges encountered when implementing the triage approach in severely depressed young people.

The study shows that CBT approach is remarkably effective than normal care given by physicians in primary care institutions. The benefits have demonstrated to last for longer periods. This suggests that physicians could cover a wide geographical region and patients can access at different times. The effectiveness of treatment could be affected by patients' response to the questions posed. The CBT method ignores the advantage of the fact that talking and writing about traumatizing experiences enhances the outcomes. This is particularly true when talking or writing about events from a religious perspective.

Bishop Dunn Lisa is a Reverend Pastor serving as a medium-sized church within the community. Jordan and his entire family have been members of this church for a long time. One year after the demise of their youngest son due to leukemia, they became more active in church activities. Jean, their seventeen-year-old daughter noticeably became withdrawn from both friends and family. In the past series of months, she had become less interested regarding her appearance. She ceased participating in youth activities while her school grades deteriorated. Jean became moody and pessimistic toward her life outlook. She complained about feeling worthless and developed a short fuse. Later, her friends reported having seen her drinking in the company of a group of older students after leaving school. Her younger brother was her best friend and she was the least accepting and most affected by his demise.

The negative and rapid changes in Jean's life indicate that she has developed a serious problem. She might be using alcohol as an attempt to deal with the unresolved grieves associated with the passing of her younger brother. It is uncommon for drug and alcohol abuse to mask grief and depression reactions. Depression is categorized as the most common manifestations of emotional problems among the youth. Experts have estimated that at least one out of every twenty teens is depressed. They also confirm that many of the depressed youths use alcohol or drugs to overcome the problem. Because Jean's school grades have dropped, it could suggest a slowed thinking and a decrease in concentration; these are common in depression. Alcohol use as self-medication is a common trend of people with high addictive potential and poor coping skills. It appears that Jean is still in denial (Derevensky & Gupta, 2010).

Jean has a large number of the indications of an adolescent who has a depression and alcohol abuse issue: she has withdrawn from family and companions and has ceased exercises she had reveled in at church. She has challenges at school and has had a noteworthy negative change in her mood and thinking. Her family reports that Jean has diminished interest in her physical manifestation. She might have advanced companion associations with youth who are utilizing alcohol. Jean's parents and Reverend Dunn decided to discuss with Jean about her new contacts. The pastor utilized her dynamic listening abilities while evaluating Jean's emotional condition. Reverend Dunn secured a caring and safe relationship as she sympathetically responded to Jean at the family home. The adolescent admitted increasing alcohol consumption. When the pastor helped Jean to remember the extent her family adored her and was worried about her, she broke down and sobbed (Aguilar-Gaxiola & Gullotta, 2008).

She started to express her profound distress over the death of her favorite sibling. Rev. Dunn helped Jean to grieve her loss, and comprehending that every person has a different approach to grieve. Evidently, she would grieve her sibling's death consistent with her inward timetable. After Rev. Dunn and Jean's family had their intercession, Jean consented to see a therapist, Dr. Barbara Miller with practical experience in adolescent

substance-abuse issues. The expert exhorted a therapeutic examination to decide on physical issues that could have triggered the depression. However, no underlying medicinal issue was discovered that might be answerable for the depression. Jean was also evaluated for anti-depressant prescriptions and was given a remedy to help her through the first numerous months (Derevensky & Gupta, 2010).

"Man seeks to escape himself in myth, and does so by any means at his disposal. Drugs, alcohol, or lies. Unable to withdraw into himself, he disguises himself. Lies and inaccuracy give him a few moments of comfort " (Pryor, 2003, p. 197).

Throughout the months of treatment, it came to be clear that Jean had started to depend on alcohol and was drinking to self-cure her depression. Jean was solidly treated as an outpatient for depression and alcohol abuse. The therapist likewise noted that Jean's family required addressing its poor correspondence, which was affirmed after the death of a relative. Jean's substance abuse was, to some degree, a manifestation of their agony as a family and their ineptitude to express their anguish in a manner that could generate healing. With some months of help, the family was fit to develop a renewed faith and deeper bonding as they combined efforts throughout the crisis.

Misuse of alcohol has a basic trend of utility featured by recurrent, negative, and significant outcomes associated with repeated use. Diagnosis demands one out of the following criterion within a period of one year:

I. Recurrent consumption of alcohol leads to failure in fulfilling major obligations at work or school
II. Repeated alcohol use in situations determined to be physically risky
III. Legal problems related to recurrent alcohol use
IV. Continued alcohol consumption despite persistent interpersonal or social problems; due to impacts of alcohol use; this could include arguments with family members or friends about the impacts of alcohol or substance use (Derevensky & Gupta, 2010).

Adolescents are diagnosed with major depression in cases where they have experienced prolonged feelings of sadness, gloom, loss of interest, lack of motivation, displeasure in activities they once enjoyed, irritable and depressed (Derevensky & Gupta, 2010). Coupled with the loss of interest of a depressed mood, the individual ought to have experienced a prolonged period (two weeks) of at least four of the following symptoms:

I. Feelings of wanting to die, life is not worth living and feeling suicidal
II. Difficulties in concentrating
III. Feelings of excessive guilt or worthlessness
IV. Loss of sexual or social interest
V. Sleeping a lot or difficulties in sleeping
VI. Excessive weight gain or loss; loss of weight or appetite
VII. Increased agitation or lethargy and
VIII. Loss of energy or fatigue

Research has demonstrated that stable families bring down the danger of drug and alcohol abuse, so church programs that may help the family might be a preventive methodology. The solid youth program that pushes exceptional correspondence and social skills is an important preventive measure. Teen drug and alcohol abusers have a tendency

to have a high social anxiety, poor assertion skills, and low self-worth. Social abilities training can improve self-control, coping, negotiation skills, assertiveness, and social problem solving, besides expanding the capability to oppose peer pressure (Aguilar-Gaxiola & Gullotta, 2008).

Supporting the youth and their families to be active in the life of the faith community is in itself an imperative preventive procedure when tending to substance abuse. Youths practicing their religious faith have positive social qualities and caring conducts. Their families are more stable than the individuals who do not practice their faith. According to recent surveys, youth regular church attendees are half as liable to utilize alcohol as youth who do not go to church regularly. These discoveries add to the impressive exploration supporting the social profit of nurturing, non-punitive religious practice in restricting and averting liquor and drug utilization.

Religion can secure young people and their parents from depression by posing as a buffer against stressful occasions. While numerous pastors report that depression is the most widely recognized issue that they are asked to help individuals succeed, they are deficiently trained to distinguish suicide or depression risk. In a national survey of pastoral and clergy care experts, one out of four accepted the church was putting forth helpful systems for the discouraged young people, and pastors rated their usefulness with teen depression as usually poor (Carlo, Crockett & Carranza, 2011). The study underscores the need for the ministry and religious leaders to establish ways of identifying mental health issues in teens. The focus must also seek to train members on ways of providing support to youths and their families. Positive social relationships outside an individual's immediate family are a defensive component against developing emotional issues such as depression in at-danger youth.

This sample is an intervention contemplation that might be adopted in a medication for juveniles experiencing alcohol abuse and depression. In the initial stages, the therapist may urge Jean to recount her story and sympathize with her perspective. This will be helpful in cultivating a therapeutic alliance. The mental health expert may also solicit Jean to examine her comprehension about the negative results of alcohol consumption and survey her level of understanding into her scenario of denial. It might be important to give a guarantee that help is accessible and that change happens with dedication (Derevensky & Gupta, 2010).

The family would be included in the early stages and frequently in mediation. They will be critical in offering insight and support because medication without their contribution will offer minimal satisfactory results. For Jean's situation, the family could be a significant part in recuperating unresolved grief. It might likewise be accommodating to improve a history of substance abuse about the extended family since relatives with abuse issues expand the danger of habit. A referral to the Alcoholics Anonymous' adolescent project can give Jean training and proceeded motivation for refraining.

