Major Depressive Episode with Somatic Complaints: A Case Study

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Abstract

Depression is known to be among one of the most common affective disorders associated with personal and functional impairment and with an impact on the general state of health, therefore remaining a subject of interest for both practitioners and researchers. Within the present case of study we start from the most commonly accepted definition of depression namely as a mood basal crash with additional sad and unpleasant, menacing feelings. The severity of its clinical tableau makes it mandatory for us to focus on factors related to the onset of depression – in our case the onset of the major depressive episode. Therefore the impact of cognitive distortions is discussed as an element of the phenomenon. In such cases cognitive behavioral therapy is recommended in order to amend the transient dis-adaptive cognition, both of the patient's and of the family members with the purpose of the acceptance of the disease.

Keywords: *depression, major depressive episode, cognitive distortions, cognitive behavioural psychotherapy.*

I. INTRODUCTION

Definition of the broadest generality considers depression as a mood basal crash with additional sad and unpleasant, menacing feelings (Ingram, Ramel, Chavira, & Scher, 2005). The symptoms of Major Depressive Episode are: depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful) (DSM V, American Psychiatric Association), the crying, the fatigue, the feelings of worthlessness or guilt almost every day, insomnia, diminished ability to think or concentrate and others. Negative thoughts or depressive cognitions are important symptoms which can be divided into three groups (Angst, 2000). The first group relates to the present. The patient

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sees the unfortunate side of each event; he thinks that everything he does has only fails and that others regard him as a loser, he no longer trusts himself. The second group concerns the future. The patient expects the worst. He generally sees failures in work, ruining the family income, a misfortune for the inevitable deterioration of his health. These ideas of despair and hopelessness are often accompanied by the idea that life no longer has any value and that death would arrive as a welcomed release. These concerns may progress to the gloomy ideas and plans of suicide. It is important to investigate such ideas in any depression case (Beck, & Alford, 2009).

The third group of ideas refers to the past. They often take the form of sense, mindless, guilt and self-accusation for minor reasons; for example, a patient may feel guilty for some inconsequential impropriety events of having hurt someone. Usually these stories seemed to be deleted for years from the patient's mind, but when he gets depressive, they return as a stream into the memory, accompanied by intense feelings (Beck, 1967). Some patients have feelings of guilt with no relation to any particular event. Many stories focus on the memories of the unfortunate; the patient remembers the sad occasions, he had failures, his chances were in decline. Those dark memories are becoming increasingly common as the depression deepens (Gilbert, 2014).

Some other mental symptoms can occur as a part of a depressive disorder, and sometimes one of them dominates the clinical picture. These include depersonalization symptoms, phobias, obsessive, and hysterical symptoms as running or paralysis of a limb (Epstein, 1977; Levi, 1992). Symptoms of weakening memory are also common (Chodosh, Kado, Seeman, & Karlamangla, 2007); they result sometimes from aging, poor concentration, and whether the patient is encouraged to make a special effort, he can be shown that apprehension and reproduction are not affected (Lemogne, Piolino, Friszer, Claret, Girault, Jouvent,... & Fossati, 2006).

The physical symptoms are common in depressive disorders (Delgado, 2004). Although depressive disposition is typically the dominant part of depressive syndromes, some patients lack that essential element, while in others it is present (Demyttenaere, Bonnewyn, Bruffaerts, Brugha, De Graaf, & Alonso, 2006). Such patients often consult different doctors for sleep or appetite, loss of energy, fatigue and other somatic complaints. They do not accuse depressive feelings and deny the existence of such feelings when they are interviewed (Klerman, & Weissman, 1994). Typically, they admit some loss of interest or pleasure for very ordinary. Due to the importance of recognition of depressive disorders to such patients, depressive disposition is not required for diagnosis. These syndromes can be considered as a "masked depression" with numerous neuro-somatic complaints and autonomic dysfunctions (Lesse, 1983). Somatic symptoms are almost constant in depressive syndromes and sometimes they predict the occurrence of the disease (Henningsen, Zimmermann, & Sattel, 2003). Digestive disorders are represented by anorexia (80-90% of patients), constipation and weight loss and those conditions are frequently present in depressive disorders (Rodin, & Voshart, 1986).

Special attention should be given to the patients suffering from Hypochondriacal syndromes and those with regular pain events and hypertension (Ladee, 1966; Escobar, Gara, Waitzkin, H., Silver, Holman, & Compton, 1998).

