Journal of Affective Disorders 141 (2012) 464–468

Contents lists available at SciVerse ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Preliminary communication

Mood-congruent and mood-incongruent psychotic symptoms in major depression: The role of severity and personality

Matteo Tonna [a], Chiara De Panfilis [b], Carlo Marchesi [b,*]

[a] Dipartimento di Salute Mentale, Azienda Sanitaria Locale di Parma, Centro Salute Mentale di Fidenza, Italy
[b] Dipartimento di Neuroscienze, Sezione di Psichiatria, Università degli Studi di Parma, Italy

ARTICLE INFO

Article history:
Received 6 December 2011
Received in revised form 7 March 2012
Accepted 7 March 2012
Available online 3 April 2012

Keywords:
Major depression
Psychotic symptoms
Mood-congruent and mood-incongruent
Personality
Severity

ABSTRACT

Background: Whether psychotic symptoms in major depression (MD) are better explained by a "severity model" or by a "vulnerability model", with personality as a predisposing factor, is still debated. The aim of the present study was to evaluate in MD the relationship between the content of psychotic features (mood congruent (MC) or mood incongruent (MI)) and severity of depression or personality traits.
Methods: 62 inpatients affected by MD with psychotic features were divided into three groups on the basis of the content of psychotic symptoms: MC, MI, mixed MC–MI. All subjects completed the SCID-IV, the Structured Clinical Interview for DSM-IV Personality Disorders and the Hamilton Rating Scale for Depression. Personality was assessed after MD remission.
Results: MI psychotic symptoms were positively associated with schizotypal traits, whereas MC symptoms were positively related to obsessive-compulsive traits and severity of depression. Patients with both MC and MI psychotic symptoms were characterized by a personality profile and depression severity standing in a middle position between the MC and MI groups.
Limitations: The main limitations of the study are represented by the small sample size, the time of assessment of personality and the inclusion of only unipolar depression.
Conclusions: Our findings suggest that both depression severity and personality profile, independently from each other, model the content of psychotic symptoms, confirming the validity of subgrouping psychotic depression into two distinct MC and MI types and supporting the inclusion of a third mixed MC–MI type because of its intermediate position in personality profile and severity between the MC or MI group.

1. Introduction

The importance of distinguishing psychotic symptoms in major depression (MD) as mood-congruent (MC) or mood-incongruent (MI) has been supported by the finding that mood incongruence is a predictor of poor outcome and diagnostic instability (Burch et al., 1994; Fennig et al., 1996; Tsuang and Coryell, 1993), even though more recent studies failed to replicate these results (Maj, 2008) and suggest "a little specific evidence for this distinction or its relevance" (Keller et al., 2007).

Moreover, the separation of psychotic symptoms in MD into two subtypes uncovers different problems since MC and MI features may coexist in the same episode (Maj, 2008; Maj et al., 2007) and the definition itself of "congruence" with depressed mood is often difficult to evaluate (Keller et al., 2007; Maj, 2008).

However, the broadening of the concept of psychotic depression to include MI subtype allows to consider bizarre or schizophrenic-like delusions or hallucinations (i.e. Schneiderian first rank symptoms) in the context of a full affective syndrome (Kendler, 1991). This view is supported by the lack of

* Corresponding author at: Università di Parma Dipartimento di Neuroscienze Sezione di Psichiatria Strada del Quartiere 2 43100 Parma, Italy. Tel.: +39 0521 393774x3792; fax: +39 0521 230611.
E-mail address: carlo.marchesi@unipr.it (C. Marchesi).

0165-0327/$ – see front matter © 2012 Elsevier B.V. All rights reserved.
doi:10.1016/j.jad.2012.03.017

diagnostic specificity of overall symptoms for schizophrenia, including non-affective positive features (Taylor and Amir, 1994) and Schneiderian first rank symptoms (Mundt, 1995). Therefore, since DSM-III (American Psychiatric Association, 1980), "psychotic depression" is defined by the occurrence of delusions and/or hallucinations only in the presence of a major mood episode regardless to the form or the content of psychotic symptoms. This reconceptualization raises the question if psychotic symptoms (specifically MI delusions) in a depressive episode may be better explained by a "severity model", as suggested in DSM-IV-TR (American Psychiatric Association, 2000) which identifies in MD a severe form with psychotic features, or by a "vulnerability model" in which personality characteristics predispose to the psychotic presentation of MD (Harrow et al., 2000). Our previous study (Tonna et al., 2011) argues against a rigid association between "severity" and "psychotic symptoms" and suggests that a specific personality profile (schizotypal and paranoid traits) and severity are independently associated with the psychotic presentation of MD.

