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Brief report

Examining age effects on prototypic melancholic symptoms as a strategy for refining definition of melancholia

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Abstract

Background: Melancholic depression appears to have a later age of onset than the non-melancholic disorders, and its phenotypic picture also appears to change with age. The latter phenomenon allows clarification of key symptoms of melancholia by examining for age effects on putative melancholic symptoms, thus enabling identification and refinement of the melancholic sub-type.
Methods: We studied 158 patients receiving a diagnosis of unipolar depression (65 melancholic: 93 non-melancholic), dichotomised by age and with a higher representation of those with melancholia in the older age band. The severity of individual DSM-IV-TR melancholic candidate symptom constructs were quantified across age groups and diagnostic sub-type.
Results: Symptom constructs identified as most clearly associated with age effects in those with melancholia were anhedonia, non-reactivity, diurnal mood variation and, to a lesser degree, psychomotor slowing. When melancholic and non-melancholic patients were compared, non-reactivity, psychomotor slowing and diurnal mood variation were the most differentiating in the older age group.
Conclusions: The capacity of certain symptoms to mark the changing phenotypic expression of melancholia with age may not only assist refined definition of melancholia but inform about underlying causes and, of key importance, explain the suggested differential impact of narrow-action and broad-action antidepressant on those with melancholia across differing age groups.

Keywords: Melancholia; Non-melancholic; Depression; Age-effects; Phenomenology

1. Introduction

Several studies (overviewed in Parker and Hadzi-Pavlovic, 1996) have indicated that the melancholic:non-melancholic ratio in depressive disorders increases with age, presumably reflecting an older age of onset of the melancholic sub-type. Additionally, a key melancholic sign – observable psychomotor disturbance – appears to become more prominent and marked in those with melancholia as they age. We have speculated that the latter change may well reflect the progressive recruitment of underpinning monoaminergic neurotransmitter systems with age (see Brodaty, 1996). If the phenotypic picture is truly influenced by age, identifying putative melancholic symptoms that are most associated with such an age effect should assist clinical definition of 'melancholia' – the aim of the current paper.

The above points benefit from some extension. First, we note representative data in relation to symptoms of

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melancholia showing an older age of onset than other depressive disorders. In an earlier study using DSM-III-R criteria (Parker et al., 1994), melancholic and non-melancholic subjects evidenced first episode mean ages of 38 years and 27 years respectively. If such a distinct age of onset differentially exists across melancholic and non-melancholic disorders, then a bimodal pattern of depression incidence might be anticipated in any general community sample. A previous report (Parker and Hadzi-Pavlovic, 2004) of a bimodal pattern in the National Comorbidity Study provides evidence of an initial peak in adolescence and a second peak in mid-life. While such a pattern could indicate that differing age-related factors are associated with onset of depression or be otherwise explained, it is also consistent with non-melancholic and melancholic depression having differing modal ages of onset.

Second, retrospective clinical panel data (Parker et al., 1999) indicate that, while the effectiveness of narrow-action antidepressants (such as selective-serotonin reuptake inhibitors or SSRIs) and broader-action antidepressants (such as tricyclics or TCAs) appear to be comparable in those with non-melancholic depression and across differing age bands, the same pattern does not hold for melancholia. Our prospective study showed that, for those with melancholia, TCAs appear superior to the SSRIs, and with that differential increasing substantially with age from around age 30 to 40 (Parker et al., 2001a,b). Third, we have also reported (Parker et al., 2006) some preliminary data indicating that, for those with melancholia, the phenotypic picture changes with age. For example, while hypersomnia is more common in younger individuals, early morning wakening becomes the dominant sleep disturbance in older individuals, perhaps reflecting a greater noradrenergic contribution with age. Such determinants of changes in the melancholic phenotype may underpin differential treatment effects. Thus, if the phenomenology of melancholia changes with age, then examining for any age effect on candidate melancholic symptoms should identify those symptoms that best define 'melancholia' and therefore best inform treatment.

To date, multiple endogeneity or melancholic symptoms have been proposed including anergia, diurnal variation of mood, anhedonia, guilt, non-reactive mood, terminal insomnia, and appetite and weight loss (Kendell, 1976). Observable sign-based characteristics such as psychomotor retardation and agitation have also displayed utility in defining melancholia (Parker et al., 2001a,b). The current study specifically limits exploration to DSM symptoms of melancholia and examines the linkage of these symptoms with age. This will be achieved through retrospective analysis of data collected from depressed patients. Given the intrinsic treatment differentials between melancholic and non-melancholic patients from the mid-30s onwards, it may be hypothesised that there exists a phenomenological change also, with melancholic features becoming more apparent with older age.

2. Methods

2.1. The Black Dog Institute Depression Clinic sample

Data collection was performed as a part of routine clinical assessment from 158 psychiatric patients referred to the Depression Clinic at the Black Dog Institute in Sydney, Australia. Those who allowed their data to be used for research studies in addition to their clinical assessment were included for the retrospective analysis. Intake to this tertiary clinic requires a referral from either a general practitioner or psychiatrist, so building to sample heterogeneity, and includes collection of symptom data (for the most recent or current depressive episode) via a

Table 1
Specific SDS items contributing to DSM-IV-TR Melancholic Specifier

Constructs and Items
Anhedonia
● Loss of interest in normally enjoyable activities (e.g. seeing a film, attending a party)
● Unable to obtain pleasure from activities that are normally enjoyable (e.g. seeing a film, attending a party)
● Unable to look forward to taking part in normally pleasurable activities
Non-reactivity (NRM)
● Inability to be cheered up when something nice or pleasant occurred
● Inability to be cheered up by friends
● Loss of capacity to laugh at humorous things
Psychomotor disturbance (PMD)
● Finding it difficult to do basic things like get out of bed and bath or shower
● Feeling physically slowed (walking/talking)
● Feeling somewhat 'paralysed' when doing basic things (e.g. write, work, get out of bed)
Cognitive slowing (Cog)
● Having difficulty making decisions
● Brain feeling foggy, making concentration difficult
● Find your thinking is slowed
Diurnal variation of mood/energy (DMV)
● Depressed mood worse in the morning
● Energy worse in the morning
Appetite/weight loss (App/weight)
● Appetite decrease (not related to medication)
● Experiencing distinct weight loss (not related to medication)
Terminal insomnia (Insomnia)
● Waking up much earlier than usual in the morning