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Making sense of the complex depressed patient

Part 3: melancholic and psychotic depression

Melancholic depression can occur in patients of any age but is more likely to have first onset in patients aged over 60 years. Patients with earlier onset melancholic depression are more at risk of developing bipolar disorder.

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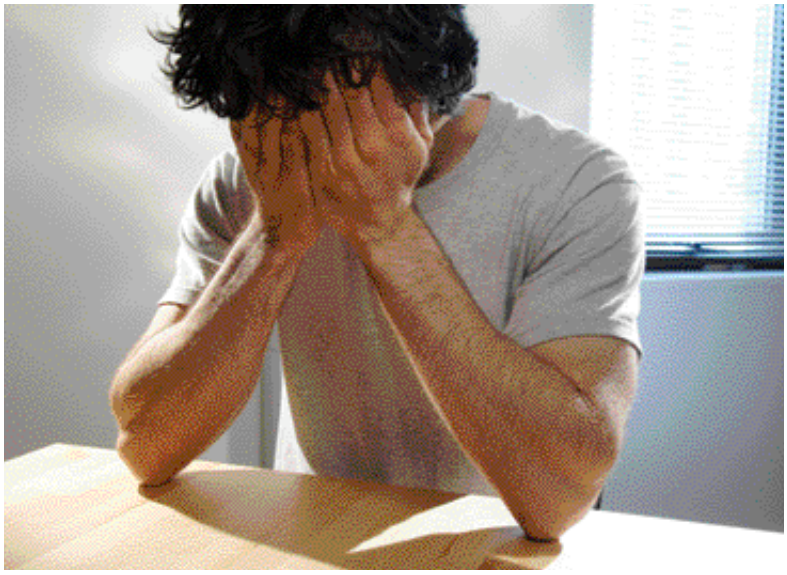
Many factors may complicate the presentation and course of depression in an individual. Contemporary thinking is that biological or psychosocial factors either alone or in combination can 'kick start' a depressive episode and that episodes may be melancholic in type in patients with the prerequisite genetic and other biological vulnerabilities. This is an advance on the categorisation of depression using the terms 'reactive' and 'endogenous' depression, where 'reactive' depression implied that the episode would resolve when the triggering event was resolved and 'endogenous' implied the episode arose solely from some physical process and only 'biological' interventions could assist.

IN SUMMARY

- **Melancholic depression and psychotic depression (melancholic depression with associated psychotic features) are associated with significant morbidity and high suicide risk.**
- **Melancholic depression is more commonly late onset (patients over the age of 60 years) and related to microvascular disease or other neurodegenerative and illness-related factors – structural melancholia.**
- **Early-onset melancholic depression (often before the age of 30 years) has a genetic predisposition – functional melancholia. These patients have an increased risk of developing bipolar disorder.**
- **Diagnosis relies on symptoms (anhedonia, non-reactivity, diurnal mood variation and early morning wakening) and observable features of psychomotor disturbance involving retardation and/or agitation with impaired cognitive processing (poor concentration and inattention).**
- **Red flags for melancholic depression include sudden and significant change in behaviour, poor sleep, sudden unexplained appetite loss, sudden inability to work effectively and complaints about being unable to think, unusual ruminations and/or preoccupations, and talk of hopelessness.**
- **Dual-action antidepressants are the treatment of choice for melancholic depression; the serotonin and noradrenaline reuptake inhibitors (SNRIs) are first line, followed by tricyclic antidepressants. Psychotic depression is treated with antidepressants and antipsychotics.**

Earlier onset depressions are more likely to be associated with a strong family history, perhaps because of an inherited vulnerability to stress-related depression and anxiety, or neuroticism. These depressions are much more likely to be nonmelancholic in nature but there is a small but significant group of people who have early-onset melancholic depression. These patients have an increased risk of developing bipolar disorder. Late-onset depressions are more likely to be melancholic and/or psychotic and are related to microvascular disease or other neurodegenerative and illness-related factors, with different treatment implications and outcomes. Melancholic depression usually requires treatment with an antidepressant, and is associated with significant morbidity and high suicide risk.