Concerning the distinction between MC and MI symptoms, the studies are scarce and the existing ones are difficult to compare because they used different diagnostic classification systems, different definitions of mood congruence and different criteria for classifying patients with both MC and MI delusions (Fennig et al., 1996). Moreover, to our knowledge, only one study (Bellini et al., 1992) investigated the relationship between mood congruence of psychotic symptoms and personality profile in patients with MD. This study found that MI delusions (persecutory/paranoid) were more frequent in patients with personality disorders (PDs) of odds cluster, compared to the other PD clusters.

Therefore the present study was aimed to evaluate the relationship between severity of depression, personality pattern and the occurrence of MC and MI psychotic symptoms in patients with MD. Particularly, we wanted to verify the hypothesis that in MD the incongruence of psychotic symptoms may be associated with a peculiar personality profile while MC symptoms may be associated with the severity of depression.

2. Methods

2.1. Subjects

Subjects included in the study were selected from patients who consecutively sought treatment at the Psychiatric Unit of the University Hospital of Parma since January 2001, because they were affected by Unipolar Major Depression with psychotic features.

Patients were included in the study if: 1) their age ranged between 18 and 75 years; 2) they achieved a remission of the MD episode (see remission criteria); and 3) their written informed consent was obtained.

Patients were excluded from the study if they were affected by: 1) current mental disorders related to a general medical condition; 2) cognitive impairment (Mini-Mental State Examination score lower than 25) which interfered with the ability to complete diagnostic interviews or questionnaires.

2.2. Procedures

All subjects completed the Structured Clinical Interview for DSM-IV Disorders (SCID-IV) (Mazzi et al., 2000), the Structured Interview for DSM-IV Personality Disorders (SIDP-IV) (Pfohl et al., 1995) and the 17-item Hamilton Rating Scale for Depression (HAM-D) (Hamilton, 1960).

The SCID-IV and the HAM-D were administered at the first visit and then monthly, whereas the SIDP-IV was administered only when complete remission was achieved (see below).

In the training phase for personality assessment, videotape recordings of patients with PD were used and a good inter-rater reliability was obtained, since the K values ranged from 0.91 for schizotypal PD to 0.79 for borderline PD (i.e. paranoid PD $k = 0.86$; obsessive-compulsive PD $k = 0.82$). The interviewers who administered the SIDP-IV were blind to the group to which each patient belonged.

According to the criteria of the DSM-IV, three groups of psychotic depressive patients were considered: 1) MD with MC psychotic features; 2) MD with MI psychotic features; 3) MD with mixed MC and MI psychotic features. The evaluation of mood congruence was consistent with DSM-IV-TR guidelines. Namely, MC symptoms included delusions of guilt, poverty, punishment, nihilism and illness and any related hallucinations such as self-deprecatory voices. MI symptoms included delusions or hallucinations the content of which was unrelated to depressive themes. As noted above, mood congruence was difficult to evaluate in some cases (i.e. persecutory delusions) and therefore we decided to label as "incongruent" psychotic themes whose congruency was uncertain.

Three scores of HAM-D were considered: the total score as a measure of global severity of depression and the "retardation" and the "agitation" item score as a measure of psychomotor disturbance, which is considered a marker of "endogeneity" (Parker et al., 2000).

Personality traits rather than categories were considered because the number of personality categories found in each subgroup of patients was too small to allow reliable evaluations. Moreover, the dimensional approach is thought to be superior to the categorical model, especially for research purpose (Widiger, 1992); therefore the dimensional model offers some advantages for the study of the relationship between depression and personality.

2.2.1. Treatment

All patients were treated with an association of antidepressants and antipsychotics.

2.2.2. Remission criteria

Patients were defined in complete remission if, for at least two months, their symptoms did not satisfy the DSM-IV diagnostic criteria for MD, including psychotic features, and if their Ham-D score was lower than 7.

2.3. Statistical analysis

One-way analysis of variance, with Bonferroni post-hoc correction, was used to compare age, age at onset, HAM-D