Cardiovascular disorders associated with depression are typically the hypotension, reducing the pulse (or enlarging it during the depressive-anxiety syndromes), to which we can add bradycardia, extra systoles, palpitations, seizures and pseudo-painful pre-cardiac venues (Musselman, Evans, & Nemeroff, 1998). Respiratory disturbances may be limited to: shallow breathing, bradipneea, pharyngeal constriction, feeling tightness and dry mucous (Schroder, & O'Hara, 2005).

II. CONTENT CASE PRESENTATION

In the Hospital of Psychiatry, the psychological evaluation is done at the request of the doctor or the patient after preparing the observation sheet. The observation sheet contains information related to personal data, place of residence, studies, current status, conditions of life and living. Reasons for admission are also added along with heredo-collateral and personal history, described by the patient; the longitudinal evolution of the subject image is related with the history of the disease; premorbid personality type, disposition, fond of emotional intensity, persistence and stability of actions and activities, the degree of sociability.

The observation sheet also includes information that concerns the history of the present illness, hospitalization, the first onset of the disease, manifested symptoms, intensity, medication, behavior in periods of remission; the continuation of the professional activity, functionality in the whole (axis V, DSM - IV TR, 2003).

The neurologic examination is required to record various aspects pertaining to the existence of pathogenic organic lesions of the brain, while the laboratory tests are performed in order to evaluate the lipid balance, electrolyte of the patient as an adjunct to diagnosis.

1. General data

The patient C.F. was admitted at her own request in a psychiatric hospital. The patient is 52 years old, is married and has two teenage children. The living conditions are adequate; she lives in an apartment together with her husband and children.

She graduated from a vocational school, subsequently working as a clinical lab supervisor in a department store. The patient had been medically retired for six years.

2. Disease history and heredo-collateral history

The patient has a long history of depressive symptoms, major depressive episode with onset at the age of 28. She has followed psychiatric medication for a long period of time. During the last 6 years she was repeatedly admitted in psychiatric hospitals, with a higher frequency when charging over strung of certain changes in her life (the death of her mother, the changes occurring in the workplace - admission on another job position, later medical retirement). Every inpatient she presents a different intensity of symptoms associated with somatic and anxiety elements.

As a result of these admissions the patient was medically retired, the disease has a moderate degree of disability with functional distress. The patient denies the presence of other disease of organic nature and the results of the investigations are in the normal range.

To be noted that the mother of the patient had an admission in Psychiatry with symptoms due to medical conditions, major psycho-organic depressive episode, following diagnosis with liver cirrhosis, death occurring at five months after the hospital discharge.

The duration of the admissions in the hospital in the past six years is of 3-4 weeks, in most cases the patient seeking discharge.

The patient accuses: depressive disposition, interest in current activities, fatigue, wake-up insomnia, automatic kept negative thoughts, and low self-esteem, a feeling of hopelessness, helplessness, and inability to control the situation. That shows that the patient is in a jam, associated with behavioral and somatic anxiety.

She comes for admission with a referral from the specialist, with the diagnosis: major depressive disorder, major depressive episode present with somatic complaints. The trigger factor for this admission is the medication discontinuation, patient considering it to be "ineffective".

The patient acknowledges her disease, she has idea-verbal coherence, bradypsychia, there are not present any qualitative disorders of perception at the time of the evaluation, nor in history; did to be register the distraction of the attention, spontaneous hypoprosexia, amnesia of the "traumatic events.

Idea is focused on the prevalent ideas with self-devaluation, self-depreciation, incurable, but without the intensity of a psychotic, with strong resistance to logical reasons. The patient does not present any suicide ideas, or antecedents.

Thinking has a current dominant content arbitrary deductions, selective abstraction, devaluation, inability to control the situation. There are present several items associated with fear and concern for the persistent somatization and inhibition of instincts.

The weekly and final assessment we put emphasis on the self-monitoring of depressive symptomatology watching the relationship between severity and nature of the dysfunctional thoughts and the intensity of the depressive symptoms. The patient's depressive disposition varies from one day to another. During the hospital stay and after a week she showed other symptoms

such as irritability and hypersomnia, and the anxious symptoms have exacerbated, influenced by the emotional judgments and of the incurability feelings.

After a period of four weeks of treatment with an SSRI antidepressant and initiation of techniques for cognitive behavioural psychotherapy, a few days before discharge, the changes of the clinical picture are as follows:

- Diminishing in severity of the basic symptoms and in terms of intensity of the associated ones; therefore it has changed the patient's attitude towards the "incurable disease";
- At cognitive level there are found to be diminished in intensity all the cognitive biases;
- At the affective level the depressive mood of dissatisfaction observed, the self-esteem, the sense of self-devaluation, all recorded a decrease in severity;
- At physiological level fatigue can still be registered after effort. Instead there were maintained the somatic symptoms that have decreased in intensity and severity; sleep is restful (only under treatment);
- At behavioural level the patient shows an increase of her interest for routine activities.