This article, the last in a series of three on the complex depressed patient, discusses the assessment and management of patients with melancholic depression. Bipolar disorder is not discussed in detail but will be the subject of several articles in future issues of *Medicine Today*. The other articles in this series discuss the presentations and management of depression in people with a medical illness and how personality style can be used to help manage patients with complex depression, and were published in the April and May 2009 issues of *Medicine Today*.[1,2]



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Melancholia and depression

'Melancholia' is a term that was used in the 2nd century AD by Soranus of Ephesus, a Greek physician practising in Rome, to describe individuals exhibiting 'mental anguish and distress, dejection,

Table 1. Functional and structural melancholic depression[4]

Functional melancholia	Structural melancholia
Generally early onset, often before the age of 30 years	Associated with later onset (patients aged over 60 years)
Associated with genetic predisposition such as a family history of depression or bipolar disorder, or change in neurotransmitters after use of some medications (e.g. corticosteroids) or illicit drugs (e.g. cocaine or amphetamines) in vulnerable people	Usually associated with vascular predisposition
Structural abnormalities rare on imaging	Structural abnormalities commonly seen on neuroimaging – usually white matter hyperintensities secondary to microvascular infarcts
Hypothesised mechanism is functional shut-down of circuits linking the basal ganglia and prefrontal cortex	Hypothesised mechanism is structural disruption of circuits linking the basal ganglia and prefrontal cortex; about one-third of patients develop dementia within five years
Has more pronounced inanition, fatigue and lack of motivation than late-onset melancholia, as well as cognitive difficulties	Has more pronounced psychomotor slowing, often with agitation, than early-onset melancholia; as well as inanition, lack of motivation and cognitive difficulties
Good response to broad spectrum antidepressants or electroconvulsive therapy (ECT)	Poorer response to antidepressants and ECT, perhaps with risk of delirium

continued

Table 2. Assessing patients with melancholic depression

Assessment issue	Questions to ask patient
Does the patient have a depressive episode?	• Are you depressed? • Has there been a change in self-esteem and/or self-worth? • Are you being more self-critical or tough on yourself than usual? These are followed by questions related to depression – appetite loss, sleep loss, loss of interest and motivation, loss of concentration, guilt, suicidal ideation and plans
Does the patient have a melancholic depression?	• How are you spending your day? How different is this from normal? • Are you able to look forward to things you normally enjoy? • Can you be cheered up? Do you enjoy activities as much as usual when you get started? What lifts your mood? • How are you sleeping? What time are you waking up? What is your normal time? • Is there a change in your mood and energy over the day? Has this a specific pattern? • Have you found it difficult to get going, especially in the mornings? Have you had difficulty getting out of bed and/or showering? Have you felt apathetic? • Have you felt empty inside? • Are you preoccupied with any thoughts or ideas? Have you any worries that seem to be getting you down? Are you worrying about things you wouldn't normally worry about?
Have there been any manic episodes? Is there a personal or family history of bipolar disorder?	• Have you ever had any mood swings where you are more energetic or 'wired'? • Has anyone ever said you were manic?
Is there evidence of psychotic depression?	• Some people find that when they are stressed, they have unusual experiences such as being overly concerned about money or health, or regrets that normally wouldn't be of concern. Have you had any such experiences? • Have you been a lot more worried about… than usual? • Have you had any unusual thoughts? • Have you thought that your illness is a punishment? • Have you felt that your life was in danger?
What is the age of first onset?	• Have you had episodes like this before? • How old were you the first time you had an episode?
Does the patient have any medical problems?	• Have you a new medical problem? What do you think is causing this? • Are you taking any new medications?
Are there any risk issues related to severity?	• Have you thought that life was hopeless/not worth living/you would be better off dead? Have you any plans to hurt yourself? • Have you been waking earlier than usual? What time? • What is on your mind when you awake?

silence, animosity towards members of their household, sometimes a desire to live, and at other times a longing for death; suspicion that a plot is being hatched against him, weeping without reason, meaningless muttering, and occasional joviality'.[3] This description is still clearly recognisable today, and the term has endured.