A specialist may work with Jean and her family in curbing the lapses and working through impermanent fallbacks in case they occur. Sessions will persistently survey the purposes behind the recuperation process; provide reassurance, support, encouragement, and praise for the process of recovery (Carlo, Crockett & Carranza, 2011). The specialist will also try to convince Jean to participate in extracurricular social and physical exercises with positive peer groups. It might be essential to distinguish and address family issues that may be confusing Jean's alcohol abuse. Family sessions could be utilized to instruct

correspondence skills and investigate underlying family dysfunctions that may be identified with the addictive conduct.

Concerning depression, a mix of cognitive-behavioral treatment, family therapy, and medication is the standard intervention. Critical depressive side effects in adolescents might be treated with pharmaceutical. Any prescription for minors must be seriously monitored, given the progressing physical and mental improvement of adolescent individuals (Aguilar-Gaxiola & Gullotta, 2008).

It is fortunate that Jean has a pastor who is psychologically oriented ready to connect her with an expert psychological health professional. This is an expert with proficient experience and training needed to help Jean effectively. There are numerous factors pointing that Jean will have a long-term positive outcome. Imperatively, Jean and her family are motivated to change and have responded positively to the intervention. Additionally, the church community and her family have given her the valuable support.

Therapists encounter barriers while treating depressed patients using religious interventions. When youth, especially spiritual youths, become depressed, their beliefs interfere with compliance and acceptance of conventional interventions such as psychotherapy. Such clients tend to shy away from secular counseling as they see it rough to their religious beliefs. Religious youth patients could feel that pursuing therapy implies abandoning their religion and faith by favoring secular interventions. As such, youths in such a scenario tend to have guilty feelings and thoughts. This makes them ashamed about their depression and failing to address the problem with the clergy. They will further shy away from seeking support within their religious community (Norman, 2013).

Traditionally, religious communities served as forefront providers of mental health across the world. They provided almost many hours of counseling similar to the members of the American Psychological Association. The clergy spent an average of 20% of their time on counseling exercises every year, serving an estimated 150 hours of service sin mental health. They were supported by nuns and chaplains who provided similar services on a full time basis. In addition, these services are free: there is no stigma related to such counseling. Hence, depressed young people often receive initial treatment by counselors and clergy within their religious community (Fitzpatrick & Kazer, 2012).

The religious community claims that religion is a resource while mental care specialists claim it is a liability. Whether a resource or a liability to depressed young people, it must be identified prior to generating down the barriers posing between religion and mental health care. In fact, religious involvement is imperative for many people globally. According to recent surveys by the Gallup Poll, at least 70% OF US citizens said that religion is a vital component of their day-to-day lives. This figure continues to increase above 80%. Likewise, comparative surveys found that 60% Americans demonstrated that religion is vital in their lives. This figure continues to increase above 70% (Norman, 2013). It is particularly true for medical clients often turning to religious beliefs in coping with illness.

Hundreds of quantitative and qualitative research documents high rates of coping based on religion in young people trying to cope with depression. In most parts of the America, almost 94 percent of hospitalized young people with depression problems use religion as a coping strategy. Nearly half of those who have used this approach report that religion is an integral factor, which keeps them going. In addition, increased religiosity

projects a speedy resolution of depression symptoms in young people depressed over time. This increases the remission speed by 60 to 80 percent overall (Tasman & Maj, 2011). Spiritual involvement is related to positive emotions like purpose and optimism in ill life, besides generosity, altruism, and gratefulness. Such characteristics enhance well being and counteract maladaptive behaviors and cognitions, which maintain depression in young people. However, the clergy are not exempted from depression, particularly when critical health problems strike. Recent surveys of hospitalized medical in patients with severe depression revealed that both were religious and spiritual, and at least 80% prayed once per day (Fitzpatrick & Kazer, 2012).

Major depression has been and continues to be a common psychiatric disease prevalent among the youth with chronic medical illness. As such, it can have an adverse effect on medical and physical health outcomes by altering endocrine and immune functions. Religion continues to be widespread and regularly utilized to cope with physical functioning and medical illness problems. This study has sought to discover whether psychotherapy taking advantage of religious resources enhances depression quickly than conventional therapy and manages the adverse effects of changes in depression.

This study presents information that is extremely useful to therapists besides those practicing pastoral counseling including secular therapists. Studies indicate that religious interventions are vital components of the daily lives. In addition, research estimates that 80% of depressed youth desire to incorporate it in therapy. Thus, all therapists with explicit training in religious counseling are expected to meet patients who prefer this method. Interestingly, studies focusing on conventional CBT versus a religious approach established that provision of religious CBT among secular therapists was not as effective as religious CBT given by religious therapists (Tasman & Maj, 2011).

Literature reviews about religion in psychotherapy elicits two major points. Firth, while therapists are less religious compared to patients, most therapists' own spiritual beliefs, which assist them to appreciate the function of religious believes owned by patients; it is not necessary for therapists to be religious experts. On the contrary, approaching spiritual patients with a willingness and openness to engage spiritual conversation helps patients feel more comfortable to express their needs and desires. Various authors conclude that religious treatment in psychotherapy could be effective if delivered by counselors with a wide array of spiritual beliefs, and not just pastoral therapists.

The relationship between depression and religion has been examined through exploring existing body of literature. Throughout this study, the correlation between depression and religion indicates that greater religiousness minimizes depression. Many people, regardless of age, gender, and ethnicity, are undergoing depression due to apparent life events. This study looks at how religion helps in addressing depression by analyzing the relationship between depression and the faith community whilst using the examples of Tolstoy and Dostoevsky.

Depression is a crippling mental illness that is both an enemy and a muse. For some writers, depression coincides with creation. Writer oriented depression is often a risk many writers, including Fyodor Dostoevsky and Leo Tolstoy are exposed to during their career. It is usually expressed in their works and becomes an element of their writing.

For Dostoevsky and Tolstoy , the mechanics of depression propels them to dig

deeper into the psyche of humans and most importantly themselves. It aids in discovery of certain aspects they would otherwise never reach. The problem is, depression affects a lot of writers and it sometimes leads to suicide. What is it about writers that lead so many to depression? More importantly, what causes depressed people to seek a career in writing?

Certain events, stress, and loss fuels depression. If one looks at the lives of many writers, one sees that they have experienced one form or another of negativity in their life. This rings true for Dostoevsky and Tolstoy. Each respectively, endured loss in some form with Dostoevsky enduring the loss of his father and Tolstoy the loss of both his parents. This loss coupled with realization of the world around them, made for an altered perception of things, and bred in them widely respected views as well as long term depression.

Fyodor Dostoevsky was known as one of the best writers of Russia. Although it is not clearly documented as true, SLOBODANKA VLADIV-GLOVER,(1993), reveals in his article Dostoevsky, Freud, and Parricide; Deconstructive Notes on the Brothers Karamzaov, an excerpt from Freud's 1928 article on the possible reason for Dostoevsky's father's death. The tale states Dostoevsky's father was murdered by his servants who drowned him with voda by pouring it down his throat. The reason they drowned him was because of his one of many fits of drunken rage. Regardless of the validity of this story, Dostoevsky's father died and left him with no clear father figure in his life.

Absence of a father figure, Dostoevsky was arrested and imprisoned in 1849 for participating in revolutionary activity against the then Tsar Nicholas I of Russia. Eventually he was sent to prison and later reformed. The writer later published deeply religious and conservative views on his country and government and lived a life critics have said of repression. This repression, expressed in his work, show his desire to hide his true feelings and sentiments and replace it with concepts and words that became the inspiration for generations of Russian people. An example of this is from Mochul'skiĭ: “Brother, I'm not depressed and haven't lost spirit. Life everywhere is life, life is in ourselves and not in the external” (Mochul'skiĭ, 1967, p. 141).

Depression does not have to be fully expressed to experience it. With Dostoevsky, his expression of depression was obscured. Instead he focused on writing stories that probed the mind and elicited a melancholy experience without emphasizing sadness. An exampleof this is Crime and Punishment where he wrote the story of a young former student named Rodion Raskolnikov.

