



## About Melancholic Depression

The melancholic subtype of depression is found in unipolar and bipolar disorders.

### Symptoms of Melancholic Depression

- Anhedonia - distinct loss of pleasure in usual interests and activities.
- Non-reactive mood – unresponsive in the consultation, nothing lifts their spirits.
- Diurnal variation - mood and energy worse in the morning (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).
- Anergia - profound and uncharacteristic lethargy, 'emptiness and inactivity' (e.g. unable to 'fire-up' and get out of bed and have a shower).
- Psychomotor disturbance - (i) cognitive processing problems (poor concentration, inattention) and (ii) motor signs (retardation or agitation affecting the face, speech and body, and the body feels heavy). See *Glossary of Clinical Terms* - an important and specific diagnostic feature of melancholic depression.
- Sleep disturbance – usually broken and reduced, with early morning waking (there is an atypical subgroup that has increased sleep).
- Appetite changes – usually reduced and with weight loss (there is an atypical subgroup that has increased appetite).

There is some variation in the symptoms depending on patient age – in younger people there is more likely to be irritability and sleep and appetite increase. Also, in the younger group be mindful of the possibility there could be a bipolar disorder.

Do not confuse degrees of severity of depression with subtyping of depression. The classification of depression subtypes is based on the particular symptoms described by a patient – not symptom severity. Obviously, each of the depression subtypes would have variations in the degree of severity of their particular symptoms.

There are treatment regimes (algorithms) for each subtype of depression.

### The CORE Rating Scale

Of most benefit if depression at its nadir - 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

[www.blackdoginstitute.org.au](http://www.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"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Facial immobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Postural slumping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Non-reactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Facial apportionment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Delay in responding verbally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Length of verbal responses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Inattentiveness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Facial agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Body immobility (amount, not speed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Motor agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Poverty of associations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Slowed movement (speed, not amount)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Verbal stereotype	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Delay in motor activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Impaired spontaneity of talk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Slowing of speech rate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Stereotyped movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NI = Non-interactiveness  
RT = Retardation  
AC = Agitation

Total CORE score = NI + RT + AC =

## Mechanisms and Age of Onset

### (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.
- On observing the patient - consider voice tone, have they have lost the 'light in their eyes'.
- They may fluctuate over the day (usually worst in mornings). It is best for the GP to see them at that the part of the day.
- Some useful questions to determine if a patient has melancholic depression:
  - 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?
  - Do you think you are losing your memory...mind not working as well?
  - Do you feel heavy or weighed down ...slow in thinking, talking or moving?
  - Are there times of agitation or restlessness...can't sit still?
- Don't forget the value of collateral observations/information (partner, children).

## Response to Physical Treatments

- The treatment choice may vary to some degree depending on the age of the patient.
- ECT is very effective. Broader spectrum antidepressants are more effective than 'narrow spectrum'. TCAs, MAOIs are better than dual action SNRIs (venlafaxine, mirtazapine, duloxetine) and dual action agents are better than single-action (SSRI or other). The superiority of TCA over SSRI antidepressants increases with age.
- If antidepressant alone brings insufficient benefit, may require brief augmentation with an atypical antipsychotic to 'kick-start' the response. Other augmenting agents may be used.
- Omega 3 can be of benefit – and is routinely prescribed in these cases.