FC58. Aspects of affective disorders

Chairs: B Müller-Oerlinghausen (D), LV Kessing (DK)

FC58-1

DETECTION OF DEPRESSIVE SYMPTOMS IN THE ELDERLY: THE IMPACT OF COGNITIVE DECLINE UPON THE PERFORMANCE OF SCREENING INSTRUMENTS

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Objective: To determine the presence of depressive symptoms and major depressive disorders in an epidemiological sample of elderly community residents. The influence of cognitive decline on the performance of instruments screening for depression was additionally examined.

Methods: 287 subjects out of the general population aged 60–99 years were personally interviewed with standardized diagnostic tools and completed both the short version of the General Health Questionnaire (GHQ-12) and the Center for Epidemiologic Studies - Depression Scale (CES-D). The perfomance of the questionnaires was assessed by receiver operating characteristics (ROC) analysis.

Results: Using strict diagnostic criteria, the prevalence of major depressive disorders was 3.5%. Single depressive symptoms were far more prevalent. The presence of cognitive decline reduced the specificity of the CES-D, whereas the performance of the GHQ-12 remained unaffected.

Conclusions: The study revealed a discrepancy between the prevalence of major depressive disorders and single depressive symptoms in a sample of older community residents. Special attention should be paid to the presence of cognitive decline when screening for depression in the elderly. Cognitive decline may affect the results of screening instruments and lead to erroneous prevalence rates.

FC58-2

THE PSEUDODEMENTIA SCALE

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Background: Reviewing the literature to gather all the claimed discriminating points to differentiate between dementia and pseudodementia, and subsequently test their discriminating power in a prospective study. Finally a simple scale was created from these discriminating points to help the clinicians in a pretreatment assessment to differentiate between organic dementia and depressive pseudodementia.

Method: 128 patients who were referred to our service with a differential diagnosis depressive pseudodementia were screened for dementia and depression. A check list of forty four characteristic features (in the form of questions that have answers yes or no) which was claimed in the literature to differentiate between dementia, depression and pseudodementia were administered to identify the most discriminating points.

Results: Forty points (questions) out of the forty four in the checklist showed high discriminating points to differentiate dementia from depressive pseudodementia ($P < 0.01$) by fisher's exact test. Principal component and factor analysis were used to identify the variables (discriminating points) that get high coefficients in the first principal component. Eighteen discriminating points were identified to discriminate accurately between groups and would classify 98% of dementia cases correctly and 95% of depression correctly. These eighteen discriminating points were used to create the pseudodementia scale that will be a simple tool in a pretreatment assessment to differentiate between organic dementia and depressive pseudodementia. The Pseudodementia scale showed two principal advantages over the widely used MMSE. First it covers a broader range of cognitive function especially remote memory and frontal lobe function. Second it detects mild degrees of cognitive impairment.

Conclusion:

- Dementia could be differentiated from Depressive Pseudodementia on clinical grounds only.
- The Pseudodementia Scale is a simple tool to identify the Pseudodementia Syndrome but needs to be tested on a new population.

FC58-3

ANHEDONIA AND PSYCHOMOTOR CHANGES IN DEPRESSION

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Objective: Anhedonia, the inability to experience pleasure, and changes in psycho-motor functions are fundamental psychopathological phenomena in major depression (ICD-10, DSM-IV). Subjectively experienced anhedonia and observer rated psycho-motor phenomena may have common underlying neurobiological mechanisms. However, the relationship between these two clinical features remains unclear because of inadequate psychometric instruments.

Methods: Patients ($n = 48$), who fulfilled diagnostic criteria for major depression (DSM-IV) were included. Severity of depression was assessed using the observer rated Hamilton-Depression-Scale (HAMD) and self rated Multiple Affective Adjective Checklist (MAACL/BfS) Psycho-motor changes were rated using a modified Psychomotor Scale (PSYMOS) (CORE, Parker et al. 1994) and anhedonia using the German version of the Snaith-Hamilton-Pleasure-Scale (SHAPS- D), a recently introduced, practical self-rated scale (Snaith et al. 1995).

Results: Scores of HAMD (21.3 ± 5.8) and SHAPS-D (7.5 ± 2.2) did not correlate significantly ($r_s = 0.23$, $p > 0.05$). However, SHAPS-D scores (7.5 ± 2.2) correlated significantly with MAACL/BFS scores (28.3 ± 12.4) ($r_s = 0.82$, $p < 0.01$) and with the retardation factor scores of HAMD (8.7 ± 3.1) ($r_s = 0.54$, $p < 0.05$) and PSYMOS (14.3 ± 5.4) ($r_s = 0.78$, $p < 0.001$).

Conclusions: Subjectively experienced anhedonia correlated with self-rated, but not observer rated global severity of depression. There was a significant correlation between experienced anhedonia and observer rated psycho-motor changes assessed with specific psychometric instruments (SHAPS-D, PSYMOS). The German version of the SHAPS (SHAPS-D), a practicable instrument to assess anhedonia which distinguishes healthy from depressive subjects, seems to be a promising tool for psychopathological research to compare subjective symptoms with objective motor signs in depression (PSYMOS). These instruments may be useful clinical tools for further studies of neurobiological mechanisms underlying anhedonia and psycho-motor changes in depression.