Melancholia is best conceptualised as a severe mood disorder superimposed on a fronto-subcortical network disruption disorder that causes psychomotor disturbance characterised by problems with cognitive functioning (problem solving, planning, social interaction) and slowing of mental and motor activity, often with associated periods of agitation. The disruption may be functional, as is generally seen in early-onset depressive disorders, or structural, as is generally seen in late-onset presentations (Table 1).[4]

The assessment of melancholia needs to consider the age of onset, presence of medical problems, bipolar disorder or

psychosis, and risk issues related to severity and suicidal thoughts.

The early onset of melancholic depression, with or without psychotic features, prompts the possibility of drug-induced depressive episodes, an underlying medical problem affecting the central nervous system or an evolving bipolar disorder or other psychotic illness, even in the absence of periods of elation, which may arise later. These possibilities should be explored.

The underlying pathological process in the structural melancholia group is commonly related to cerebrovascular disease. The term 'vascular depression' has been coined to describe depression developing in patients aged 60 years or older who have a high number of vascular risk factors such as hypertension or smoking.[7] It has been noted that patients presenting with vascular depression typically show greater cognitive dysfunction, functional disability, psychomotor retardation and anhedonia, and less agitation, guilt and psychosis than those with nonvascular depression.[8]

Repeated episodes of melancholic depression have been associated with decreased brain volume in the basal ganglia and hippocampus.[5] One study reported that decrease in brain volume is related to the duration of depression prior to the taking of antidepressant medication and it appears that antidepressants may have a neuroprotective role.[6]

Patients with melancholic depression of either early or later onset are at risk of further depressive episodes, which are generally severe and do not resolve spontaneously. It is worth keeping a 'watching brief' on all these patients.

In patients with psychotic depression (melancholic depression with associated psychotic features such as loss of insight, delusions and hallucinations, guilty ruminations), delusions are more common than hallucinations. The delusions (such as 'I'm a failure', 'I have no money', 'I have sinned', 'I have cancer') are generally consistent with mood, less bizarre and may seem appropriate as exaggerations of some current situation. However, these patients remain inconsolable even after reasonable and frequent reassurance to the contrary. The presence of agitation and other profound psychomotor change in psychotic depression is very distressing for the patient and can lead to serious harm to self and/or others. These features should be treated as a psychiatric emergency.

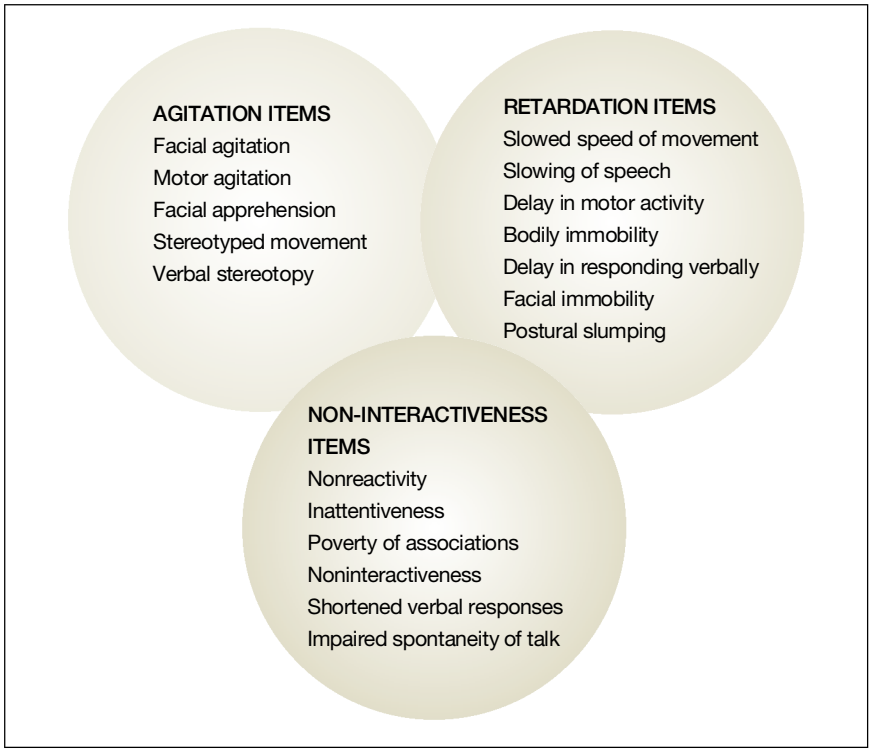

Figure 1. The elements of psychomotor disturbance that are assessed in the CORE assessment of psychomotor change.