In the end, the clinical picture shows a cooperative patient, with a good intra-hospital conduct and which wishes the continuation of the cognitive-behavioural psycho-therapy outside the hospital.

At the time of her discharge, the patient has the consciousness of her mental illness and agrees with the medication. The recommendations after discharge were periodic admission, screening for drug treatment and continuation of the psychotherapeutic intervention.

III. CONCLUSIONS

In depressive disorder it is indicated to use the medicinal therapy with antidepressants, psychotherapy with cognitive-behavioural therapy. The second purpose is to amend the transient dis-adaptive cognition, both of the patient's and of the family members with the purpose of the acceptance of the disease. The whole medical approach combined with the psycho-therapy intervention for the prevention of the relapse/recurrence and for learning the preventive measures of mental hygiene in order to maintain a mental balance between the own person - environment - future.

References

Angst, J. (2000). Course and prognosis of mood disorders. In, Gelder, M.G., Lopez-Ibor, J.J., & Andreasaon, N.C. *The New Oxford textbook of psychiatry*. Oxford University Press, Oxford.

Beck, A. T., & Alford, B. A. (2009). *Depression: Causes and treatment*. University of Pennsylvania Press.

Beck, A. T. (1967). *Depression: Clinical, experimental, and theoretical aspects* (Vol. 32). University of Pennsylvania Press.

Chodosh, J., Kado, D. M., Seeman, T. E., & Karlamangla, A. S. (2007). Depressive symptoms as a predictor of cognitive decline: MacArthur Studies of Successful Aging. *The American journal of geriatric psychiatry, 15*(5), 406-415.

Delgado, P. L. (2004). Common pathways of depression and pain. *Journal of Clinical Psychiatry*.

Demyttenaere, K., Bonnewyn, A., Bruffaerts, R., Brugha, T., De Graaf, R., & Alonso, J. (2006). Comorbid painful physical symptoms and depression: prevalence, work loss, and help seeking. *Journal of affective disorders, 92*(2), 185-193.

***Dictionary of Psychiatry*. Springer Science & Business Media, 2012.

EPSTEIN, W. (1977). Hysteria, anxiety, depression and related neurotic states. *Clinical Concepts of Neurological Disorders*. Baltimore: Williams and Wilkins.

Escobar, J. I., Gara, M., Waitzkin, H., Silver, R. C., Holman, A., & Compton, W. (1998). DSM-IV hypochondriasis in primary care. *General hospital psychiatry, 20*(3), 155-159.

Gilbert, P. (2014). *Depression: The evolution of powerlessness*. Psychology Press.

Henningsen, P., Zimmermann, T., & Sattel, H. (2003). Medically Unexplained Physical Symptoms, Anxiety, and Depression: A Meta-Analytic Review. *Psychosomatic medicine, 65*(4), 528-533.

Ingram, R. E., Ramel, W., Chavira, D., & Scher, C. (2005). Social anxiety and depression. *The essential handbook of social anxiety for clinicians*, 241-264.

Klerman, G. L., & Weissman, M. M. (1994). *Interpersonal psychotherapy of depression: A brief, focused, specific strategy*. Jason Aronson, Incorporated.

Ladee, G. A. (1966). *Hypochondriacal syndromes*. Elsevier Pub. Co..

Lemogne, C., Piolino, P., Friszer, S., Claret, A., Girault, N., Jouvent, R., ... & Fossati, P. (2006). Episodic autobiographical memory in depression: Specificity, autonoetic consciousness, and self-perspective. *Consciousness and cognition, 15*(2), 258-268.

Lesse, S. (1983). The masked depression syndrome: Results of a seventeen-year clinical study. *American journal of psychotherapy*.

Levi, M. I. (1992). *Basic notes in psychiatry*. Kluwer Academic Publishers.

Musselman, D. L., Evans, D. L., & Nemeroff, C. B. (1998). The relationship of depression to cardiovascular disease: epidemiology, biology, and treatment. *Archives of general psychiatry, 55*(7), 580-592.

Rodin, G., & Voshart, K. (1986). Depression in the medically ill: an overview. *Am J Psychiatry, 143*(6), 696-705.

Schroder, C. M., & O'Hara, R. (2005). Depression and obstructive sleep apnea (OSA). *Ann Gen Psychiatry, 4*(1), 13.