Rodion was bent on executing a murder of a horrible pawnbroker that would benefit him, and in his mind, benefit society. Seeing himself as a “superman” he saw no negative ramifications to his actions. And in his contemplation of the murder, one can see Dostoevsky reflected. “The old woman was a mistake perhaps, but she’s not the point! The old woman was merely a sickness . . . I was in a hurry to step over . . . it wasn’t a human being I killed, it was a principle! So I killed the principle, but I didn’t step over, I stayed on this side . . . All I managed to do was kill. And I didn’t even manage that, as it turns out . . .” ("Sparknotes 101: Literature", 2004, p. 160) Dostoevsky believed success was the most important aspect of life. He sought success to pay for his gambling debts and saw success a means to an end.

But he failed to see why he needed the success in the first place. His depression not only affected his writing, it also affected the way he saw the world. The death of his wife in 1864 and his brother subsequently after left him deeply depressed. *The Gambler,* a work by

Dostoevsky, to keep him from losing the copyrights to his work. Dostoevsky suffered many setbacks in life from imprisonment, to exile, and loss. But his workings do not directly deal with depression and the feelings he endured. His work although propelled by depression was written to gain him success and financial stability.

Leo Tolstoy, another great Russian writer, unlike Dostoevsky, wrote about his life and how he felt towards depression. Events that led to Tolstoy's depression were caused by the death of his parents at an early age, his gambling debt which led to his stint in the army, and his eventual dysfunctional marriage caused by his radical religious views. The main influence that started his writing career was his time in the army and an 1857 Paris execution. His sadness over how the government corrupted its citizens motivated him to speak out and express his disillusionment with society.

In his book, *A confession and other religious writings,* he shares with the reader his journey of discovery and his transition of beliefs. “So my wandering among the sciences, far from freeing me from my despair, only strengthened it. One kind of knowledge did not reply to life's question, the other kind replied directly confirming my despair, indicating not that the result at which I had arrived was the fruit of error or of a diseased state of my mind, but on the contrary that I had thought correctly, and that my thoughts coincided with the conclusions of the most powerful human minds” (Tolstoy & Kentish, 1987, p. 20). It is in being in such a depressive state that heralds Tolstoy to seek a different state of being. This led to his work later focusing on religious context surrounding the Christian religion and Jesus Christ.

Writers who exhibit depressive qualities are often examined. Their lives reveal many errors in judgment that lead to longer bouts of depression along with severe consequences. Tolstoy's failed marriage being one of them and Dostoevsky's imprisonment, debt, and exile. A study done by Beiling (2001), shows how different types of depressed people react and what motivates their depressive state. It also mentions the mentality depressed people adapt and how that mentality may cloud their judgment and perspective. “Depressives are thus subject to a variety of errors in thinking which lead them to negative evaluations of themselves and their relationships” (Bieling & Alden, 2001, p. 18).

People who suffer from depression usually end up making choices that do not benefit them in the end. With writers, these decision, although lead them to a deepened depressed state, inspire work that at times propelled their careers. And from analysis of the lives of Tolstoy and Dostoevsky, it seems that depressed states motivated these two writers to start their career. In fact many writers who experienced depression stated they started writing after a tragic event.

A recent article written by Page (2013), states how often writers emerge from depressed people. “Writing is one of the top 10 professions in which people are most likely to suffer from depression, with men particularly at risk from the illness,according to US website health.com ”(Page/The Guardian, 2010, p. 1). It is not a coincidence depression and writing go hand in hand. Depression is fueled by tragedy and so is writing. Writing entails expressing emotion, mistakes, loss, and countless other things. When an individual is depressed, they force themselves to take a look at their lives and see what caused them to be this way. It also forces them to seek expression to deal with the despair brought on by depression.

Writers are and will always be connected to depression because art is a form of expression and depression is as well. People have to expel the feelings emitted by mistakes

and strong emotions stemming from depression and some learn to make careers out of it. Whether the motivation to continue writing is resolution from depression, money, or evolving perspective, it is important to understand the correlation. Writer-oriented depression is a very real situation and it affects some of the greatest writers and works of all time.

In conclusion, writers sometimes are made through tragic and unsettling events. They learn to perfect their craft and develop their writings into a lucrative career. Dostoevsky and Tolstoy used their experiences to write some of the greatest works in history. And although their depression led to some demoralizing and destructive consequences, it also led to amazing and inspiring literature. Writers are connected to depression, because art is connected to tragedy.

Depression is among the most popular mental disorder worldwide because most people have reported suffering from depression. While depression is viewed as prevalent, it has also become costly. The global market for antidepressants has been expanding since 1993 with reports of depression. In the US, an estimated $15 billion in the workforce is lost to depression every year (Colbert, 2009). Further depression has been found to be the leading cause of physical disability and is a risk factor for cardiovascular mortality.

Emotional expression facilitates coping with stress; highly religious persons are highly expected to benefit from the religious community. This increases the magnitude of the relationship between depression and religion. Altruistic messages common to most world religions focusing on the problems and needs of other people during crisis reduces the self-focused attention characterizing depression. Therefore, it is evident that the faith community assumes a remarkable role in addressing depression among persons of all ages, sex, gender, and ethnic background.

Religious involvement is another factor, which has received significant attention throughout the literature on depression. High profile studies have demonstrated that some religious aspects like intrinsic religious motivation can be inversely associated with depression. Great religious participation is also related to minimal depression. Notably, studies indicate that public involvement in religious activities such as church attendance is inversely connected to depression among the aging population; intrinsic religious participation has been associated with speed by which depression episodes abated (Schab, 2008). Various researchers have made similar conclusions by reviewing the overall literature on depression and religion. In his writings, Dostoevsky used characters who were mostly meek Christians and destructive nihilists. Some short stories like *The Idiot*, *The Brother Karamozov*, and *Crime and Punishment* focused on the mentality of his characters. This enabled him to establish clearly the relationship between spirituality and the psychology of a person. Tolstoy too spent a great deal of his time writing about depression affected him (Dostojevskij, 2001).

Research studies focusing on such issues are ongoing. Notably, studies dating as far as 1880s point towards religion as a potential influence on the severity and occurrence of depression (Kheriaty & Cihak, 2012). Currently, researchers have suggested that scholars summarize and quantify this literature by using meta-analysis to enable an objective assessment of religion as a predictor of depressive symptoms.

If religion and depression are indeed related, there must be factors that influence this relationship. It is challenging to give a theoretical account, which is both comprehensive and elegant because research has not confirmed the variables moderating the relationship. In addition, identification of mediating and moderating variables is imperative but challenging because a host of social, biological and psychological, influences religion and depression factors (Colbert, 2009). It is further complex because the factors with which depression and religion are related typically are not a one-way relationship. According to the probability of reciprocal associations, various variables considered as the causes of depression are consequences of depression. This applies to religion. However, a relationship between depression and religion exists. Previous studies indicate that there are some possibilities, which must inform future studies, although some of them cannot be addressed by with existing meta-analytic models.

Genetic influences: religion may be associated with depression due to similar genetic influences. Various studies established that at least fifty percent variations in religion might be attributed to addiction genetic variations (Phillips, 2007). Some genes confer resistance to depression contributing to the development of religious sentiments. This may lead some people to project a negative relationship between depression and religious involvement.

Developmental influences: such factors conferring resistance to depression may foster the development of spiritual interests in adolescents and children. For instance, a caring and warm child parent bond may be both a protective variable against depression and a positive variable in the development of spiritual interests. Thus, parental closeness, warmth, and caring may explain certain relationships between resistance and religion to depression (Ebaugh, 2011). On the contrary, negative life experiences in childhood that may confer risk for depression may similarly disincline people from concerns with our interests in religious matters. Studies have pointed that poor child-parent relationships may predispose a person to depression and contribute to the absence of interest in spiritual matters. Additionally, it may be that some people seek out spirituality to compensate for poor child-parent relationships.

Besides the probability that the relationship between depression and religion are influenced by common developmental variables, we have sufficient reasons to believe that depression may influence religiousness. Individuals who experience severe depression might find a diminishing pleasure in previous religious activities. Over time, this may erode their private and public engagements with their faith community (Schab, 2008). In addition, to the extent that an individual's depression may include a physical disability or a lack of energy, people who were previously religious may become unable to engage in religious endeavors, this can make them appear less religious on various metrics used to measure spirituality. Conversely, depression is apparently prompting some individuals to seek comfort in religion resulting in heightened religious activities (Dostojevskij, 2001).

