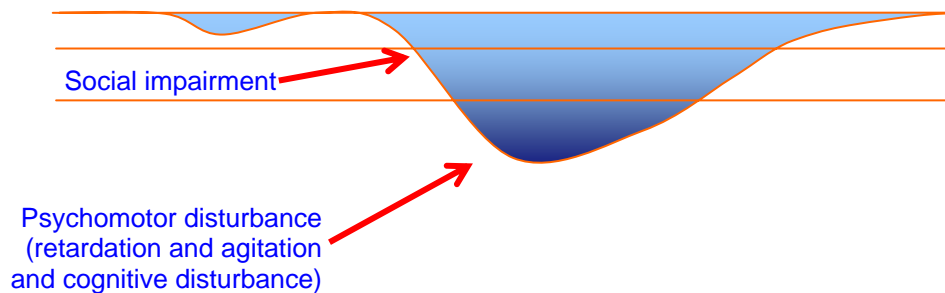




## About Melancholic Depression

**Melancholic depression is a very distressing condition.** It may have a unipolar or bipolar course.



### Symptoms of Melancholic Depression

- Anhedonia (distinct loss of pleasure in usual interests and activities)
- Non-reactive mood
- Mood and energy worse in the morning\*
- Profound and uncharacteristic inanition – ‘emptiness and inactivity’ (eg. unable to ‘fire-up’ and get out of bed and have a shower).
- **Observable psychomotor disturbance** (see *Glossary of Clinical Terms*) is a very important and specific diagnostic feature of melancholic depression → It includes **cognitive processing problems** (poor concentration, inattention) and **motor signs**: Retardation and agitation affecting the face, speech and body
- \*Usually worse in the mornings: Signs tend to fluctuate during the course of the day. This is best observed first hand by the general practitioner. Family and friends may report change in behaviour but not be aware of the significance of this feature.

### The CORE rating Scale

The CORE rating scale can be used to assess psychomotor retardation (**Observable psychomotor disturbance**), which is a very important and specific diagnostic feature of melancholic depression

The CORE rating scale is included in the toolkit in the section ‘Proformas: Outcome tools and mental health care plans’ or alternatively at the institute’s website [blackdoginstitute.org.au](http://blackdoginstitute.org.au)

**Scoring Sheet for the CORE Assessment of Psychomotor Change**

After entering the item ratings in the boxes sum the columns to obtain the scores on the three scales; then sum the three scale scores to obtain the total score.

1. Non-interactiveness	<input type="checkbox"/>		
2. Facial immobility		<input type="checkbox"/>	
3. Postural slumping		<input type="checkbox"/>	
4. Non-reactivity	<input type="checkbox"/>		
5. Facial apprehension			<input type="checkbox"/>
6. Delay in responding verbally		<input type="checkbox"/>	
7. Length of verbal responses	<input type="checkbox"/>		
8. Inattentiveness	<input type="checkbox"/>		
9. Facial agitation			<input type="checkbox"/>
10. Body immobility (amount, not speed)		<input type="checkbox"/>	
11. Motor agitation			<input type="checkbox"/>
12. Poverty of associations	<input type="checkbox"/>		
13. Slowed movement (speed, not amount)		<input type="checkbox"/>	
14. Verbal stereotypy		<input type="checkbox"/>	
15. Delay in motor activity		<input type="checkbox"/>	
16. Impaired spontaneity of talk	<input type="checkbox"/>		
17. Slowing of speech rate		<input type="checkbox"/>	
18. Stereotyped movements			<input type="checkbox"/>
NI = Non-interactiveness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RT = Retardation		<input type="checkbox"/>	
AG = Agitation			<input type="checkbox"/>
Total CORE score = NI + RT + AG =	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

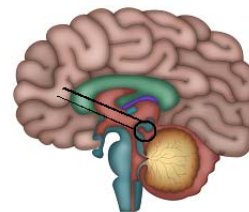


## **Mechanisms and Age of Onset**

Melancholic depression is a biologically based condition, but mechanism is different in different age groups:

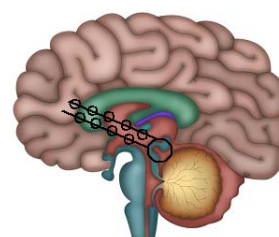
### **(a) Functional Melancholia**

- Younger onset (eg <60 years), ? genetic predisposition
- Often strong family history of depression
- Structural abnormalities rare on imaging
- Good response to broad spectrum antidepressants, ECT
- Mechanism: *Functional* shut-down of circuits linking basal ganglia and pre-frontal cortex.



### **(b) Structural Melancholia**

- Older onset (eg > 60 years), ? vascular predisposition
- Family history of depression less common, but cerebrovascular disease more common
- Structural abnormalities on imaging
- Poorer response to antidepressants & ECT, risk of delirium
- Mechanism: *Structural* disruption of circuits linking basal ganglia and pre-frontal circuits, preceding full dementia in months or years.



## **Observational Assessment**

- Individuals with good social skills or psychosis may underplay inner distress and despair
- When observing the patient, consider factors such as voice tone, whether the 'light in their eyes' is lost
- Individuals may fluctuate over the day, usually worst in the mornings. It is best for the GP to see them during the part of the day when they report being slower, more hopeless. This is usually in the morning.
- Some useful questions which can help to determine if a patient is suffering from melancholic depression include:
  - Do you still read the newspaper... watch TV?
  - What do you do all day – what would you normally do?
  - What do you still enjoy...hobbies...children/grandchildren...sunrise?
  - Do you feel worse in the morning or the evening?
  - How do you sleep? Do you wake early in the morning?
  - Can you be cheered up? What lifts your mood?

## **Response to Treatment**

- ECT is highly effective. Broader spectrum antidepressants are more effective than 'narrow spectrum', that is TCAs, MAOIs are better than > SNRIs (venlafaxine, mirtazapine, duloxetine) > SSRI and other single-action drugs. The superiority of TCA over SSRI antidepressants increases with age.
- If antidepressant alone fails, brief augmentation of antipsychotic may 'kick-start' response.