Diagnosis and assessment of melancholic depression

Establishing a diagnosis of melancholic depression in a patient with an episode of depression of clinical significance involves both of the following:

- identifying symptoms related to melancholic depression (that is, anhedonia, non-reactivity, diurnal mood variation and early morning wakening), and
- observing psychomotor disturbance involving retardation and/or agitation in association with impaired cognitive processing (poor concentration and inattention).

A suggested hierarchy of questions to ask patients is outlined in Table 2.

The CORE rating scale can be used to assess psychomotor retardation. This tool comprises 18 signs (observable features) that are rated by the clinician or a trained observer at the end of a clinical interview. Summing subsets of the items produces scores on three dimensions found to underlie psychomotor change: noninteractiveness, retardation and agitation (Figure).[9] The timing of use of the rating scale should take into consideration the presence of diurnal mood variation, as the signs may fluctuate over the day. Further information about the CORE system is available at the Black Dog Institute website (see the box on page 26). Family members often report significant changes in behaviour in

continued

Website resources for GPs and patients

Beyondblue

The beyondblue website is http://www.beyondblue.org.au
Downloadable fact sheets and resources for health professionals are available from:
http://www.beyondblue.org.au/index.aspx?link_id=7.102
Downloadable information resources for patients are available from:
http://www.beyondblue.org.au/index.aspx?link_id=7.980

Patient information

- Medical treatment – http://www.beyondblue.org.au/index.aspx?link_id=89.581
- Antidepressants – http://www.beyondblue.org.au/index.aspx?link_id=89.581
- Depression and dementia. Fact sheet 25 – http://www.beyondblue.org.au/index.aspx?link_id=89.585&tmp=FileDownload&fid=930
- Helping yourself – http://www.beyondblue.org.au/index.aspx?link_id=89.586

Black Dog Institute

The Black Dog Institute website is http://www.blackdoginstitute.org.au
Downloadable information sheets, fact sheets and other resources, including a list of self-help books, for health professionals and patients are available from:
http://www.blackdoginstitute.org.au/healthprofessionals/resources/overview.cfm

GP resources mentioned in article

- **The CORE rating sheet and booklet.** The observable psychomotor signs of melancholic depression can be rated using the CORE rating sheet. This and an explanatory booklet are available at: http://www.blackdoginstitute.org.au/docs/2.COREAssessmentScoringSheet.pdf and http://www.blackdoginstitute.org.au/docs/COREbooklet.pdf
- **A rational model for antidepressant drug prescription.** A GP information sheet about prescribing antidepressants for various depression types. Available at: http://www.blackdoginstitute.org.au/docs/arationalmodelforantidepressantdrugprescription_000.pdf
- **An integrative depression model** and **Understanding your depressive episode.** An assessment and management tool, including a sheet for patients and doctors to collaborate on. Available at: http://www.blackdoginstitute.org.au/docs/UnderstandingYourDepressiveEpisode_000.pdf
- **Relapse signature: learning from experience.** Patient handout. Available at: http://www.blackdoginstitute.org.au/docs/18.RelapseSignatureLearningfromExperience.pdf

Patient information

- Melancholic depression – http://www.blackdoginstitute.org.au/public/depression/depressionexplained/types.cfm#Melancholic
- Bipolar depression – http://www.blackdoginstitute.org.au/public/bipolardisorder/bipolardisorderexplained/ bipolardepression.cfm
- Treatments for depression – http://www.blackdoginstitute.org.au/public/depression/treatments/index.cfm
- Depression in teenagers and young adults – http://www.blackdoginstitute.org.au/public/depression/inteenagersyoungadults.cfm
- Depression in the over-65 age group – http://www.blackdoginstitute.org.au/public/depression/inover65s.cfm
- The book *Dealing with Depression: a Common Sense Guide to Mood Disorders*, 2nd edition, by Professor G Parker and published by Allen and Unwin, Sydney in 2004 (http://www.blackdoginstitute.org.au/aboutus/blackdogbooks.cfm).

patients with melancholic depression. These changes include change in tone of voice, loss of 'light in their eyes', and changes in posture, gait, speed of movement and speech. It is also worth noting that patients with good social skills may underplay their inner distress and despair by maintaining a veneer of good manners ('Don't worry about me', 'Other people need you more', 'I'll be alright').