An alternative possibility that variables related to religion, influence depression has been granted the most attention in emerging empirical literature. Most scholars suggest that religion reduces vulnerability to depression by various substantive psychological

mechanisms. While extensive possible mechanisms are not feasible, this paper illustrates using four possible mechanisms:

Lower use of substance - surveys carried out nationwide illuminate high comorbidity rates between depression, drug dependence, and drug abuse. This suggests that drug dependence and drug abuse may be risk factors for the development of depression. Evidence demonstrates that involvement in religious activities is associated with lower substance abuse rates (tobacco, drugs, and alcohol) among both adults and adolescents. The impacts of religion in deterring the use of drugs can be encouraged by discouraging interaction and endorsing moral prescriptions with peers using them. Religious participation may indirectly influence the susceptibility of individual someone with depression by deterring the use of drugs among adults and adolescents (Anderson & Anderson, 2010).

Social support: involvement in religious activities may grant individuals social support opportunities. Recently, this has been found to safeguard against depression. Individuals engaged in religion have informal social contacts and tend to be active in civic participation than individuals who are not. Religious participation places individuals in touch with such social support sources; such participation may be a mechanism explaining the inverse relationships between religion and depression (Schab, 2008).

Cope with stress: Many religious behaviors and cognitions helpful to religiously involved individuals cope with stress may curb adverse health outcomes. Evidently, medically ill men using religion as a strategy to cope with their physical health conditions have minimal depression. Similarly, other psychological, demographic, and physical predictors of depression will be under control. As such, religion protects individuals against depression and depressive symptoms as it helps them avert the adverse psychological symptoms frequently associated with life events that are stressful (Ebaugh, 2011).

As far as religion is inversely connected to depression, it can be conceived that this relationship applies equally to individuals regardless of their levels of life stress they experience. This effect signifies that the relationship between religion and depression is notable and adverse when average across all life stress levels. Conversely, it may be conceived that the adverse link between religion and depression becomes stronger in persons undergoing increased stress levels like most psychological variables related to depression (Anderson & Anderson, 2010). Possibly, religion is associated with significantly lower levels of depression. This association may even become stronger in persons experiencing high stress levels. Certain scholars have established that the adverse association between religion and depression becomes strong among persons experiencing severe depression. Symptoms of depression may be notable sources of life stress requiring secondary mechanisms of coping for persons to avoid being entangled in a downward spiral (Dostojevskij, 2001).

This study suggests that there is a robust positive relationship between religion and depression. This can be illustrated by developmental factors influencing both religious involvement and vulnerability to depression. With the recent heritability of depression and

the vulnerability of depression, common genetic factors are answerable for the relationship between religion and depression. Similarly, environmental variables like parental modeling of emotional engagement, social skills, and disciplinary styles provide simultaneous influences on the vulnerability to depression and the development of religiousness (Phillips, 2007).

Possible mechanisms explain how the faith community exerts pressure on depression. For instance, highly religious persons are less expected to become substance abusers than persons who are less religious. As a result, persons with low or moderate levels of religious involvement tend to engage in substance abuse during distress times with a corresponding increase with depression. On the other hand, highly religious persons remain comparatively low in their substance abuse even under distress. The social support stemming from the religious community explains how religion reduces depression and depressive symptoms (Anderson & Anderson, 2010). Comparatively, highly religious persons are more expected to be married, form stable family relationships, and have high quality relationships. At higher distress levels, persons with social support can draw on such sources (religious community) for assistance while those without social support are prone to develop depression.

Depression is a very serious condition which can have some surprising effects on those who are experiencing this mental state. Depression is often looked upon as a negative consequence of the human condition as it sends a message to the world that life is not worth living and the zest and appeal of all that life has to offer is not available for that person experiencing depressed moods. Depression cause the acute and noticeable signs most commonly associated with the mental state, but also that depression may be the cause of other physical ailments.

According to the National Institute of Mental Health "everyone occasionally feels blue or sad. But these feelings are usually short-lived and pass within a couple of days. When you have depression, it interferes with daily life and causes pain for both you and those who care about you. Depression is a common but serious illness." Depression is something stronger than negative thoughts. Depression is a sign that something is not right in the mind and body and help is needed.

There are several types of depression that can help narrow down the specific problem a person is having. Major depression is serious and will have significant ramifications in the sufferers' daily life. Most people will experience some bout of major depression in their lifetime and the unfortunate will have several battles with this illness. People suffering from minor depression where the symptoms are less acute, must be careful to monitor their condition in case it increases in severity. The most afflicted with depression are diagnosed with psychotic depression where "which occurs when a person has severe depression plus some form of psychosis, such as having disturbing false beliefs or a break with reality (delusions), or hearing or seeing upsetting things that others cannot hear or see (hallucinations)," (National Institute of Health, nd).

No one is really confident in the causes of depression but most researchers and scientists believe that the problem is rooted in brain chemistry. Kenny (2012) wrote "some

people are more prone to it, and it can develop for no apparent reason. You may have no particular problem or worry, but symptoms can develop quite suddenly. So, there may be some genetic factor involved that makes some people more prone to depression than others." These is unfortunate for those cursed with genes predisposed to depression.

The symptoms of depression are important for everyone concerned about their mental health to realize. A person in a constant sad or lowered mood may be a person who is depressed. Those who have lost interest in the joys and pleasures of life should be considered suffering from sort of depression. Changes in appetite, sleep problems and feelings of sluggishness and worthlessness are other common symptoms as well, (Kenny, 2012).

Depression in people who suffer from this illness may have a significant and long lasting negative effect on the immune system. The immune system as the main line defense to any physical illness is vulnerable during a bout of depression and puts the sufferer at a heightened risk of a worsening physical condition.

Depression has the tendency to increase the risk of developing cardiovascular disease as well. Some researchers suggest that depression also may influence the risk of developing diabetes. Patients with depression are not of sound mind and will ignore solid medical advice and will not obey orders to follow healthy diets. Untreated depression has been shown to dramatically increase the risk of dying after a heart attack. "Data suggest that depression itself may be a risk factor for heart disease as well as its increased severity. Patients with heart disease who are depressed tend to have more severe cardiac symptoms than those who are not depressed, and a poorer quality of life. Depression can worsen the prognosis of heart disease and increase the risk of death, " (Simon, 2013).

Depression can cause real physical pain in those suffering in the grips of this dreadful illness. Marano (2002) identified the confusing nature of depression on the physical operations of the body. She wrote "In a study of over 25,000 patients at 15 primary care centers on five continents, Seattle researchers found that 50% of all depressed patients worldwide report multiple unexplained physical symptoms. It's wasn't that such patients were any less willing or able to express emotional distress. They readily acknowledged depressed mood when specifically asked about it."

The behaviors and mood of a depressed person affect the whole family in ways that are very difficult to detect. Most sufferers of depression are quite grumpy and dissatisfied with life which creates an impulse that starts conflicts and distorts family dynamics. The negative thought patterns of a depressed person permeate the environment with negative vibrational energy and creates a dour and somber mood within the household. As depressed family members begin to withdraw from the family unit, the fissure that is created becomes another layer of stress that needs to be addressed in order for healing to begin.

A strong family circle and good friends can sometimes be the best cure for depression. This further frustrates the situation at times because families can supply care,

comfort, even cure. They are extremely important to proper recognition and treatment of the disorder, not just at the beginning but throughout the entire process.

Families can create a positive atmosphere to the situation where drugs and treatments often fail. Iowa State researchers discussed an important study to help demonstrate the practicality of using family in healing those who are depressed. "They found that family adversity persists in children by initiating depressive symptoms in adolescence. That influence increases the occurrence of early disruptive life events. Their study of 485 Iowa adolescents over a 10-year period (1991-2001) found that early socioeconomic adversity experienced by children contributes to poor mental health by the time they become teens -- disrupting their successful transition into adulthood by endangering their social, academic and occupational attainment as young adults."

