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Validation of a new prototypic measure of melancholia

Gordon Parker[a,b,*], Stacey McCraw[a,b], Kathryn Fletcher[a,b], Paul Friend[b], Shulamit Futeran[b]

[a]School of Psychiatry, University of New South Wales, Sydney, Australia
[b]Black Dog Institute, Sydney, Australia

Abstract

Multiple approaches have been adopted in an attempt to effectively identify and discriminate melancholic and non-melancholic depressive subtypes. We recently developed the Sydney Melancholia Prototype Index (SMPI) which incorporates antecedent and illness course variables as well as symptoms, with clinician-rated and self-rated SMPI versions, and with the former having been shown to have superior sensitivity and specificity in discriminating melancholic from non-melancholic depression. The aim of this study was to further evaluate the capacity of the SMPI to identify melancholia in comparison to DSM-based and clinician-judged assignments. The sample comprised 214 patients diagnosed with melancholic or non-melancholic depression according to a detailed clinical assessment and by the Mini International Neuropsychiatric Structured Interview (MINI) assessing formal DSM-IV melancholia criteria. DSM-IV assignment to melancholic versus non-melancholic depression was contrasted with clinician-judged allocation, the combination of these two strategies ("concordant diagnoses"), and to the SMPI (CR or clinician-rated and SR or self-report versions), with the likely validity of each approach examined against historical ascriptions for melancholia. DSM-IV criteria assigned the highest percentage of the sample with a melancholic diagnosis (64%), whereas the SMPI-SR assigned the smallest percentage with a melancholic diagnosis (37%). DSM-IV assignment was associated with the fewest number of validating variables, whilst SMPI-CR and independent clinician diagnosis were associated with the greatest number of differentiating variables including negative childhood experiences, past and recent stressors, satisfaction with life and perceived social support. These comparative analyses provide further support for the SMPI-CR in identifying and discriminating melancholic depression from non-melancholic depression. Replication of these findings in other samples with independent raters is recommended.

1. Introduction

Depression has historically been conceptualized from either a binary or unitary perspective. Originally, the binary view described an autonomous or "endogenous" depressive sub-type that ran its own course once precipitated as against other depressions that were "reactive" to the environment. The unitary view (of depression being a single entity varying by severity) gained momentum in the late 1920's, when Mapother concluded that, since he was unable to determine any differences between diagnosed endogenous and non-endogenous depressive conditions with regard to causation, prognosis and treatment ("a complete graduation"), it was pointless to distinguish between them and argued for all neurosis to be placed on a continuum. This dimensional view has subsequently largely prevailed.

Currently, the distinction between depressive subtypes is not "sharp"; however, knowledge has advanced and with clearer distinctions emerging through analysis of illness course as well as symptom variables. Reviews of melancholic depression [1,2] have suggested a number of ascriptions and differential features. For example, melancholic depression—in comparison to a residual group of non-melancholic depressive conditions—is weighted to a greater prevalence or likelihood of certain symptoms and signs including vegetative features (decreased appetite and weight loss), early morning awakening, psychomotor disturbance, diurnal variations in mood and energy, and an anhedonic and non-reactive mood. It also differs in illness course and treatment response relative to other (non-melancholic) depressions in a way suggesting the greater relevance of genetic and other biological determinants compared to psychosocial factors, with episodes being less likely to spontaneously remit and with selective response to physical treatments such as broad action antidepressant medication and electroconvulsive therapy (ECT) [3]. Conversely, we position [4,5] the "non-

* Corresponding author. Black Dog Institute, Prince of Wales Hospital, Randwick 2031, Sydney, Australia.
E-mail address: g.parker@unsw.edu.au (G. Parker).

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melancholic depression" as a heterogeneous residue of conditions more reflecting the impact of stress and/or a predisposing personality style or anxiety condition and lacking the so-called endogeneity features more prevalent or specific to melancholic depression.