Red flags for melancholic depression are listed in Table 3.

Management of melancholic depression

It can be very wearing being with someone with a melancholic depression because he or she may be cognitively slowed, self-deprecatory and demanding frequent reassurance. Those patients who are agitated and psychotic may be particularly taxing;

Table 3. Red flags for melancholic depression

- Sudden and significant change in behaviour, leading to social withdrawal, onset of intense agitation and/or panic; this is often noted by relatives and may have a diurnal pattern
- Poor sleep (middle or late insomnia), early morning waking (around 3 a.m.)
- Sudden unexplained appetite loss, with significant weight loss, constipation
- Sudden inability to work effectively, complaints about being unable to think
- Unusual ruminations/preoccupations (fatal illness, no money, past misdeeds and failures); there may be some justification for the concerns but the levels of concern and preoccupation are completely out of proportion
- Talk of hopelessness, 'no point to life'

continued

An overview of drugs commonly used in managing patients with depression

Antidepressants

- **Selective serotonin reuptake inhibitors (SSRIs).** SSRIs are narrow-action antidepressants, having an effect only on serotonin reuptake. SSRIs available in Australia are citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine and sertraline.*
- **Serotonin and noradrenaline reuptake inhibitors (SNRIs).** SNRIs are dual-action antidepressants, having both serotonergic and noradrenergic effects. SNRIs available in Australia are desvenlafaxine, duloxetine and venlafaxine.*
- **Tricyclic antidepressants (TCAs).** TCAs are also dual-action antidepressants, blocking the reuptake of serotonin and noradrenaline. They are less often used nowadays because more selective and safer drugs are available, but they are still appropriate to use in severe cases of major depression because of their effectiveness. Imipramine and nortriptyline are considered as the less sedating TCAs, and amitriptyline, dothiepin, doxepin and trimipramine as the more sedating TCAs.*
- **Noradrenergic and specific serotonergic antidepressants (NaSSAs).** The NaSSAs mianserin and mirtazapine (the 6-aza analogue of mianserin) are dual-action antidepressants.* The main side effects of mirtazapine are drowsiness and weight gain and it is therefore of use when a more sedating antidepressant is needed, such as when there is significant anxiety or insomnia. Mianserin is also of use for its sedating properties.
- **Noradrenaline reuptake inhibitors (NRIs).** NRIs have a positive effect on concentration and motivation in particular. Reboxetine is of use when an antidepressant with a stimulating effect is required.*
- **Noradrenaline–dopamine reuptake inhibitors (NDRIs).** As well as having antidepressant effects, the NDRI bupropion also acts as a nicotine-receptor antagonist. Its antidepressant effect is considered to be mediated by its dopaminergic and noradrenergic action. Its antismoking effects are thought to be due to a combination of its noradrenergic, dopaminergic and nicotine-receptor blockade effects in attenuating the effects of nicotine withdrawal. It is also of use in other substance withdrawal. Bupropion is not indicated on the TGA for depression, but is indicated as an aid for smoking cessation.*
- **Monoamine oxidase inhibitors (MAOIs).** MAOIs prevent the breakdown of the monoamine neurotransmitters serotonin, noradrenaline and dopamine. Moclobemide, a reversible inhibitor of monoamine oxidase A (RIMA), is shorter-acting than the older MAOIs such as phenelzine and tranylcypromine but generally not as effective in depression.* Phenelzine and tranylcypromine have significant side effects because of their irreversibility, and should be initiated by a psychiatrist.

Antipsychotics, mood stabilisers and antianxiety agents

- **Typical antipsychotics.** First-generation antipsychotics; examples are chlorpromazine, haloperidol and trifluoroperazine.*
- **Atypical antipsychotics.** Second-generation antipsychotics; examples are olanzapine, quetiapine and risperidone.* Olanzapine and quetiapine have mood-stabilising effects.
- **Lithium.** Lithium is an antipsychotic with mood-stabilising effects (it is TGA indicated for mania).*
- **Sodium valproate**. Sodium valproate is an anticonvulsant and antipsychotic with mood-stabilising effects (it is TGA indicated for mania).*
- **Lamotrigine.** Lamotrigine is an antiepileptic with mood-stabilising effects.*
- **Benzodiazepines.** Diazepam is an example of an anxiolytic benzodiazepine.