While it is obvious in many cases to see symptoms of depression in people who are suffering from this illness, there are unfortunately many hidden risks to this mental condition. The physical risks the body is exposed to during bouts of depression is a pathway to further serious physical conditions such as heart problems and diabetes. Besides these hidden risks, the impact on the family unit and its inability to help in the healing processes further complicates the situation for those who have been genetically predisposed to this condition. It is important that research and academic energy are funneled into new ways of treating these conditions that can incorporate the natural family environment into the solution.

The birth of a new family member often alters family dynamics. Families are forced to adjust to new situations. Although families are happy and excited because of childbirth, postnatal depression affects approximately twenty percent of mothers annually.

Pregnancy and childbirth bring strong social, physical, and psychological changes to a woman's life. They also mark the beginning of growth into parenthood. Because couples are forced to redefine their roles in their relationship and the society, they undergo changes. Researchers have demonstrated that a good relationship is the most vital resource for managing change (Rutledge & Bannister, 2007). The father of the child is often the prime source of support for the mother. If the father is greatly involved in childcare, it will be easier for the woman to become a mother and acclimate to the changes generated by the birth of a child. After childbirth, women require massive support from their spouses, from their parents and the immediate environment. The husband's life tends to be affected by childbirth and growth into fatherhood seems to be problematic.

Childbirth alters the relationship between spouses either by making it weaker or stronger. A positive pregnancy experience and the arrival of a new child often strengthen the relationship between couples. Moreover, a positive experience of childbirth likewise facilitates adaptation to the new lifestyle. Postnatal depression affects approximately twenty percent of mothers (Westall & Liamputtong, 2011). Symptoms of postnatal depression include weeping, hopelessness, panic attacks, and anxiety. Feelings of being a failure as a new mother are common: they might have difficulties in coping with their everyday chores. Nevertheless, it is difficult for mothers to admit their depression, not only

to other people but also to their partner. For this reason, they are left wondering where to seek help.

Research shows that men also suffer from postnatal depression. It is typical that women develop depression shortly after childbirth: depression for fathers starts at least one year later. Depression among fathers is linked to the concurrent depression of the spouse and the father's earlier episodes of depression. Postnatal depression in a mother induces feelings of frustration and helplessness in the partner: he is likely to feel that he is incapable of supporting his spouse. In addition, anger feelings might arise, and the partners might grow apart. Unsatisfactory spousal relationship and lack of social support have been blamed for postnatal depression in women. The practical support and presence of the partner help mothers get used to the new roles (Rutledge & Bannister, 2007).

Postnatal depression in mothers manifests as physical and psychological symptoms, related to the environment, in experiencing closeness as a distress, in fear of loss and in striving for perfection. Physical symptoms entail lack of appetite, sleep disorders, heart palpitations, and trembling. Sleep disorders comprises of difficulties in falling asleep, constant fatigue and frequent sleeplessness at night. Mothers tend to lose their appetite and even experience inability to eat. Trembling in the whole body and particularly the limbs are likely to happen, and palpitations are common. Psychological symptoms include tension and nervousness to a point where the mother develops a panic disorder. They experience insecurity and fear, particularly related to their capability as a mother. They experience feelings of loneliness, failure and restlessness, couples with violent mood swings. Guilt feelings are common: the mother may be angry because the time after childbirth is not what she thought would be. Feelings of insignificance might drive mothers to the brink of exhaustion and stagnation (Westall & Liamputtong, 2011). However, denial of the circumstances is a common phenomenon and the mother will always to try to go on with her life in order to provide good physical care to the infant. If this depression is prolonged, the mother could lose track of time and experience unreal feelings.

Families find it hard to admit to depression: they may prefer blaming sleeplessness as cause of fatigue. It is easier to admit to physical fatigue than depression. Families always deny and conceal their problems. They view depression as a mental illness, which demonstrates a weakness and thus as unacceptable. However, it is often difficult to identify depression because it develops slowly and may affect both spouses. The attitude of the mother towards the environment is likely to change as she becomes depressed (Orshan, 2008). The depression will make her withdraw from social contacts: she will see the environment as oppressive hence fear that the infant might get hurt. This will be accompanied by avoiding other people as she feels that they would not understand her. Meeting with other mothers also tends to be difficult because a depressed mother always sees other mothers as good mothers and successes, which makes her situation even harder to bear.

Childbirth and associated life changes caused by marital discord, unspoken expectations and unsettled conflicts tend to resurface and lead to conflicts. Emotions and thoughts that would have been unaddressed in the absence of pregnancy and childbirth often arise. One spouse might withdraw to silence while the other may work hard to

address the situation by violent means. Childbirth leads to spousal estrangement. Partners sometimes pay inadequate attention to one another and may be jealous of one another in terms of time usage. Fathers feel as if they have become onlookers, and excluded from the child-mother dyad. On the other hand, the mother envies the father's autonomy to leave the house, meet other people and go to work. Partners' lack of time together and their fatigue results in arguments. Silence seems to aggravate the situation and results in misunderstanding. The mother feels solely responsible for the child because the father is out working. The father begins to avoid coming home due to the oppressive situation, and the mother feels that he does not understand the infant. The mother gradually transmits her depression to the partner (Bifulco, 2013).

Alterations in family life might lead to such a deep discord between spouses and separation will be considered as the best solution. Even the infant might keep the couple together for a while; ultimately, they will want to end the difficult relationship. Separation is the result of a deadlock situation, in which spouses tend to be incapable of explaining or discussing their thoughts to each other. Thoughts of separation will easily surface when a mother becomes depressed after the birth of a child because of the deadlocked situation. Childbirth distresses the man to a point where he becomes unable to handle it and feels it is easier to feel it easier to get out. Unresolved conflicts before pregnancy and childbirth are likely to reach critical proportions and separation is seen as the only way out (Domino, 2007).

Strong reactions to alterations in the family unit characterize families of postnatal depressed mothers. Childbirth changes the existing structure of family and elicits strong reactions from involved persons. Parents see the infant as demanding and their energy is drained by childcare. They feel that they are on round-the-clock responsibility. A constant condition of alertness drains them physically and deprives them of the chance to spend time together because the infant is the center of life. Parents suffer from feelings of inadequacy when infant appear to have infinite needs. Parents are caught in a cycle of fatigue, and the father tries to help the spouse when at home but finds it difficult as work takes most of his time. The father develops feelings of exhaustion and inadequacy. The mother becomes tired of childbirth when an infant seems to be in a constant need of something. Life routines changes with childbirth and the infant responsibility changes the way parents view daily issues (Bifulco, 2013). The lack of a rhythm in the infant distresses parents and everything must be planned in accordance with the infant's needs. They feel that have lost control over their lives because their daily lives is out of control and their lives appears to be unstable.

The situation of being tied down to the newborn and the parent's new role drives them into a situation that needs urgent support from the external environment. Failure of the mother to get support from the spouse in the new life causes feelings of loneliness and distress in the mother. Therefore, mothers need encouragement and support from their spouses and view it as a necessity. The concrete presence of the father is of great importance to the mother. His support in childcare brings the partners closer together and helps understand the emotional confusion generated by the infant (Westall & Liamputtong, 2011).

Grandparents are also a vital source of support as they are always enthusiastic about grandchildren. If a mother had a positive relationship with her mother before childbirth, the grandmother might be the appropriate source of support. Parents appreciate the presence of grandparents and their tangible help. Research shows that peer groups are another important source of support. Discussion with other mothers helps understand that they are not alone and other parents struggle with similar issues (Domino, 2007).

Women, precisely those expecting their first child must be informed about potential changes after childbirth. Postnatal depression has been widely covered to show how it affects the partners, family relationships, and family functioning. Everyday human relationships, family life change, and the parents' attitudes towards the infant and the depression manifest themselves in different ways. It is evident that support one another as spouses is important if depression is to be tackled.

Mental health disorder is a continuum ranging from a severe disorder to minor distress of behavior or mind. The prime target of the health initiative is to enhance the social functioning and health of mentally ill persons (Halpern & Kaste, 2013). Oral health problem contributes to quality of life, general health, and self-esteem. Although it might have a minimal priority in the context of depression, the impact of mental health and treatment of oral health need to be addressed.

