

Pessimism, Worthlessness, Anhedonia, and Thoughts of Death Identify DSM–IV Major Depression in Hospitalized, Medically Ill Patients

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Background: Major depression can be difficult to diagnose in medically ill patients, as distinct mood states may not be adequately differentiated. Previous research has found several dimensions of mood states, including demoralization (hopelessness/helplessness) and anhedonia (inability to experience pleasure). DSM–IV major depression was highly prevalent in the clusters of participants typified by high levels of demoralization, and to a slightly lesser extent, anhedonia.

Objective: The present study provides a further analysis of 312 medically ill patients, examining how key individual symptoms of demoralization and anhedonia relate to DSM–IV major depression. **Method:** The authors used logistic-regression and classification and regression-tree (CART) analysis to relate variables of demoralization/anhedonia and major depression. **Results:** Two combinations of symptoms 1) pessimism and worthlessness; and 2) pessimism, loss of interest in others, and thoughts of death, were highly associated with major depression. **Conclusion:** The identification of key symptoms, particularly those involving pessimism, may aid clinical understanding and treatment of depression. (Psychosomatics 2010; 51:302–311)

Depression is common in hospitalized medically ill patients, with prevalence reported at approximately 20% to 30%.¹ This disorder is associated with increased healthcare costs, reduced compliance, and increased morbidity and mortality.^{2,3}

In order for depression to be treated, it must first be identified—which poses a particular problem in medically

ill patients. Depression may be regarded by some clinicians, as well as by patients and relatives, as an expected or “natural” consequence of illness or hospital stay;⁴ therefore, the boundary between clinical depression and normal sadness is unclear. There is also growing opinion that, within clinical depression, traditional diagnostic systems do not allow differentiation between different mood states commonly experienced in medically ill patients.⁵ For example, the criteria for major depression used by the 4th Edition of the Diagnostic and Statistical Manual (DSM–IV)⁶ essentially views depression as a single condition, varying only in severity, yet it has been found to be heterogeneous with regard to clinical presentation, course, treatment, genetics, and neurobiology.⁷

In our previous research, we found evidence for subtypes of depression in medically ill patients. We did this, first, by exploring the dimensional structure of both psychological and somatic symptoms, and thus identified five

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traits or factors, which we termed 1) demoralization; 2) anhedonia; 3) autonomic anxiety; 4) somatoform symptoms; and 5) grief.⁸ Anhedonia was typified by diminished interest and the inability to experience pleasure,⁹ and demoralization was characterized by feelings of hopelessness, helplessness, and despair.¹⁰

In subsequent research, we found several classes or clusters of patients with similar scores on the above five factors.¹¹ DSM-IV major depression was highly prominent in the clusters typified by high scores on the demoralization factor, and, to a slightly lesser extent, high scores on the anhedonia factor. Further evidence for the distinction and importance of demoralization and anhedonia was provided in our later study of 271 severely medically ill patients, where we used self-report measures of depression.¹² Together, these results suggest that there are different dimensions or types of depression, primarily distinguished by levels of demoralization and anhedonia.

Although both anhedonia^{13,14} and demoralization^{15,16} have been operationalized and observed in other populations, such as adolescents,¹⁷ as well as medically ill patients,^{18–21} there has been little formal research into the relationship between them and the commonly-used category of major depression. It is evident that there is overlap between these constructs however, which should be further investigated. For example, “feelings of worthlessness,” a key feature of demoralization,¹⁰ is a component of the DSM-IV major depression symptom of “feelings of worthlessness or excessive or inappropriate guilt.” Similarly, “markedly diminished interest or pleasure,” fundamental to the concept of anhedonia,⁹ is, along with depressed mood, a core symptom of DSM-IV major depression. Also, loss of interest or pleasure, along with lack of reactivity to usually pleasurable stimuli, is a core feature of DSM-IV major depression with melancholic features.

There has recently been renewed interest in major depression at the symptom level, including examination of which specific symptoms are most important in making the diagnosis.^{22,23} The present study seeks to extend our previous findings regarding constructs of demoralization and anhedonia, those mood states most highly associated with major depression in medically ill patients. We further analyzed the sample of 312 medically ill patients in order to identify which specific key symptoms of our previously identified demoralization and anhedonia factors⁸ are most highly associated with a diagnosis of DSM-IV major depression. Both logistic-regression and a computational method using classification and regression trees (CART)²⁴

were applied. We first used logistic-regression to examine the relationship between DSM-IV major depression and the key symptoms of demoralization and anhedonia taken individually and together. CART was then used to look for subgroups of patients defined by particular combinations of key symptoms, which were then further analyzed by logistic regression. The identification of combinations of specific symptoms within the major depression construct will clarify whether or not the latter is truly heterogeneous and may clarify different qualitative subtypes of depression. This could have implications for clinical treatment. Finally, core symptoms or groups of symptoms that identify major depression especially well in medically ill patients, might be used as markers or screening tests for depression in this group.

METHOD

Recruitment and Screening

The study was conducted at Monash Medical Centre, a university-affiliated general hospital in Melbourne, Australia. A sample of 312 patients who provided written, informed consent were recruited from consecutive admissions to the medical and surgical wards, after being screened for probable psychiatric caseness. The latter was defined as having a threshold or cutoff of ≥ 21 on the 36-item version of the General Health Questionnaire (GHQ-36),²⁵ scored using the chronic binary method.²⁶ This cutoff was used because it has demonstrated good sensitivity for a broad range of disturbances in a medical population.⁸ The sample was restricted to probable cases in order to approximate the type of clinical sample that would generally be referred to consultation-liaison psychiatry within a general hospital.

Patients were administered a structured psychiatric interview, described below, and completed a self-report questionnaire. Exclusion criteria were cognitive impairment and insufficient fluency in the English language. The 312 patients had a mean age of 47.5 years (range: 18 to 85 years) and were predominantly female (61%); these characteristics were similar to those of the general hospital population.²⁷ Patients had been admitted to the hospital with a range of medical conditions: predominantly, cardiovascular (22%); gastrointestinal (17%); respiratory (15%); rheumatological (13%); and neurological (11%). The mean severity of illness, assessed in consultation with hospital medical staff using a 4-point Likert scale, was 2.4.

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