MOOD DISORDER- DEPRESSIVE EPISODE (CLINICAL FEATURES)

COURSE: PSYCHOPATHOLOGY
Paper III (PGDCP; SEM I); Unit 2
By
Dr. Priyanka Kumari
Assistant Professor
Institute of Psychological Research and Service
Patna University
Contact No.7654991023;
E-mail- drpriyankakumari1483@gmail.com

Depressive Episode

The life-time risk of depression in males is 8-12% and in females is 20-26%. However, the life-time risk of major depression (or depressive episode) is about 8%. The typical depressive episode is characterised by the following features (which should last for at least two weeks for a diagnosis to be made):

Depressed Mood

The most important feature is

- The sadness of mood or loss of interest and/or pleasure in almost all activities (*pervasive sadness*),
- Present throughout the day (*persistent sadness*).

This sadness of mood is quantitatively as well as qualitatively different from the sadness encountered in 'normal' sadness or grief. The depressed mood varies little from day to day and is often not responsive to the environmental stimuli.

The loss of interest in daily activities results in

- Social withdrawal,
- Decreased ability to function in occupational and interpersonal areas and
- Decreased involvement in previously pleasurable activities.

In severe depression, there may be complete *anhedonia* (inability to experience pleasure).

Depressive Ideation/Cognition

Sadness of mood is usually associated with pessimism, which can result in three common types of depressive ideas. These are:

- Hopelessness (there is no hope in the future).
- Helplessness (no help is possible now).
- Worthlessness (feeling of inadequacy and inferiority).

The ideas of worthlessness can lead to self reproach and guilt-feelings.

Other features

- Difficulty in thinking,
- Difficulty in concentration,
- Indecisiveness, Slowed thinking,
- Subjective poor memory,
- Lack of initiative and Energy.
- Ruminations (repetitive, intrusive thoughts) with pessimistic ideas. Thoughts of death and preoccupation with death are not uncommon.

- Suicidal ideas may be present.
- In severe cases, delusions of nihilism (e.g. ‘world is coming to an end’, ‘my brain is completely dead’, ‘my intestines have rotted away’) may occur.

Psychomotor Activity

In younger patients (< 40 year old), retardation is more common and is characterised by slowed thinking and activity, decreased energy and monotonous voice. In a severe form, the patient can become stuporous (*depressive stupor*).

In the older patients (e.g. post-menopausal women), agitation is commoner. It often presents with marked anxiety, restlessness (inability to sit still, hand wriggling, picking at body parts or other objects) and a subjective feeling of unease.

Anxiety is a frequent accompaniment of depression. Irritability may present as easy annoyance and frustration in day-to-day activities, e.g. unusual anger at the noise made by children in the house.

Physical Symptoms

Heaviness of head, vague body aches are particularly common in the elderly depressives and depressed patients from the developing countries (such as India).

Multiple physical symptoms (called *general aches and pains*) are present in most patients even in the Western world and they can be elicited only if physicians routinely ask the patients for their presence.

Hypochondrical features may be present in up to a quarter of depressives presenting for treatment.

Another Common symptom is the complaints of reduced energy and easy fatigability.

Biological Functions

Disturbance of biological functions is common, with

- *Insomnia* (or sometimes increased sleep),
- *Loss of appetite and weight* (or sometimes hyperphagia and weight gain), and
- Loss of sexual drive.

When the disturbance is severe, it is called as melancholia (*somatic syndrome* in ICD-10-DCR; Diagnostic Criteria for Research).

The presence of somatic syndrome in depressive disorder signifies higher severity and more biological nature of the disturbance.

Somatic Syndrome in Depression (ICD-10)

The somatic syndrome is characterised by:

- Significant decrease in appetite or weight
- Early morning awakening, at least 2 (or more) hours before the usual time of awakening
- Diurnal variation, with depression being worst in the morning
- Pervasive loss of interest and loss of reactivity to pleasurable stimuli
- Psychomotor agitation or retardation.

Psychotic Features

About 15-20% of depressed patients have psychotic symptoms such as delusions, hallucinations, grossly inappropriate behaviour or stupor. The psychotic features can be either mood-congruent (e.g. nihilistic delusions, delusions of guilt, delusions of poverty, stupor) which are understandable in the light of depressed mood, or can be mood-incongruent (e.g. delusions of control) which are not directly related to depressive mood.

Suicide

Suicidal ideas in depression should always be taken very seriously. Although there is a risk of suicide in every depressed patient with suicidal ideation, presence of certain factors increases the risk of suicide

Suicidal Risk: Some Important Factors

Suicidal risk is much more in the presence of following factors:

a. Presence of marked hopelessness

b. Males; age>40; unmarried, divorced/widowed

c. Written/verbal communication of suicidal intent and/or plan

d. Early stages of depression

e. Recovering from depression (At the peak of depression, the patient is usually either too depressed or too retarded to commit suicide)

f. Period of 3 months from recovery.


Thank
You