Studies indicate that high comorbidity and chronic dental pain are the most commonly recognized dental implications. Literature on chronic pain and depression extends to describe the reciprocal relation between depression and dental pain. Decreased motivation and energy, coupled with negative self-opinions associated with depression might cause a detrimental effect on oral hygiene habits and adherence to treatment interventions (Kandel, 2012). Depressed patients frequently have minimal interest in basic self-care activities. Adverse cognitive distortions worsen the depressive effects making the patients care less about themselves.

Additionally, besides the vegetative impacts of depression, physiological approaches might also affect oral health. Depression is always connected with a declined metabolism of serotonin, which is later linked to the high carbohydrate intake. This lays the foundation for favorable conditions for the development of acidduric bacteria. The existence of a high prevalence of these bacteria indicates the growth and progression of dental caries. The existence of pathogenic bacteria colonization can be caused by impaired functioning of the immune system linked to depression (Niedert & Dorner, 2009).

Persons with a high percentage of symptoms related to depression are prone to suffer periodontitis. It is theorized that neglect of oral hygiene, altered immune response, and increase in smoking facilitates an increase in colonization by pathogenic bacteria. This alters the periodontal attachment. Persons receiving antidepressants might occasionally develop a movement disorder that includes grinding or clenching of the teeth (Dumitrescu, 2010). This will further worsen the periodontal condition. This might happen because these antidepressants increase the levels of extrapyramidal of the serotonin hence inhibiting dopaminergic routes that control movements. Dumitrescu (2010) writes:

> "*The relation between periodontitis and depressive mood, depressive mood, depressive syndrome and depression/major depressive disorder remains largely unknown, although there are a variety of hypotheses. An explanation at the behavioral level might be that depressed patients neglect oral hygiene and regular dental check-ups as a result of reduced drive, mood, affectivity, and interest.*" (p.251).

The regular treatment of depression is antidepressants, which has demonstrated numerous side effects, including those that affect dental teeth. Both antidepressants and depression have been linked to xerostomia. According to research findings, one of the physiological effects of depression is an altered monoamine and endocrine regulatory systems. This contributes to modifications in the nature and amount of salivary production. Depression is partly a dysfunction of neurotransmitter metabolism; thus, antidepressants target this process. Secretion by the salivary glands tends to be mediated by neurotransmitters: as such, these medications regularly have the side effects of decreasing the production of saliva (Ashton, 2013).

Researchers describe the impacts of antidepressants on blood circulation to the granular cells. It alters the filtration and metabolism process. Anticholinergic drugs reduce the secretion. Although the side effects are temporary, it might not reduce the production of saliva. There is a multitude of potential sequellae of drug-induced hyposalivation such as thirst, a sensation of oral dryness, and an increase in incidents of oral infection including periodontal disease (Dumitrescu, 2010). Dental caries might be observed in persons taking antidepressants. Medical practitioners must always diagnose a burning sensation in the mouth triggered by an oral infection with a burning mouth syndrome. Despite the common impacts of anticholinergic drugs, the association between possible oral infection and hyposalivation, studies quantifying this link has yielded conclusive findings. There is a relationship between sub-median periodontal treatment outcome (SMPTO) and depression. Symptoms of depression have been associated with periodontal status, dental caries and a number of teeth issues among a sample of fifty-year-old patients in the United States (Kandel, 2012).

Some evidence suggests that use of antidepressants might similarly have a link to an increase of bruxism. Researchers have recently reported that bruxism can be effectively treated with either buspirone or gabapentin. They have also discussed the relevance of behavioral interventions as an alternative treatment intervention to antidepressants. Use of local esthetic interventions containing adrenaline as a vasoconstrictor for patients on antidepressants tends to be controversial because of the fear of triggering a hypertensive problem and a cardiac arrhythmia (Niedert & Dorner, 2009). The main approach to terminate the trigger action of adrenergic amines such as epinephrine is through re-uptake via sympathetic nerve fibers that precludes their receptor locales. However, antidepressants block this re-uptake process.

In addition, the antidepressants block adrenergic and muscarinic receptors thus directly depress the heart. Therefore, it is feared that the combination of antidepressants and adrenaline might result in an increase in a cardiac arrhythmia and a systolic blood pressure. As a result, standard doses of anesthetic solutions can be recommended: they should not contain epinephrine like three percent mepivacaine. Nevertheless, the US Dental

Practitioners have not observed any untoward outcomes. Plainly, the level of adrenaline used in the preparation of dental aesthetics is substantially insignificant to interact with the antidepressants (Dumitrescu, 2010). However, experts recommend that professionals must administer at least less than two capsules of two percent lidocaine with epinephrine. In this case, professionals must exercise great care to avoid intravenous administration. Ashton, Q. (2013) showed that

> "*If a patient fails to respond adequately to the initial antidepressant, typically three pharmacotherapy options are available to the practitioner. The dose of the current therapy can be minimized, a change can be made to a different drug, or the current regimen can be augmented with another drug."* (p.8).

Other negative drug interactions between antidepressants and medications used in dentistry might occur. The respiratory depressant impact of narcotic analgesics is triggered by tricyclic and the metabolism of antidepressants might be accelerated by the barbiturates thereby attenuating their antidepressant impact. The administration of medications containing anticholinergic elements like scopolamine and atropine causes an increase in intracellular pressure and worsens occult referred to as angle glaucoma. This calls for care when prescribing acetaminophen due to its ability to reduce the metabolic rate of antidepressants (Halpern & Kaste, 2013).

Patients receiving psychiatric treatment for depression might be reluctant to admit it due to the historic or local stigma associated with mental health disorders. To overcome such obstacles, dentists must be supportive, non-judgmental, and patient in offering advice to such patients. Such information must be held confidential as part of the provision of safe dental care. Scientists emphasize the paramount nature of preventive dental education for such patients and their families (Ashton, 2013). Patients should be given instruction on proper tooth brushing and flossing strategies, which maximize the removal of dental plaque. Antiseptic mouthwash, sodium fluoride mouth rinse, and artificial saliva products are prescribed for a majority of patients with symptoms of xerostomia. Dental medication must consist of root planning, curettage and subgingival scaling, dental restorations and application of fluoride. Niedert and Dorner (2009) confirmed, "*Depression or depressive symptoms significantly affect the quality of life. Level of function, productivity, and perceived physical and emotional health are also impaired*." (p.15).

Persons with severe depression tend to show poor oral health behaviors and are less engaged in oral health hygiene activities. In terms of individual's self-efficacy, the paper shows that self-efficacy is directly related with objective oral health. The paper offers a challenge to providers to reflect to revise how to enhance oral health behaviors or patients in order to increase positive oral health efforts. This paper provides a comprehensive complex set of variables that triggers oral health problems among depressed patients. Self-efficacy plays a crucial role in countering the effects of depression of oral health.

The relationship between depression, dental health, and religion has been examined through the exploration of the existing body of literature. In this study, the correlation between the three indicates that greater religiousness minimizes depression while

depression worsens dental health. Many people, regardless of age, gender, and ethnicity, are undergoing depression due to apparent life events. This paper looks at how religion helps in addressing depression by analyzing the relationship between depression, dental health and the faith community.

Depression is among the most popular mental disorder worldwide: many people have reported suffering from depression at one point in their lives. While depression is viewed as prevalent, it has also become costly. The global market for antidepressants has been expanding since 1993 with reports of depression. In the US, an estimated $15 billion in the workforce is lost to depression every year (King & Carson, 2012). Further depression has been found to be the leading cause of physical disability and is a risk factor for cardiovascular mortality. With such depression prevalence and the associated burdens, this paper has invested great deals of efforts attempting to identify factors, which could be useful in enhancing its diagnosis and detection. Some of the most profound risk factors include gender, genetic factors, social isolation, and personality traits like dependency.

Mental health disorder is a continuum ranging from a severe disorder to minor distress of behavior or mind. The prime target of the health initiative is to enhance the social functioning and health of mentally ill persons. Oral health problem contributes to quality of life, general health, and self-esteem. Although it might have a minimal priority in the context of depression, the impact of mental health and treatment of oral health need to be addressed (King & Carson, 2012).

