DEPRESSIVE PSYCHOSIS PRESENTING AS CHRONIC PAIN DISORDER
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SUMMARY
Depression can be disguised by somatic symptoms, chronic pain, hypochondriacal or psychosomatic disorder. The predominant somatic presentation may render such cases to be misdiagnosed, wrongly investigated and treated. In this study 30 consecutive patients diagnosed as MDP Depression, who lacked sadness but presented with chronic pain have been described. The patients were mainly female, middle aged and from urban background. Pain, usually at multiple sites, was reported to be severe by most patients. Predominant depressive symptoms were lack of interest in surrounding (97%), though this was not directly reported, early morning awakening (87%), loss of appetite (93%), suicidal ideas (67%). None had marked sadness or weeping spells. Lack of reactivity of mood was present in only two cases. The clinical implications of such patients is discussed.

Introduction
The concept of depression, as viewed by laymen and even most physicians, depends upon the presence of a mood designated as sadness, melancholy, despair, dejection, despondency, weeping, and so on. If this pattern is not prominently seen, then for all intents and purposes the patient is not considered as being depressed. There are a number of reports which have highlighted the fact that depressions may be disguised as various types of somatic symptoms, chronic pain, hypochondriacal and psychosomatic disorders (Lesse 1967, 1968a, 1974, Lopez-Ibor, 1972). The terms masked depression or depressive equivalent imply that if one probes behind the psychosomatic symptoms one will find a depressive core from which an overt depressive affect may eventually evolve. In many cases the depressive affect (sadness, weeping spells, dysphoria) may not evolve at all, but other features of endogenous depressive disorder (Manic depressive psychosis) may be clearly evident. It is such cases which are likely to be misdiagnosed and treated for their "Pain" rather than treatment of the endogenous depressive psychosis. This study draws attention towards this interesting phenomenon, which is also of a grave clinical importance.

The aim of this study was to examine the characteristics of patients diagnosed as endogenous depression, who lack sadness, but have the predominant complain of chronic pain. Further this study has attempted to describe the clinical characteristics of such patients with special attention to the presence of 'endogenous features'.

Material and Methods
The study was conducted at the department of Psychiatry, National Institute of Mental Health and Neuro Sciences, Bangalore. The sample of patients was selected using the following inclusion/exclusion criteria.

Inclusion Criteria
i) Main complaint of pain
ii) Duration longer than six months
iii) Absence of organic pathology
iv) Having at least 2 of the features of 'endogenicity' during the illness: early morning awakening, diurnal variation in symptoms, loss of appetite, loss of weight, feelings of sin or guilt, loss of libido.

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Exclusion criteria

i) Evidence of organic pathology or physical disease to explain nature and intensity of pain.

ii) Drug dependence or abuse.

iii) Mental retardation.

iv) Predominant sadness or weeping episodes consistently for more than a week during the course of illness.

Consecutive new patients were screened to look for those who fulfilled the above criteria. Thirty such cases were included into the study for further evaluation. The demographic data of the patients was recorded. The clinical characteristics of illness and pain characteristics were also systematically noted. Depressive symptoms and features of endogeneity were elicited during the mental state examination of the patients. Definitions conforming to PSE (Present State Examination by Wing et al 1974) were utilized for categorising the symptoms. Also, details of family morbidity and past illness were collected. The patient and accompanying relative, spouse or friend were interviewed to collect the above information. Frequency distribution of the clinical characteristics were computed.

Results

The study included 30 patients (9 males, 21 females). Eight were young (below 30 years), 14 were between 31-45 years age and 8 were above 45 years age. Majority (19,63%) were from an urban background. The education was upto high school in 12, above high school in 9 and primary or no education in 9 patients. The sample consisted of 13 housewives, 6 labourers and 11 who were in professional or clerical occupation.

The clinical characteristics are presented in Table 1. The duration of illness was less than a year in 67% of cases. Other noticeable characteristics were insidious onset (87%), lack of precipitating factor (77%), positive family history (37%), and a gradually worsening course (63%).

| Clinical Characteristic         | n | %  |
|--------------------------------|---|----|
| **Duration of Illness**         |   |    |
| 6 months - 1 year               | 20 | 67 |
| More than - 1 year              | 10 | 33 |
| **Onset**                       |   |    |
| Sudden                         |   |    |
| Insidious                       | 26 | 87 |
| **Precipitating factor**        |   |    |
| Present                        | 7  | 23 |
| Absent                         | 23 | 77 |
| **Family History**              |   |    |
| Positive                       | 7  | 23 |
| Absent                         | 23 | 77 |
| **Previous Episode**            |   |    |
| Present                        | 7  | 23 |
| Absent                         | 23 | 77 |
| **Course of Illness**           |   |    |
| Static                         | 4  | 14 |
| Fluctuating                    | 7  | 23 |
| Deteriorating                  | 19 | 63 |

Most patients reported multiple sites of pain (57%). Headache was the commonest site. Low back pain was reported infrequently (only 2 cases). Pain was reported to be severe by 57% and moderately severe by 43%. Mild dull ache was not reported by anyone. Pain was continuous in 47%, and occurred daily in another 40% (Table 2). Depressive symptoms are presented in Table 3. Though sadness was conspicuous by its absence (selection criteria) mild infrequent sadness was reported by 9 cases (30%). Lack of interest in surroundings or in activities of usual interest was a conspicuous observation in all (but one) cases. This was not directly reported or complained about, rather was elicited both from
the family member and the patient. Sleep disturbance with characteristic early morning awakening was reported by 87% cases and loss of appetite was another very common feature (93%); suicidal ideas were harboured by 2/3 of these cases. Most patients could smile when the situation warranted and loss of reactivity of mood was seen during examination in 2 cases only. Table 3 shows that endogenous features were very commonly seen in these cases. The clinical diagnosis was Manic Depressive Psychosis (depressed type) in all the cases. Seven patients had previous depressed, somatised or manic episode.