* TRADE NAMES: Atypical antipsychotics: olanzapine – Zyprexa; quetiapine – Seroquel; risperidone – Rispa, Risperdal, Rixadone. MAOIs: moclobemide – Amira, Aurorix, Clobemix, Maosig, Mohexal; phenelzine – Nardil; tranylcypromine – Parnate. NaSSAs: mianserin – Lumin, Tolvon; mirtazapine – Avanza, Avanza SolTab, Axit, Mirtazon, Remeron. SNRIs: desvenlafaxine – Pristiq; duloxetine – Cymbalta; venlafaxine – Efexor-XR. SSRIs: citalopram – Celapram, Celica, Ciazil, Cipramil, Citalobell, Talam, Talohexal; escitalopram – Esipram, Lexapro; fluoxetine – Auscap 20 mg Capsules, Fluohexal, Fluoxebell, Lovan, Prozac, Zactin; fluvoxamine – Faverin, Luvox, Movox, Voxam; paroxetine – Aropax, Extine, Paxtine; sertraline – Concorz, Eleva, Sertra, Setrona, Xydep, Zoloft. TCAs: amitriptyline – Endep; dothiepin – Dothep, Prothiaden; doxepin – Deptran, Sinequan; imipramine – Tofranil, Tolerade; nortriptyline – Allegron; trimipramine – Surmontil. Typical antipsychotics: chlorpromazine – Largactil; haloperidol – Serenace; trifluoroperazine – Stelazine. Other drugs: bupropion – Clorprax, Prexaton, Zyban SR; diazepam – Antenex, Ducene, Ranzepam, Valium, Valpam; lamotrigine – Elmendos, Lamictal, Lamidus, Lamitrin, Lamogine, Seaze; lithium – Lithicarb, Quilonum SR; reboxetine – Edronax; sodium valproate – Epilim, Valpro.

the family are often frightened about the change in their loved one. This may be especially so if any other family members have had a serious mood disorder.

Information sheets about depression and caring for a person who is depressed are available on the beyondblue and Black Dog Institute websites (see the box on page 26).

Pharmacological management

Although selective serotonin reuptake inhibitors (SSRIs; citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline) may be sufficient in patients with initial episodes and those without pronounced psychomotor change, the dual-acting antidepressants, the serotonin and noradrenaline reuptake inhibitors (SNRIs; desvenlafaxine, duloxetine, venlafaxine) are likely to be the most

appropriate class of antidepressant drug to use in the management of melancholic depression. If there is no improvement on using the SNRIs, the tricyclic antidepressants (TCAs; amitriptyline, dothiepin, doxepin, imipramine, nortriptyline, trimipramine), which are also dual-action antidepressants, should be considered next. The drugs commonly used in the management of patients with depression are discussed in the box on page 28.

The rationale for these drug choices is that episodes that are later onset, more complex in terms of medical and psychiatric comorbidity and are recurrences are more likely to have psychomotor change, which is thought to also involve noradrenergic systems. Psychotic symptoms are more evident in older people and those with bipolar disorder, stimulant abuse or significant family history of psychosis, and are thought to also involve dopaminergic systems. This is explained in the information sheet 'A rational model for antidepressant drug prescription', available on the Black Dog Institute website and summarised in the box on this page.[10]

It is expected that GPs will consult a psychiatrist in most cases of melancholic depression, particularly if the depression is first onset, complex and/or associated with prominent psychomotor signs, suicidal ideation or psychosis. The steps below illustrate the likely sequence of antidepressant use in patients with melancholic depression.

- If no previous medication or episodes:
  - Step 1: if younger onset or no distinct psychomotor disturbance change, start with an SSRI; if older onset or distinct psychomotor disturbance, start with a dual-action antidepressant (an SNRI)
- If the SSRI failed or improvement is only partial, or there was lack of response to SSRIs on previous occasions, go straight to:
  - Step 2: an SNRI; then, if there is no improvement, trial a TCA
  - Step 3: psychiatrists may consider other medications, such as a monoamine oxidase inhibitor (MAOI; usually phenelzine), or electroconvulsive therapy.