Religious involvement is another factor, which has received significant attention throughout the literature on depression. Emerging high profile studies demonstrate that some religion aspects such as intrinsic religious motivation could be inversely associated with depression where great religious participation being related to minimal depression. Notably, studies indicate that public involvement in religious activities such as church attendance is inversely connected to depression among the aging population; intrinsic religious participation has been associated with speed by which depression episodes abated. It is evident that various researchers have reached similar conclusions after reviewing the overall literature on depression and religion. Notably, studies dating as far as 1880s point towards religion as a potential influence on the severity and occurrence of depression (Koenig & Cohen, 2002). Currently, researchers have suggested that scholars summarize and quantify this literature by using meta-analysis to enable an objective assessment of religion as a predictor of depressive symptoms.

Studies indicate that high comorbidity and chronic dental pain are the most commonly recognized dental implications. Literature on chronic pain and depression describes the reciprocal relation between depression and dental pain. Decreased motivation and energy, coupled with negative self-opinions associated with depression might cause a detrimental effect on oral hygiene habits and adherence to treatment interventions. Depressed patients frequently have minimal interest in basic self-care activities. Adverse cognitive distortions worsen the depressive spinal whereby patients neglect care of self (Ireland, 2010). Additionally, besides the vegetative impacts of depression, physiological approaches might likewise affect oral health. Depression is perhaps connected with a decline in metabolism of serotonin, which is in turn linked the

uncontrolled intake of carbohydrates. This lays the foundation for favorable conditions for the development of acidduric bacteria. The existence of a high prevalence of these bacteria indicates the growth and progression of dental caries. The existence of pathogenic bacteria colonization can be caused by impaired functioning of the immune system linked to depression.

Persons with a high percentage of symptoms related to depression are prone to suffer periodontitis. It is theorized that neglect of oral hygiene, altered immune response, and increase in smoking facilitates an increase in colonization by pathogenic bacteria. This causes the alteration of the periodontal attachment. Persons receiving antidepressants might occasionally develop a movement disorder that includes grinding or clenching of the teeth. This will further worsen the periodontal condition. This might happen because these antidepressants increase the levels of extrapyramidal of the serotonin hence inhibiting dopaminergic routes that control movements.

The religious community claims that religion is a resource while mental care specialists claim it is a liability. Whether a resource or a liability to depressed young people, it must be identified prior to generating down the barriers posing between religion and mental health care. In fact, religious involvement is imperative for most people across the world. According to recent surveys by the Gallup Poll, at least 70% OF US citizens said that religion is a vital component of their day-to-day lives. This figure continues to increase above 80%. Likewise, comparative surveys found that 60% Americans demonstrated that religion has been vital in their lives. This figure continues to increase above 70%. It is particularly true for medical clients often turning to religious beliefs in coping with illness (Koenig & Cohen, 2002).

Quantitative and qualitative researchers have shown high rates of coping behaviors based on religion in young people who try to manage with depression. In most parts of the America, almost 94 percent of hospitalized young people with depression problems use religion as a coping strategy. Nearly half of those who have used this approach report that religion are an integral factor, which keeps them going. In addition, increased religiosity projects a speedy resolution of depression symptoms in young people depressed over time. This increases the remission speed by 60 to 80 percent overall (Ireland, 2010). Spiritual involvement is related to positive emotions like purpose and optimism in ill life, besides generosity, altruism, and gratefulness. Such characteristics enhance well being and counteract maladaptive behaviors and cognitions, which maintain depression in young people. However, the clergy are not exempted from depression, particularly when critical health problems strike. Recent surveys of hospitalized medical in-patients with severe depression revealed that both were religious and spiritual, and at least 80% prayed once per day.

The cognitive behavioral theory contends that a relationship is created between compulsive ritual acts in depression, which minimize anxiety generated by disturbing thoughts or impulses. In effect, the decrease in anxiety adversely reinforces the ritual. Historically, cognitive behavioral perspective argues that behavior is a bi-product of an individual's environment and is reinforced negatively or positively. Further, it can be

punished negatively or positively. People learn to change behavior in accordance with the response they receive from their environment (Aguilar-Gaxiola & Gullotta, 2008).

Possible mechanisms explain how the faith community exerts pressure on depression. For instance, highly religious persons are less expected to become substance abusers than persons who are less religious. Eventually, persons with moderate low or moderate levels of religious involvement tend to engage in substance abuse during distress times resulting in increased depression. On the other hand, highly religious persons remain comparatively low in their substance abuse even under distress. The social support stemming from the religious community explains how religion reduces depression and depressive symptoms, comparatively, highly religious persons are more expected to be married and form stable family relationships, as well as have high quality relationships. At higher distress levels, persons with social support can draw on such sources (religious community) for assistance while those without social support are prone to develop depression.

Persons with severe depression tend to show poor oral health behaviors and are less engaged in oral health hygiene activities. In terms of an individual's self-efficacy, the paper shows that self-efficacy is directly related to objective oral health. Emotional expression facilitates coping with stress; highly religious persons are highly expected to benefit from the religious community. This increases the magnitude of the relationship between depression and religion. Altruistic messages common to most world religions focusing on the problems and needs of other people during crisis reduces the self-focused attention characterizing depression. Therefore, it is evident that the faith community assumes a remarkable role in addressing depression among persons of all ages, sex, gender, and ethnic background.

Studies relating to dental and oral health of hospitalized depressed patients indicate that it is often poor, and are in dire need of urgent dental-care interventions. People with chronic mental illness are commonly found with dry mouth, coronal smooth and tongue lesions. However, depressed patients receive psychiatric interventions, which tend to interfere with interpretation of medical results. A number of animal and human studies indicate a relationship between periodontal disease and stress. In addition, the concepts of depression and stress are related. There is substantial evidence that changes of the stress hormone system play a key role in the development of depressions.

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Additionally, besides the vegetative impacts of depression, physiological approaches might likewise affect oral health. Depression is perhaps connected to the decline in

metabolism of serotonin and later turn is linked to the high intake of carbohydrates. This lays the foundation for favorable conditions for the development of acidduric bacteria. The existence of a high prevalence of these bacteria indicates the growth and progression of dental caries. The existence of pathogenic bacteria colonization can be caused by impaired functioning of the immune system linked to depression (Chandra, 2002).

Persons with a high percentage of symptoms related to depression are prone to suffer periodontitis. It is theorized that neglect of oral hygiene, altered immune response, and increase in smoking facilitates an increase in colonization by pathogenic bacteria. This later alters the periodontal attachment. Persons receiving antidepressants might occasionally develop a movement disorder that includes grinding or clenching of the teeth. This will further worsen the periodontal condition. This might happen because these antidepressants increase the levels of extrapyramidal of the serotonin hence inhibiting dopaminergic routes that control movements.

Therapists encounter barriers while treating depressed patients using religious interventions. When youth, especially spiritual youths, become depressed, their beliefs interfere with compliance and acceptance of conventional interventions such as psychotherapy. Such clients tend to shy away from secular counseling as they see it rough to their religious beliefs. Religious youth patients could feel that pursuing therapy implies abandoning their religion and faith by favoring secular interventions. As such, youth in such a scenario tend to have guilty feelings and thoughts. This makes them feel ashamed about their depression and the failure of the clergy to address the issue facing them. They will further shy away from seeking support within their religious community. Halpern, and Kaste, (2013) confirmed: "*as health professionals, dentists are not necessarily called on to diagnose depression, but are capable of screening for this condition and referring patients as needed. Depression has dental and systemic sequelae beyond the disease itself.*" (p..28)

Traditionally, religious communities served as forefront providers of mental health across the world. They provided almost many hours of counseling similar to the members of the American Psychological Association. The clergy spent an average of 20% of their time on counseling exercises ever year, serving an estimated 150 hours of service sin mental health (Lamster & Northridge, 2008). Nuns and chaplains who provided similar services on a full time basis supported them. In addition, these services are free and the stigma related with such counseling does not exist. In fact, depressed young people often receive initial treatment by counselors and clergy within their religious community.

