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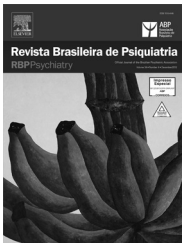

EDITORIAL

Bringing melancholia out of the shadows

For over 2,000 years, a binary model presented two broad contrasting depressive 'types': first, reactive/neurotic depressive states that appeared to be a consequence of life events and predisposing personality traits and second, a depressive 'disease' variably called melancholic, endogenous, vital or Type A depression. Long-held beliefs about melancholia included the presence of a strong genetic component, a foundation in biological factors, and a minimal placebo response rate but treatment specificity (because it is distinctly more likely to respond to physical treatments, such as antidepressant drugs, than to psychotherapy).[1]

The classification of depression moved to a dimensional model following the introduction of the DSM-III in 1980, with depressive conditions defined as 'major' or 'minor'. The DSM-III and DSM-IV decision rules indicate that individuals meeting the criteria for major depression may be assigned to the 'with melancholia' classification if they meet several criteria. This editorial argues that the criterion list is problematic. The first criterion, 'distinct quality' is quite vague; it is defined as a mood state that differs from grief, which is essentially a negative definition (akin to defining soccer as not tennis). Empirical studies show that the phrase is variably interpreted by clinicians.[2] A second criterion ('excessive or inappropriate guilt') is similarly vague, particularly because most clinically depressed patients have some level of guilt. Other 'melancholic' symptoms (e.g., psychomotor disturbance, anhedonia, weight loss and excessive guilt) are also criteria for major depression. Because only four of these symptoms are needed for melancholia (although each is a criterion for major depression), DSM-IV melancholia overlaps with major depression.

There are multiple consequences of this classification. First, the DSM criteria risk over-diagnosing melancholia. Second, the failure to separate melancholia ensures that studies seeking to differentiate melancholic from major depression based on clinical features, causes and treatment responses are doomed to be compromised.

It seems unlikely that the DSM-5 will redress these concerns. Despite advocacy[3] for positioning melancholia as a distinct depressive condition with criteria independent of those that define major depression, the DSM-5 architects have stated that the criteria and positioning of melancholia will remain unchanged. It would be unfair to address these concerns only to the DSM-5 process when the definition of melancholia (whether by symptom indices or by measures of 'signs') has failed to generate a criteria list or measure that is sufficiently precise to satisfy clinicians and researchers. Over the last three decades, our research group has pursued numerous definitional approaches. Our most recent strategy incorporates criteria related to both symptoms and the course of illness (rather than symptoms alone). This strategy has been quantified as having high classificatory success in the recently published development study[4] describing the 'Sydney Melancholia Prototype Index'. Because this index is designed to assist clinicians and researchers in defining melancholia, its evaluation in differing regions and cultures will be important. The long-standing interest in melancholia shown by many South American psychiatrists supports the consideration of the utility of this measure at both clinical and research levels.

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Disclosures

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**** Significant. Amounts given to the author's institution or to a colleague for research in which the author has participation, not directly to the author.*

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