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Brief report

# Does major depressive disorder with somatic delusions constitute a distinct subtype of major depressive disorder with psychotic features?

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**Abstract**

*Background:* Among patients with major depression with psychotic features, little is known about the extent to which those with and without somatic delusions differ.
*Methods:* The first 183 participants in the STOP-PD study were divided into two groups based on the presence or absence of somatic delusions and were compared on multiple demographic and clinical characteristics.
*Results:* In the multivariate analysis, those with somatic delusions reported more somatic symptoms, rated their health as worse, and were less likely to have persecutory delusions.
*Conclusions:* Based on the methods we used, we could not detect meaningful differences between subjects with and without somatic delusions. This suggests that the presence of irrational somatic ideation does not define a distinct clinical subgroup among patients with psychotic depression. This finding needs to be replicated.


*Keywords:* Depression; Psychosis; Somatization; Psychotic depression; Delusions; Subtype

## 1. Introduction

Major depressive disorder with psychotic features (MD-Psy) constitutes a significant health problem. Also called delusional depression, MD-Psy is present in up to

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25% of younger patients and 45% of older patients in psychiatric hospitals for the treatment of major depression (Coryell et al., 1984; Meyers and Greenberg, 1986).

Clinical and biological evidence suggests that MD-Psy with somatic delusions may represent a specific subtype of MD-Psy. Specifically, patients with MD-Psy with somatic delusions are more likely to be women older (Meyers, 1992) than those with other delusions. They may also have a higher rate of suicide (Schneider et al., 2001) and greater REM activity during sleep (Kupfer, 1976). The presence of somatic delusions may also influence health care seeking behaviors and quality of life. Depressed patients with somatic preoccupations use more medical services than depressed patients without these preoccupations (Barsky et al., 2005) and the presence of somatization predicts poor health-related quality of life among older primary care patients (Sheehan et al., 2005).

Thus, we conducted an analysis to determine whether MD-Psy patients with and without somatic delusions present with differing clinical features. We compared baseline demographic and clinical characteristics of participants with and without somatic delusions among the first 183 participants in STOP-PD (Study of Pharmacotherapy of Psychotic Depression), a randomized controlled trial. We hypothesized that participants with somatic delusions would differ from those without somatic delusions: they would be older, more likely to be female, have a higher objective burden of physical illness, lower self-rated health, poorer health-related quality of life, a higher degree of non-delusional somatic complaints, and higher utilization of health care services.

## 2. Methods

STOP-PD is an NIMH-sponsored trial conducted at Cornell University, the University of Massachusetts, the University of Pittsburgh, and the University of Toronto. Participants were enrolled based on systematic screening of inpatients and on solicitation of outpatient referrals in these academic centers. Inclusion criteria included: age 18 and older, ability to speak English fluently, a Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV; APA, 1994) diagnosis of MD-Psy based on the Structured Clinical Interview for DSM-IV (SCID-patient version; Spitzer et al., 1995), a score of 21 or higher on the 17-item version of the Hamilton Depression Rating Scale (HDRS-17; Hamilton, 1960), the presence of one or more delusions as indicated by a score of 3 or greater (delusion definitely present) on the delusion item of the Schedule for Affective Disorders and Schizophrenia (SADS; Spitzer and Endicott, 1979). We also required a score of 2 or higher on one or more of the two conviction items that assess the extent to which reality testing about a possible delusional idea is lost (i.e., subjective feeling of certainty; failure of accommodation to confrontation with evidence contradicting the belief) of the Delusional Assessment Scale (DAS; Meyers et al., 2006). This criterion assures that potentially irrational ideas were held persistently. We excluded patients with current or past DSM-IV diagnosis of bipolar disorder or schizophrenia; current body dysmorphic disorder, obsessive compulsive disorder, or brief psychotic disorder; substance abuse or dependence, including alcohol, within the last three months; Alzheimer dementia, vascular dementia or history of ongoing significant cognitive impairment (from informant report) prior to the index episode; unstable medical illness; medical conditions (such as hypothyroidism), metabolic abnormalities (such as folate or B12 deficiency), or medication (such as carbidopa) that might contribute to psychopathology, confound response to pharmacotherapy, or render patients unable to tolerate or complete the study; inability to tolerate the study medications (sertraline or olanzapine) or having failed to respond to olanzapine 15 mg/day or greater for at least 4 weeks during the index episode; being pregnant or planning to become pregnant; or being sufficiently ill to require immediate open pharmacotherapy or ECT (e.g., due to imminent risk or suicide or refusal to eat). Recruitment was stratified by age on a 1:1 basis to allow for comparisons between younger (<60 years) and older adults. Written informed consent was obtained from all participants (or substitute decision makers, when applicable) using procedures approved by local Institutional Review Boards prior to the initiation of any research assessments.

Upon enrollment, in addition to the SCID, HDRS-17, SADS, and DAS, each participant was administered a battery of clinical instruments at baseline, including the 18-item Brief Psychiatric Rating Scale (BPRS; Overall and Gorham, 1962), Scale for Assessment for Positive Symptoms (hallucinations and delusion items only; SAPS; Andreasen, 1984), Mini-Mental State Examination (MMSE; Folstein et al., 1975), Cumulative Illness Rating Scale for Geriatrics (modified to exclude the psychiatric subscale; CIRS-G; Miller, 1992), 36-item short form of the Medical Outcome Study (SF-36; Stewart et al., 1988) with the Self-Rated Health (SRH) item, physical component scale (PCS) and mental component scale (MCS), Utvalg for Klinisky Undersogelser (UKU; Lingjaerde et al., 1987) which assesses somatic complaints, and Cornell Health Services Index (CSI; Sirey et al., 2005) which assesses use of heath services over the past 3 months. Inter-rater reliability was established for the HDRS-17, BPRS and