Table 2

| Characteristics of pain | n | % |
|-------------------------|---|---|
| **Site**                |   |   |
| Single                  | 13| 43|
| Multiple                | 17| 57|
| **Intensity**           |   |   |
| Mild                    | 0 | 0 |
| Moderate                | 13| 43|
| Severe                  | 17| 57|
| **Frequency**           |   |   |
| Daily                   | 12| 40|
| Alternate days          | 4 | 13|
| Continuous              | 14| 47|

Table 3

| Depressive symptoms          | n  | %  |
|------------------------------|----|----|
| Sadness (mild)               | 9  | 30 |
| Lack of Interest-mild        | 13 | 43 |
| Early awakening              | 26 | 87 |
| Loss of appetite             | 28 | 93 |
| Feelings of Guilt            | 17 | 57 |
| Diurnal variation            | 24 | 80 |
| Suicidal ideas               | 20 | 67 |
| Anxiety symptoms             | 7  | 23 |
| Loss of reactivity of mood   | 2  | 7  |

**Discussion**

Hypochondriasis, psychosomatic disorders and pain are the most common masks of depression among adults in the United States (Lesse 1981b). These types of masked depression rival overt depressions in frequency. They represent the commonest types of depression seen by non-psychiatric physicians.

The clinical observations made in the group of patients described here are comparable with those of other studies on masked depression. In a study of patients who had depressions masked by hypochondriasis or psychosomatic disorders Lesse (1968b) reported 73% of patients to be women. In the present study 71% patients were women.

Age distribution is also comparable to that reported by Lesse (1967). But the duration of illness in the present study is much shorter than that reported by Lesse (1967, 1981a). This difference is perhaps due to the difference in types of depressions masked in the two studies. Whereas in the present study only depressive psychosis has been considered, Lesse had included chronic depressions and neurotic depressions also.

In another study on masked depression in adolescents Lesse (1987a) found common symptoms of endogenous depression (which were denied by the patient initially) like – being listless, sleep disturbance, morning fatigue, inability to perform routine chores, social withdrawal and inability to concentrate. Suicidal ideas of various frequencies and intensities were recorded in 11% of adolescent patients (Lesse 1981a), and 45% of adult patients (Lesse 1975). The rate of 67% in the present study is higher because of the psychotic nature of depression. This study thus stresses that intensity and frequency of suicidal ideas and the imminence of suicidal drives must be ascertained in all instances to prevent this unfortunate act. The severity of depression in these pain patients calls for immediate intervention in the form of anti-depressant
medications with or without electroconvulsive treatment.

Masked depression is represented in all cultures and it may be much more in the oriental cultures (Lesse 1983, Katon et al 1982). The masking veneer or facade may vary depending upon many factors, including the culture, age of patient, socio-economic and socio-philosophic background, hereditary and congenital processes and on-togenic development (Lesse 1983).

Masked depressions pose severe challenges to all clinicians and especially physicians to whom these patients present first due to the obvious nature of their symptom (Pain). In these instances the clinician must be able to uncover the mask, identify the psychiatric nature of the problem and either ensure proper therapy or refer to the nearest psychiatrist.

References

KATON, W., KLEINMAN, A. & ROSEN, G. (1982). Depression and Somatization, A review. The American Journal of Medicine, 72, 127-135.

LESSE, S. (1967). Hypochondriacal and psychosomatic disorders masking depression. American Journal of Psychotherapy, 21, 607-618.

LESSE, S. (1968a). Masked depression: a diagnostic and therapeutic problem. Diseases of Nervous system, 29, 169-173.

LESSE, S. (1968b). The multivariant masks of depression, American Journal of Psychiatry, 124, 11-18.

LESSE, S. (1975). The range of therapies in the treatment of severely depressed suicidal patients. American Journal of Psychotherapy, 29, 308-320.

LESSE, S. (1981a). Hypochondriacal and Psychosomatic disorders masking depression in adolescents. American Journal of Psychotherapy, 35, 356-367.

LESSE, S. (1981b). Unmasking the masks of depression, Carrier Foundation Letter, 74, 1-4.

LESSE, S. (1983). Masked depression. Current Psychiatric Therapies, 81-87.

LOPEZ-IBOR, J.J. (1972). Masked depression. British Journal of Psychiatry, 120, 245-258.

WING, J.K., COOPER, J.E. & SARTORIUS, S. (1974). The measurement and classification of psychiatric symptoms, London, Cambridge, University Press.