However, treatment within the religious community is not all the time effective, this is particularly for severe depression that requires referral to mental health experts for further treatment. In this case, the issue is that the association between mental health professionals and the clergy has been at crossroads. Indeed, mental health professionals have recorded a long history of conflict beginning with Ann Freud's definition of religion terming it the worldwide obsessional neurosis. In conventional mental health care, there is regularly as resistance to considering religious beliefs. Such a resistance is clear from emerging discussions among British psychiatrists. Great Britain is not the only country demonstrating negative attitudes towards faith by mental health professionals. A systematic analysis of religious content established that almost half of all cases mental

health problems incorporate religious descriptions. Emerging publications continue to insist an absence of concern for religious beliefs owned by patients. In addition, recent surveys focusing on US psychiatrists discovered that at least 60% never or rarely inquire about spiritual issues in young people suffering from depression or anxiety (Halpern & Kaste, 2013).

Based on such negligence perspective held by most mental health experts towards spirituality, religious experts have become reluctant to refer youth members to mental healthcare professionals. This is particularly psychotherapy that functions to alter religious beliefs and attitudes. Failure of the religious community to refer depressed young people prevents them from receiving the required treatment. In addition, if depressed young people are members of a religious community, and this community fails to reinforce or counteracts the benefits of psychotherapy, then these benefits will be short term (Chandra, 2002).Chandra, (2002) shows that:

> "*denial of this simple source of satisfaction and deprivation may lead to depression in old age of some individuals. Loss of anterior teeth has adverse effect on esthetics and brings down self-esteem and the patients tend to socially isolate themselves."* (p.246).

The regular treatment of depression is antidepressants, which has demonstrated numerous side effects, including those that affect dental teeth. Both antidepressants and depression have been linked to xerostomia. According to research findings, one of the physiological effects of depression is an altered monoamine and endocrine regulatory systems. This modifies the nature and amount of salivary production. Depression is partly a dysfunction of neurotransmitter metabolism: antidepressants target this process. Secretion by the salivary glands tends to be mediated by neurotransmitters: these medications regularly have the side effects of decreasing the production of saliva (Gochman, 2007).

Researchers describe the impacts of antidepressants on blood circulation to the granular cells. It alters the filtration and metabolism process. Anticholinergic drugs reduce the secretion although the side effects are temporary; it might not reduce the production of saliva. There is a multitude of potential sequalae of drug-induced hyposalivation such as thirst, a sensation of oral dryness and an increase in incidents of oral infection including periodontal disease. Dental caries might be observed in persons taking antidepressants. Medical practitioners should not find any burning sensation in the mouth triggered by an oral infection with a burning mouth syndrome (Halpern & Kaste, 2013). Despite the common impacts of anticholinergic drugs, the association between possible oral infection and hyposalivation, studies quantifying this link has yielded conclusive findings. There is a relationship between sub-median periodontal treatment outcome (SMPTO) and depression. Symptoms of depression have been associated with periodontal status, dental caries and a number of teeth issues among a sample of fifty-year-old patients in the United States (Chandra, 2002).

Many people, regardless of age, gender and ethnicity and nationality are undergoing depression due to apparent life events. This study looks at how religion helps in addressing depression by analyzing the relationship between depression, dental health, and the faith community.

Depression is among the most popular mental disorder globally since most people have reported suffering from depression. While depression is viewed as prevalent, it has also become costly. The global market for antidepressants has been expanding since 1993 with reports of depression. In the US, an estimated $15 billion in the workforce is lost to depression every year (Dayringer & Eicher, 2011). Furthermore, depression is seen the leading cause of physical disability and a risk factor for cardiovascular mortality. With such depression prevalence and the associated burdens, this paper has invested great deals of efforts attempting to identify factors, which could be useful in enhancing its diagnosis and detection. Some of the most profound risk factors include gender, genetic factors, social isolation, and personality traits like dependency. Mental health disorder is a continuum ranging from a severe disorder to minor distress of behavior or mind. The prime target of the health initiative is to enhance the social functioning and health of mentally ill persons. Oral health problem contributes to quality of life, general health, and self-esteem. Although it might have a minimal priority in the context of depression, the impact of mental health and treatment of oral health need to be addressed.

Religious involvement is another factor, which has received significant attention throughout the literature on depression. Emerging high profile studies demonstrate that some religion aspects such as intrinsic religious motivation could be inversely associated with depression: great religious participation being related to minimal depression. Notably, studies indicate that public involvement in religious activities such as church attendance is inversely connected to depression among the aging population; intrinsic religious participation has been associated with speed by which depression episodes abated. While reviewing the overall literature on depression and religion, various researchers have reached similar conclusions. Research studies focusing on such issues continue to accumulate. Notably, studies dating as far as 1880s point towards religion as a probable control on the harshness and the occurrence of depression (Koenig, 2010). Currently, researchers have suggested that scholars summarize and quantify this literature by using meta-analysis to enable an objective assessment of religion as a predictor of depressive symptoms.

Negative drug interactions between antidepressants and medications used in dentistry might occur. The respiratory depressant impact of narcotic analgesics is triggered by tricyclics and the metabolism of antidepressants might be accelerated by the barbiturates thereby attenuating their antidepressant impact. The administration of medications containing anticholinergic elements like scopolamine and atropine causes an increase in intracellular pressure and worsens occult referred to as angle glaucoma. This calls for care when prescribing acetaminophen due to its ability to reduce the metabolic rate of antidepressants (Aguilar-Gaxiola & Gullotta, 2008).

Patients receiving psychiatric treatment for depression might be reluctant to admit it due to the historic or local stigma associated with mental health disorders. While seeking to overcome such obstacles, dentists must be supportive, non-judgmental, and patient in offering advice to such patients. Such information must be held confidential as part of the provision of safe dental care. Scientists emphasize the paramount nature of preventive dental education for such patients and their families. Patients should be given instruction

on proper tooth brushing and flossing strategies, which maximize the removal of dental plaque. Antiseptic mouthwash, sodium fluoride mouth rinse, and artificial saliva products are prescribed for the majority of patients with symptoms of xerostomia. Dental medication must consist of root planning, curettage and subgingival scaling, dental restorations and application of fluoride.

Possible mechanisms explain how the faith community exerts pressure on depression. For instance, less religious persons are less expected to become substance abusers than persons who are less religious. As a result, persons with moderate low or moderate levels of religious involvement tend to engage in substance abuse during distress times with a corresponding increase in depression. On the other hand, highly religious persons remain comparatively low in their substance abuse even under distress. The social support stemming from the religious community explains how religion reduces depression and depressive symptoms (Koenig, 2010). Comparatively, highly religious persons are more expected to be married, form stable family relationships, and have high quality relationships. At higher distress levels, persons with social support can draw on such sources (religious community) for assistance while those without social support are prone to develop depression.

Involvement in religious activities could grant individuals social support opportunities. Recently, this has been found to safeguard against depression. Individuals engaged in religion have informal social contacts and tend to be active in civic participation than individuals who are not. Religious participation places individuals in touch with such social support sources: such participation could be mechanisms accounting for certain inverse relationships between religion and depression (Dayringer & Eicher, 2011).

The religious community claims that religion is a resource while mental care specialists claim it is a liability. Whether a resource or a liability to depressed young people, it must be identified prior to generating down the barriers posing between religion and mental health care. In fact, religious involvement is imperative for most people across the world. According to recent surveys by the Gallup Poll, at least 70% OF US citizens said that religion is a vital component of their day-to-day lives. This figure continues to increase above 80%. Likewise, comparative surveys found that 60% Americans demonstrated that religion continues to be vital in their lives. This figure continues to increase above 70% (Aguilar-Gaxiola & Gullotta, 2008). It is particularly true for medical clients often turning to religious beliefs in coping with illness.

Hundreds of quantitative and qualitative research has shown high rates of coping behaviors based on religion in young people trying to battle depression. In most parts of the America, almost 94 percent of hospitalized young people with depression problems use religion as a coping strategy. Nearly half of those who have used this approach report that religion are an integral factor, which keeps them going. In addition, increased religiosity projects a speedy resolution of depression symptoms in young people depressed over time. This increases the remission speed by sixty to eighty percent overall (Koenig, 2010). Spiritual involvement is related to positive emotions like purpose and optimism in ill life, besides generosity, altruism, and gratefulness. Such characteristics enhance well being and counteract maladaptive behaviors and cognitions, which maintain depression in young

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