A model for the management of acute unipolar melancholic depression is outlined by Professor Gordon Parker and Dr Vijaya Manicavasagar in their book *Modelling and Managing the Depressive Disorders: a Clinical Guide*.[4]

Notes on antidepressant use

- Consider target symptoms, past history, risk of overdose, medical history, current medications and past sensitivities and interactions.
- The superiority of TCA over SSRI antidepressants increases with patient age but their use needs to be considered against possible cardiac risk factors.
- If an antidepressant alone fails, brief augmentation with an antipsychotic may 'kick-start' response. Possible augmentation strategies include lithium, olanzapine or another antipsychotic at each step. Antipsychotic medications may also have mood-stabilising properties.
- If there is evidence of anxiety, use a more sedating antidepressant (e.g. mirtazapine, some TCAs [small doses of amitriptyline, dothiepin, doxepin and trimipramine]) or a short course of a benzodiazepine such as diazepam.

Choosing antidepressants – the Black Dog Institute model*

The Black Dog Institute, Sydney, has developed a model for a rational approach to the choice of antidepressant drugs.[10] Although speculative, the model has been supported by a number of effectiveness studies.

In this model, the various types of depression are thought to have different aetiological processes, and the ratios of the neurotransmitters serotonin, noradrenaline and dopamine associated with each depression are different. The neurotransmitter serotonin is involved in all depressions and is the main neurotransmitter implicated in nonmelancholic disorders, while it is thought that noradrenaline plays a more important role in melancholic depression, and that dopamine is also important in psychotic depression.

Targeting the neurotransmitter(s) associated with a particular depression type guides antidepressant choice.

- **Nonmelancholic depression.** The associated neurotransmitter is serotonin, so use a narrow-action (serotonergic) antidepressant: a selective serotonin reuptake inhibitor (SSRI).
- **Melancholic depression.** The associated neurotransmitters are serotonin and also noradrenaline, so use a dual-action (serotonergic and noradrenergic) antidepressant. Start with a serotonin and noradrenaline reuptake inhibitor (SNRI); if no response, trial a tricyclic antidepressant or mirtazapine.
- **Psychotic depression.** The associated neurotransmitters are dopamine and also noradrenaline and serotonin, so use a broad-action antidepressant strategy. This may be achieved by the prescription of a dual-action antidepressant plus an antipsychotic drug (for its dopaminergic activity).

Each antidepressant agent can have its profile 'broadened' by augmentation with an atypical antipsychotic, most of which have dopaminergic and serotonergic activities.

* 'A rational model for antidepressant drug prescription.' http://www.blackdoginstitute.org.au/docs/arationalmodelforantidepressantdrugprescription_000.pdf

- If there is evidence of agitation, anticipate the presence of psychotic symptoms and use a sedating antipsychotic agent such as olanzapine, quetiapine or chlorpromazine. Use risperidone if less sedation is required. If the patient becomes more agitated on treatment, it is worth considering the presence of akathisia or the syndrome of inappropriate antidiuretic hormone secretion, particularly in older people or those on multiple medications.
- Patients with agitation and/or psychotic symptoms generally require an antipsychotic agent from the start of treatment. Urgent psychiatric support should be enlisted.
- If there is evidence of bipolar disorder, the patient should be observed closely as prescription of an antidepressant may 'switch' him or her into a manic episode.
- In a younger person with a first or early episode of melancholic depression, it is worth being wary of precipitating a first manic episode.
- It is best to consult a psychiatrist and/or mental health team and use a mood stabiliser (e.g. lithium, sodium valproate, lamotrigine or an atypical antipsychotic such as olanzapine) concurrently with an antidepressant.
- When patients become extremely agitated, stop eating and drinking or consider suicide based on delusional beliefs of guilt, the situation constitutes an emergency and requires urgent psychiatric attention.

Psychosocial management

In addition to a severe mood disorder, patients with melancholic depression may have a reversible cognitive impairment affecting thinking speed, reasoning and judgement. They should be discouraged from making major decisions while depressed.