Our research group has sought for several decades to differentiate melancholia from non-melancholic depressive disorders, evaluating the utility of candidate "endogeneity" symptoms and observable signs of psychomotor signs [3] as against simply weighting symptom severity [6]. Most recently, we have examined the utility of prototypic clinical patterning, incorporating antecedent and illness course variables as well as symptoms [7]. The last approach involved the development of both a self-report and clinician-rated measure which lists 12 items (8 symptoms and 4 non-symptoms) weighted to melancholic depression in a left-hand column and 12 items (6 symptoms and 6 non-symptoms) in a right-hand column and with the rater (patient and clinician respectively) requested to tick all items that matches their judgment of the depression when at its worst. Non-symptom melancholic items include depressive episodes "coming out of the blue," or severity of episodes being worse than circumstances would expect, as well as early development and current work and social relationships being generally unremarkable. Non-melancholic non-symptom items include depressive episodes being preceded by a stressor and with the depression severity consistent with the impact of the stressor, the individual being generally "emotional" and a "worrier," having had distinctive stressful developmental events and, when euthymic, having difficulties in family and work relationships.

The recent development study [7] of what has now been labeled the Sydney Melancholia Prototype Index (SMPI) established that, while an identical cut-off score of four or more melancholic than non-melancholic items was affirmed in ROC analyses of both the clinician-reported and self-reported measures, the former was superior to the self-report measure in terms of validating items. For the clinician-rated measure, the "difference" score (the sum of melancholic "A" items minus the sum of non-melancholic "B" items) had respective positive and negative predictive values of 0.90 and 0.88, and a sensitivity of 0.84 and a specificity of 0.92, suggesting a high level of discrimination in relation to depressed patients clinically assigned as either having a melancholic or non-melancholic depressive episode. Those assigned a "melancholic" depression by the SMPI-CR were currently experiencing a longer depressive episode, were less likely to have a lifetime anxiety disorder, had experienced fewer lifetime and current stressors, scored lower on five of eight personality styles predisposing to depression, and returned higher cooperativeness and effectiveness scores (indicating a lower probability of disordered personality functioning). In a subsequent study of patients with bipolar depression [8], independent analyses quantified an identical SMPI cut-off score for differentiating those with melancholic and non-melancholic depression.

In this paper we examine the comparative validity of the clinician-rated SMPI against the self-reported SMPI, DSM-IV diagnosis, clinician diagnosis and a composite of the latter two strategies, to determine the likely comparative capacity of such differing measures to identify "melancholia." Our candidate validation variables weighted historically identified correlates of melancholia [1,2,9,10]—including older age, older age at first episode, no gender differences, briefer but more severe episodes, fewer distal or proximal life event stressors, a greater likelihood of a "healthy" premorbid personality and lack of a precipitant for episodes.

2. Methods

2.1. Participants and setting

As for the SMPI development study [7], current study participants were recruited from the Black Dog Institute Depression Clinic in Sydney, a service providing specialist psychiatrist diagnostic and management advice to patients with a mood disorder and referred by a health practitioner. While recruitment for the development study occurred from May 2009 till December 2010, recruitment for the current study occurred from May 2009 and continued till February 2012, so that the current study can be viewed as an extension study in terms of sampling. Written informed consent was provided by each participant and the study was approved by the University of New South Wales Ethics Committee.

All patients underwent a detailed clinical assessment with a clinic specialist psychiatrist who, if they diagnosed the patient as having a primary unipolar depressive disorder, was required to make a clinical judgment as to whether it was a "melancholic" or "non-melancholic" depression, and also noted whether there were any comorbid anxiety disorders present. Clinician judgements (about depressive diagnosis) were derived from their interview of the patient—which focuses on depressive symptom patterns, examines family history, developmental factors, personality profile and previous response to any drug and non-drug treatments. Interviews would sometimes involve corroborative witnesses (e.g., family members, referring health practitioners) and a consensus meeting with a senior psychiatrist. However, not all patients were assessed at the nadir of their episode (including some being in partial remission) as a consequence of clinic waiting time. A clinical diagnosis of melancholic (compared to non-melancholic) depression weighted a relatively brief set of clinical features, including the patient reporting an anhedonic and non-reactive depressive mood, distinct anergia, mood and anergia being worse in the morning, as well as psychomotor disturbance (including impaired concentration). The clinician completed the clinician-rated SMPI (SMPI-CR) following the interview.

Patients were also requested to complete an assessment booklet as part of their referral, with the booklet including questions assessing current and lifetime psychosocial variables, illness correlates and treatments. Specific measures