



written by Professor Gordon Parker

## mind over matter

# Persistent melancholia

Once again a perfectionist patient suffers depression – but this time melancholia is a major feature.

## PRESENTATION

Mr C, a work-stressed 52-year-old perfectionistic school teacher (a profile similar to last month's Mr B), was referred with treatment-resistant depression.

## HISTORY

Mr C's depressive episodes had commenced in his mid-20s. For the first two decades, the episodes had responded to a tricyclic antidepressant. On medical advice, he would usually cease antidepressants after six months – largely because of troubling side-effects – and then remain episode-free for years.

Mr C's current episode commenced three years ago. His GP had prescribed moclobemide and two SSRIs without success. The GP then referred him to a psychiatrist who, after trialling two other SSRIs without noticeable improvement, judged that Mr C's depression was drug-resistant and proposed ECT.

## MANAGEMENT QUESTION

So, what type of depression did Mr C have? Was it a non-melancholic depression brought about by teaching stresses and a predisposing personality (perfectionistic) style? Mr C was clearly perfectionistic and described most of his episodes as preceded by work environmental stressors. However, when melancholia screening was undertaken, Mr C was positive.

## CLUES FOR IDENTIFYING MELANCHOLIA

Back in the old days, medical students were required to learn a set of endogeneity symptoms to detect endogenous depression (now termed melancholia).

While some symptoms are common in melancholia (for example, early morning wakening and appetite loss), they are also common in non-melancholic depression – and grief situations – and thus lack specificity.

The key phenotypic feature to melancholia is psychomotor disturbance.

During the depressed state, the individual's concentration ('psycho' component) is usually affected ("I feel in a fog, Doctor"; "I usually cook the meals, but I can't even remember how to cook an omelette").

The 'motor' disturbance is usually retardation, but some individuals have agitation superimposed on retardation, with the motor components generally more subtle in younger sufferers.

Retardation is very observable and best assessed as a 'sign' (rateable by the CORE measure). The individual's voice modulation is restricted; they are slowed physically and verbally, with the speech sometimes monosyllabic. Screening ques-

tions pursue such features, but the one I find most useful is: "When in that state, is it hard to get out of bed to even have a bath or shower?" Such profound anergia is characteristic.

Agitation is the motoric manifestation of mental perturbation – the individual can't sit still or may rub their hands slowly in semi-purposeful ways – feeling mentally tortured and with a characteristic coda: "What will become of me?"

Some melancholic symptoms capture the physicality of melancholia (that is, the inability to be cheered up; distinct anhedonia), often with such mood and energy symptoms showing diurnal variation, being worse in the morning.

## TREATMENT APPROACH

The primary treatment is 'physical', usually involving an antidepressant drug or, in severe and treatment-resistant cases, ECT. Non-physical approaches (for example, psychotherapy) may be adjunctive or unnecessary. Commonsense counselling (offering a confident prognosis, managing suicidal risk, and addressing the impact of the associated impairment on work and family) is fundamental.

## PHARMACOTHERAPY

Younger subjects with melancholia may respond to a narrow-action antidepressant such as an SSRI. As they age, their chance of responding may diminish. If such drugs fail, the clinician should adopt progressively broader-action antidepressants. Thus, if a 'dual action' antidepressant fails, consider a tricyclic or monoamine oxidase inhibitor. If these fail or only induce a partial response, consider brief augmentation with an atypical antipsychotic drug.

## PROGRESS

Mr C partially responded to a tricyclic (at full dose). When a low-dose atypical antipsychotic was added, he described rapid remission over the next week.

The antipsychotic was ceased a week later, and it was recommended that he stay on an antidepressant drug regime for an extended period. In essence, not a 'treatment resistant' depression, more a persistent disorder requiring a broader-action antidepressant strategy.

## MESSAGE

The suggested determinants to depression onset (stress and personality) can be shared across differing depressive types (as for Mr B and Mr C). For Mr B, they were 'necessary and sufficient' explanations; for Mr C, they were triggers at best, and a biological treatment focus was required.

**MO**  
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Information reference: See CORE rating scale of psychomotor disturbance, and 'Rational Model for Antidepressant Drug Prescription' on the website [www.blackdoginstitute.org.au](http://www.blackdoginstitute.org.au).