Family members are often worried and frightened by the changes that melancholic depression brings to their loved ones. It is important to educate and support the family as much as possible.

Patients should be encouraged to participate in as much activity as possible. This can involve gentle exercise and some scaled down pursuit of regular interests. If there is marked diurnal mood variation, it may be possible to schedule some activities for the part of the day when the patient is more motivated (usually in the afternoon and evening).

Although melancholic and psychotic depressions are largely 'biologically driven', there are often stressors that require attention. With early-onset melancholia, there is a need to review the experience, consider

the family history, talk about ensuring good sleep and diet, educate about keeping away from substances and discourage smoking, as these will have profound effects on disease burden if the patient goes on to have repeated episodes of depression and/or bipolar disorder. It is often a time when family secrets are revealed (such as other family members with depression or who have attempted suicide), and these need to be dealt with sensitively. With late-onset depression, there is a need to ensure a healthy lifestyle to help decrease cardiovascular risk factors and maintain healthy blood pressure, observe cognitive function and address psychosocial issues related to ageing.

Factors complicating recovery

Slow recovery from an episode of melancholic depression may be an indication that there are factors complicating the recovery. It can be worth checking for factors such as those listed below, some of which may only emerge after the diagnosis has been made:

- comorbid alcohol, substance, analgesic and/or sedative abuse or dependence; nicotine dependence
- medical illness, including endocrine disorder, malignancy, respiratory disease and renal disease – either previously known or became apparent during episode
- medication use – such as sedatives, analgesics, corticosteroids
- microvascular disease and/or other degenerative process including evolving dementing process and Parkinson's disease
- 'unfinished emotional business' – especially grief and anger
- psychotic symptoms – not as bizarre as in schizophrenia, and may go unrecognised; these should always be suspected in the presence of agitation.

Reappraisal further down the track

When in the depths of a melancholic depressive episode, a patient may be unable to articulate any current problems because their mood state is so overwhelming. On recovery from the episode, it is important to 'have another look' at the patient to reassess any biological or personality vulnerability that can be improved to reduce the risk of future relapse or recurrence. This can be done by asking the questions, 'Why this person?' and 'Why now?'. The 'Understanding your depressive episode' fact sheet on the Black Dog Institute website can be completed with a patient as a way of making sense of the vulnerabilities and precipitants of depressive episodes in that individual.

It is worth considering whether there are any personality/temperamental vulnerabilities to address after a patient has recovered from an acute episode (see the second article in this series).[2]

For patients with a younger age of onset, constructing a family tree over previous generations can reveal recurrent depression, bipolar disorder, psychotic illness or deliberate self-harm in relatives. For older-onset depression, the emphasis is more on a family history of vascular disease or other neurodegenerative disease, such as dementia.

It is also worth making a relapse plan, noting any characteristic 'relapse signature'. Rather than frighten the patient by talking of more episodes, this can be done by working out what can be learned from the episode, and what could be done differently next time. A patient handout about the relapse signature is available on the Black Dog Institute website.

A watchful presence of patients should be maintained after recovery. Follow-up at regular intervals (say, six-monthly) should be considered to check general health, note any changes in mood and psychomotor disturbance and reinforce healthy lifestyle messages.

Conclusion

Melancholic depression, whether it is of early or late onset, is associated with significant morbidity and high suicide risk. Diagnosis relies on the identifying of symptoms such as anhedonia, nonreactivity, profound lack of motivation, cognitive difficulties, diurnal mood variation and early morning wakening, and on observing specific features of psychomotor disturbance indicating noninteractiveness, retardation and agitation. Comorbid alcohol, substance, analgesic and/or sedative abuse or dependence, nicotine dependence, medical illness, medication use, microvascular disease, other degenerative processes, 'unfinished emotional business' and psychotic symptoms may complicate the course of the depression.

Antidepressants are generally required for patients with melancholic depression, and antipsychotics may also be needed. Patients with associated psychotic features will require both antidepressants and antipsychotics.

The Black Dog Institute and beyondblue websites have many downloadable resources for both health professionals and patients on all aspects of depression. MT

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COMPETING INTERESTS: Professor Wilhelm has written material for GP workshops on depression-related topics and also resources that appear on the Black Dog Institute website.